

<b>Title:</b> The Care Act 2014: Regulations and guidance for implementation of Part 1 of the Act in 2015/16 <b>IA No:</b> 6107 <i>This replaces previous IA number 6107, last updated on 23/05/2014.</i> <b>Lead department or agency:</b> Department of Health <b>Other departments or agencies:</b>	<b>Impact Assessment (IA)</b>			
	<b>Date:</b> 16/10/2014			
	<b>Stage:</b> Final			
	<b>Source of intervention:</b> Domestic			
	<b>Type of measure:</b> Primary legislation			
<b>Contact for enquiries:</b> Phillip Anderson 020 7210 5696 (policy) Francis Dickinson 020 7210 5441 (analyst)				
<b>Summary: Intervention and Options</b>				<b>RPC Opinion:</b> 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, One-Out?	Measure qualifies as
£19,373.1m	£0	£0	No	N/A

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

The legislative framework for adult care and support in England is outdated. It focuses on crisis intervention rather than prevention and early intervention; and it is focused on the provision of services rather than supporting the system to be centred around the health and wellbeing of people and carers. It therefore does not reflect the modern priorities of care and support and is in need of reform.

The current legal framework contains many gaps and is confusing for those who deliver and manage the service, and for individuals receiving services or trying to understand their own entitlements. Government intervention is required to reform the entire legal framework to fit the purpose of modern care and support.

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

The primary objective of the policy is to modernise the legal basis for adult care and support in England, to provide a statute that ensures direction and leadership is provided within a strong, single legislative framework. This will make the law easier to understand and apply, and will bring greater clarity, consistency and equality of access to care and support. The intended effect is also to improve the outcomes and experience of care, and secure a more effective use of public and community resources by improving the personalisation of services, giving people more choice and control over how their desired outcomes are achieved.

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

Two options have been considered:

- Option 1: Do nothing. This would mean retaining a complex and confusing legal framework. This option will not support the current and proposed system of care and support, creating unnecessary burdens on local authorities and people wishing to access services.
- Option 2 (preferred option): Simplify legislation, consolidating and updating the existing legislation to clarify local authority responsibilities and individual entitlements to care and support.

<b>Will the policy be reviewed?</b> Yes					
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.	<b>Micro</b> No	<b>&lt; 20</b> No	<b>Small</b> No	<b>Medium</b> No	<b>Large</b> No
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)			<b>Traded:</b> 0	<b>Non-traded:</b> 0	

*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 Minister: 

**Summary: Analysis & Evidence**

Description: MODERNISE CARE AND SUPPORT LEGISLATION

Date: 20/10/2014  
Policy Option 1

Price Base Year 2015	PV Base Year 2015	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: -	High: -	Best Estimate: 12,372
<b>COSTS (£m)</b>	<b>Total Transition</b> (Constant Price) Years		<b>Average Annual</b> (excl. Transition) (Constant Price)		<b>Total Cost</b> (Present Value)
Low	-		-		-
High	-		-		-
Best Estimate	-51.3		-394.5		-3457.4
<b>Description and scale of key monetised costs by 'main affected groups'</b>					
The main costs relate to improved legal rights for carers (rising to £175m pa). There may be additional costs for example where local authorities face increased demand for services due to improved information. Cost savings are also identified in relation to public expenditure savings of improved support for carers. These cost savings outweigh other new costs overall. All the costs detailed fall on the Government and will be fully funded.					
<b>Other key non-monetised costs by 'main affected groups'</b>					
Direct costs where identified have been monetised. These improvements should also allow for more effective and efficient service planning, but might identify additional need. There may be additional costs where local authorities for example have increased demand for services due to improved information. These costs are discussed in more detail in the sections below.					
<b>BENEFITS (£m)</b>	<b>Total Transition</b> (Constant Price) Years		<b>Average Annual</b> (excl. Transition) (Constant Price)		<b>Total Benefit</b> (Present Value)
Low					
High					
Best Estimate	0		1,952.5		22,885.7
<b>Description and scale of key monetised benefits by 'main affected groups'</b>					
The monetised benefits relate to quality of life gains for carers from improved legal rights and improved access to support. There are also likely to be benefits to local authorities through better coordination, more proactive, preventative measures and planning of care and support functions, for example preventing crisis and escalation of need, including via improving information, personalisation, and assessment of carer need. Monetisable benefits are set out in more detail below.					
<b>Other key non-monetised benefits by 'main affected groups'</b>					
People with care and support needs will benefit from improved wellbeing, better prevention of care and support need, greater clarity, consistency and equality of access to care and support and reduction of unmet need. Improved information, advice and cooperation between organisations will help people to navigate the system more easily and with greater freedom, flexibility and choice. This will improve the outcomes and experiences of people who use care and support services, carers and their families.					
Key assumptions/sensitivities/risks					<b>Discount rate (%)</b> 3.5%*
The Care Act reforms and modernises the legal framework, including powers to make regulations and statutory guidance. Many impacts on local authorities cannot be considered until regulations have been made and hence further impact assessments will be required. Proposals assume commencement of legislation from April 2015, but are subject to Parliamentary approval. (*Benefits discounted at 1.5%)					

#### BUSINESS ASSESSMENT (Option 1)

<b>Direct impact on business (Equivalent Annual) £m:</b>			<b>In scope of OIOO?</b>	<b>Measure qualifies as</b>
<b>Costs:</b> -	<b>Benefits:</b> -	<b>Net:</b> -	No	N/A

# Evidence Base (for summary sheets)

## Introduction

This impact assessment provides analysis of the costs and benefits of the Government's intention to reform the existing legal framework relating to care and support in Part 1 of the Care Act. It relates to the costs and benefits of the specific reforms which are to be implemented, through the Act and supporting regulations and guidance, in April 2015.

It should also be read in the context of the May 2011 report of the Law Commission<sup>1</sup> and the accompany consultation impact assessment<sup>2</sup>, the recommendations of which have greatly influenced the approach to reforming legislation.

These proposals do not involve any additional regulatory measures that impose costs on business or civil society. The changes to the law proposed in the Care Act relate to the responsibilities of local authorities and other public sector partners for planning and commissioning of adult social care services and for meeting the needs of their local population. All the costs that fall on Government will be fully funded.

The specific areas considered by this impact assessment are noted below.

### 1. Consolidation and modernisation of the legal framework

This section of the impact assessment considers areas which are included in Part 1 of the Care Act and supporting regulations and guidance, and which are the result of:

- i. consolidation of existing law – replacing existing provisions with updated provisions that retain the same effect and do not expand the statutory requirements or costs on local authorities; or,
- ii. modernisation of the legal framework – bringing into the statute existing practice and priorities which are not currently reflected in the existing legislation, and whose inclusion does not create new costs for local authorities.

In this section, all proposals noted do not represent a change in policy or create substantial new costs on local authorities (with the exception of potential minor transitional costs). This section considers proposals related to Sections 1-8, 14, 17-19, 21-27, 30-33, 39-41, 58-66 and 69-70, 73-75 and 77-79.

### 2. Substantial policy reforms

This section of the impact assessment considers in more detail the most substantial policy reforms in Part 1 of the Care Act, the supporting regulations and guidance. This covers areas which include new or amended legal provisions and represent the most significant costs to local authorities:

- 2A. Assessment, eligibility and continuity of care (Sections 9, 11-13 and 37-38)
- 2B. Assessment and provision of support for carers (Sections 10 and 20)
- 2C. Access to independent advocacy (Sections 68-69)
- 2D. Care and support for people in prison and approved premises (Section 76)
- 2E. Safeguarding adults from abuse and neglect (Sections 42-47)
- 2F. Implementation of legal reform
- 2G. Provisions relating to the universal deferred payment scheme (Sections 34-36);
- 2H. Provisions relating to oversight of the care and support provider market and responsibilities for continuity of care in the case of provider failure (Sections 48-57).

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<sup>1</sup> [http://lawcommission.justice.gov.uk/docs/lc326\\_adult\\_social\\_care.pdf](http://lawcommission.justice.gov.uk/docs/lc326_adult_social_care.pdf)

<sup>2</sup> [http://lawcommission.justice.gov.uk/docs/lc326\\_adult\\_social\\_care\\_impact\\_assessment.pdf](http://lawcommission.justice.gov.uk/docs/lc326_adult_social_care_impact_assessment.pdf)

***This impact assessment does not consider the provisions to reform the funding system for care and support (Sections 15-16, 28-29 and 71-72), which are to be implemented in 2016/17 and will be the subject of a separate assessment, when proposals are published for consultation later in 2014.***

The tables below summarises the costs, savings and monetised benefits identified in this impact assessment, and referred to in the relevant sections which follow.

**Table 1 – Overview of costs and savings**

<i>£ million, 15/16 prices</i>	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	after 24/25	Total
<b>Continuity of care</b>												
Total recurring costs	4.4	9.9	13.4	13.4	13.4	13.4	13.4	13.4	13.4	13.4		121.9
<b>Eligibility threshold – extra assessments</b>												
Total transition costs	3.0											3.0
Total recurring costs	25.3	25.3	25.3	25.3	25.3	25.3	25.3	25.3	25.3	25.3		253.2
<b>Support for carers - assessments</b>												
Total recurring costs	31.3	36.6	41.8	41.8	41.8	41.8	41.8	41.8	41.8	41.8		402.3
<b>Support for carers - services</b>												
Total recurring costs	73.3	187.4	233.3	247.5	251.0	251.0	251.0	251.0	251.0	251.0		2247.5
Recurring savings	154.7	196.3	282.1	355.7	429.3	429.3	429.3	429.3	429.3	429.3		3564.6
Monetised health benefits	683.7	1607.4	2110.5	2262.9	2308.8	2308.8	2308.8	2308.8	2308.8	2308.8		20517.0
<b>Access to advocacy</b>												
Total recurring costs	14.5	34.6	49.5	67.1	67.1	67.1	67.1	67.1	67.1	67.1		568.0
<b>Care and support in prisons</b>												
Total recurring costs	11.2	10.3	10.3	10.3	10.3	10.3	10.3	10.3	10.3	10.3		104.2
<b>Safeguarding - Boards</b>												
Total recurring costs	6.4	6.4	6.4	6.4	6.4	6.4	6.4	6.4	6.4	6.4		64.2
<b>Deferred Payment Agreements</b>												
Total recurring costs	83.5	121.1	132.1	118.5	87.3	67.7	51.8	45.6	39.2	26.2	-688.6	84.3
Financial transfers to individuals	83.5	121.1	132.1	118.5	87.3	67.7	51.8	45.6	39.2	26.2	-688.6	84.3
Monetised peace of mind benefits	35.6	26.1	32.8	35.5	39.1	38.9	37.7	39.9	41.8	43.4		371.0
<b>Market oversight regime</b>												
Total recurring costs	1.8	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7		17.2
Monetised benefits	12.9	12.9	12.9	12.9	12.9	12.9	12.9	12.9	12.9	12.9		129.0
<b>Implementation of legal reform</b>												
Transition cost total	4.7	2.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		7.0
Opportunity cost	27.6	13.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		41.4
Recurring savings	0.0	0.0	13.6	17.2	17.2	17.2	17.2	17.2	17.2	17.2		134.1
<b>Summary</b>												
<i>£ million, 15/16 prices</i>	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25		Total
Total transition costs	35.2	16.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		51.3
Total recurring costs	251.8	433.4	513.9	532.0	504.4	484.8	468.9	462.6	456.3	443.3	-688.6	3862.8
Total costs	287.0	449.5	513.9	532.0	504.4	484.8	468.9	462.6	456.3	443.3	-688.6	3914.1
Total costs discounted	287.0	434.3	479.7	479.9	439.5	408.2	381.4	363.6	346.5	325.3	-488.2	3457.3
<b>Savings</b>												
Total recurring savings	238.2	317.4	427.8	491.4	533.8	514.2	498.3	492.1	485.7	472.8	-688.6	3783.0
Total savings discounted	238.2	306.7	399.4	443.2	465.2	432.9	405.3	386.8	368.9	346.9	-488.2	3305.2
<b>Monetised benefits</b>												
Total recurring monetised benefits	732.2	1646.4	2156.2	2311.3	2360.8	2360.6	2359.3	2361.5	2363.5	2365.0	0.0	21016.8
Total monetised benefits discounted	732.2	1622.0	2093.0	2210.3	2224.3	2191.2	2157.7	2127.8	2098.1	2068.4	0.0	19525.1
<b>Net Benefit</b>												
Net Benefit	683.4	1514.3	2070.1	2270.6	2390.2	2390.0	2388.7	2391.0	2392.9	2394.5		20885.7
Net Present Value (net Benefit discounted)	683.4	1494.4	2012.6	2173.6	2250.0	2216.0	2181.6	2150.9	2120.4	2090.0		19373.1

## 1. CONSOLIDATION AND MODERNISATION OF LEGISLATION

### Background – case for change

- 1.1 How adult care and support is defined and delivered is determined by the law which underpins it. The key elements, including the responsibilities of those who commission and provide care and support, the range of support available and the rights of people who use care and support, are established in statute. Well-crafted legislation makes a fundamental difference to the ease of implementation on the ground and the clarity provided for professionals and the public.
- 1.2 Unfortunately, the current legal framework is anything but well-crafted and has been roundly criticised as opaque, complex and anachronistic. Over 60 years, a patchwork of legislation has grown and evolved. There are well over a dozen existing Acts of Parliament and there is much overlap and duplication between the various statutes. In addition to the primary legislation, there is a vast array of regulations, directions, circulars and guidance. The net result is complexity and confusion for those who have to navigate through the law – including social workers, care users and carers.
- 1.3 The Law Commission acknowledged this problem and conducted a three-year review into social care legislation. In May 2011, it published its report with 76 recommendations for reform to Government.
- 1.4 The law provides the underpinning framework for care and support and is critical to the way care is delivered on a day-to-day basis to people who need it. It therefore needs to align with and support the Government's policy objectives for adult care and support. The law has failed to keep pace with the shared ambitions of Government, the care sector and people who use care and support. Moreover, ONS population projections suggest that the number of people aged 85 and over will rise from 1.3m in 2008 to 3.3m in 2033, suggesting that a failure to act now will only exacerbate the problems already encountered.
- 1.5 As a result of its piecemeal development, the current legislation also has significant gaps and fails to reflect existing care and support priorities and established practice. The most significant gaps are:
  - the absence of clear underlying principles to reflect the modern focus of care and support upon the promotion of individual well-being and prevention of need;
  - a lack of focus on or support for local authority relationships with other organisations and the need to join up services;
  - outdated and limited provisions which restrict access to universal information and advice on care and support;
  - failure to reflect local authority responsibilities to promote diversity and quality in the care and support provider market;
  - the legislative framework does not support the cultural and systemic change needed for personalisation and self-directed support; and,
  - a lack of provisions to support transition into adult care and support for children.
- 1.6 These are discussed in turn below.

***The absence of clear underlying principles to reflect the modern focus of care and support upon the promotion of individual well-being and prevention of need***

- 1.7 As set out in the Government's *A Vision for Adult Social Care*, a considerable proportion of care needs could be avoided, reduced or delayed as a result of earlier intervention.<sup>3</sup> The *Vision* stated that prevention is best achieved through community action working alongside statutory services, and described local government's role as being a catalyst for social action. The *Vision* described carers as the first line of prevention and articulated the need to properly identify them and offer personalised support.<sup>4</sup>
- 1.8 During the *Caring for our future* engagement, we heard that the current system is geared too much towards intervention at the point of crisis rather than helping individuals to postpone or prevent the onset of illness or loss of independence. Assessment and eligibility systems focus on whether people are 'needy' enough to be in the system. A recent DH survey suggested that around 80% of local authorities currently set their eligibility criteria threshold at substantial or critical levels of need, meaning that they do not make support available to people who are assessed as having moderate or low needs. Only 2% provide funding at "low" levels, indicating that investment is not focused on avoiding people's needs from getting worse. Support for people to be proactive in early planning of their care needs helping them navigate the system that can be confusing. However, many local authorities do invest and there are good practice examples of local authorities investing in prevention and early intervention measures.
- 1.9 A health and social care system that intervenes at crisis points rather than in a preventative manner is likely to deliver poorer outcomes. For example, too many older people are admitted to hospital as emergencies that could be avoided if the right community services were in place.<sup>5</sup> It should be noted that there is a scarcity of evidence on the cost-effectiveness of prevention.
- 1.10 Current barriers to an improved focus on prevention include:
- Risk aversion - local authorities see it as risky to spend on lower need rather than higher need;
  - Pressure on resources - immediate needs are prioritised over longer term prevention;
  - Barriers in shifting expenditure upstream, and concerns that prevention requires new investment leading to double running rather than divestment to a strategic prevention shift;
  - Difficulties in identifying and targeting who can best benefit from prevention; and,
  - Difficulties in measuring success.

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<sup>3</sup> Department of Health, *A Vision for Adult Social Care: Capable Communities and Active Citizens*, 2010.

<sup>4</sup> Proposals to further support and improve outcomes for carers are discussed in more detail in the corresponding IA "Assessment, eligibility and portability for care users and carers".

<sup>5</sup> Department of Health, *Shaping the future NHS: long term planning for hospitals and related services consultation document on the findings of the national beds inquiry*, 2000.

***A lack of focus on or support for local authority relationships with other organisations and the need to join up services***

- 1.11 Government intervention is required to remove organisational barriers to greater integration. This should facilitate increased joint commissioning across health, social care and public health and allow for the implementation of services that use the “whole person” approach. Incentives for individuals to take preventative steps should also be improved – for example by linking duties to integrate explicitly to a focus on preventing or reducing needs.
- 1.12 It is likely to be more efficient for Government to disseminate best practice on integration and prevention than for local areas to work alone to identify which models of integration work better. However, we recognise that local authorities are best placed to determine what approach works best for their population and they will continue to have flexibility to adapt and adopt approaches to integration to suit local circumstances.

***Outdated and limited provisions which restrict access to universal information and advice on care and support***

- 1.13 The availability of information and its quality is a critical enabler for both consumers and commissioners to make choices and drive up quality. Better access to information can play an important role in enabling greater collaboration at local level. Together, increased access to quality information and joined up working across local public services can support better planning and prevention and enable more personalised approaches to care.
- 1.14 However, rather than being shaped around the needs of individuals, services have tended to develop based on systems, structures and funding flows. There are still significant barriers preventing people from having choice and control over how they are supported to achieve their desired outcomes. This has affected the extent to which care and support is personalised and integrated with other public services, with consequential implications for quality of outcomes, user experience and efficient use of public resource.
- 1.15 Government needs to provide coordination and direction to ensure more consistent, comprehensive and joined-up access to information at the local and national levels to help inform people about the benefits of support and advice, and reduce the costs of searching for information, which is often required at short notice.

***Failure to reflect local authority responsibilities to promote diversity and quality in the care and support provider market***

- 1.16 The *Caring for our Future* White Paper set out the government’s intention to promote a diverse market of high quality care and support services, to improve service quality through individual choice and control.
- 1.17 A well-functioning market should match services to the needs and demands of users, efficiently and effectively. Where there is demand backed by willingness to pay, quality should increase. This is the same for care and support as in other markets. The effectiveness of the care market has significant implications for individuals, families, providers and local authorities.



1.18 In particular:

- Individuals and families benefit from having a variety of services to choose from because this allows them to tailor their care package to achieve the outcomes they want. Being able to select services that are appropriate for them should have a positive effect on levels of user satisfaction, as set out above.
- The Government has set out its ambition for at least 70% of people receiving care and support to be able to access a personal budget by 2013. However, feedback from the *Caring for our future* engagement suggested that even when people are given access to a personal budget, many struggle to find services to meet their needs.
- Carers have consistently highlighted a lack of suitable, high quality services.<sup>6</sup> Carers have said that a paucity of suitable services can mean that they can have to care for more hours than they would ideally like too. As such, improving the range of services on offer should help better meet carer needs.<sup>7</sup>
- It is in the interests of providers to be able to operate within an effective market – one that enables them to make reasonable returns on capital by effectively matching their services to demand. Around 92% of care home places are now provided by the independent sector in the UK and 81% of home care purchased by councils in England is provided by the independent sector.<sup>8</sup> This Act helps providers to match their services to demand by requiring local authorities to consider current and likely future demand for services, and how providers might meet that demand.
- The wider financial services sector who lend money to companies, company shareholders and the markets want to have the reassurance of an effectively operating framework and see a reasonable return on capital.

1.19 However, evidence suggests that there are a number of barriers that prevent the care market from operating as well as it could and as such, it may not be delivering the best possible outcomes for individuals, carers and families.

1.20 There are many reasons why care and support does not meet expectations and why the market could operate more effectively, as highlighted by the *Caring for our future* engagement. These include:

- i. Variation in the quality of care purchased as a result of commissioning strategies.

In December 2009, the Care Quality Commission (CQC) published analysis of local authority commissioning practices which found that the proportion of council-supported residents in care homes rated good or excellent varied by authority from 45% to 97%, indicating a wide variety in the quality of care received.<sup>9</sup>

Although there can be reasonable variability between local authorities, the extent of the variation implies inconsistency in the effectiveness of commissioning strategies. In some areas at least, providers are not

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<sup>6</sup> Evidence given to the Dilnot Commission by charities representing carers.

<sup>7</sup> Further proposals to improve support for carers are discussed in the corresponding Impact Assessment “Assessment, eligibility and portability for care users and carers”.

<sup>8</sup> Laing & Buisson, Care of Elderly People Market Survey, 2012/13.

<sup>9</sup> Care Quality Commission, “Our statement on the quality of adult social care”, December 2009.

sufficiently incentivised to improve service quality. As well as reducing variation between areas, our proposals should shift the mean and improve the absolute levels of quality.

- ii. A lack of information for people who require care and support services on the services available, and for providers on the demand for services that they need to meet.

Feedback from the Caring for our future engagement and the consultation on the Care and Support Act indicated that a lack of comparable information for care and support users and carers makes it difficult to distinguish between care providers. Information is available on whether a care provider meets the 'essential standards' set out by the CQC, but there is no information on the quality of a provider, for example how satisfied users and carers were.

The engagement suggested this disadvantages both people accessing the care and support system and also providers. It means that users and carers are not sufficiently empowered to make informed choices at a time when individuals are becoming increasingly responsible for buying their own care. Care providers do not have an incentive to improve the quality of the care they offer, as they cannot demonstrate to potential customers what improvements have been made.

***The legislative framework does not support the cultural and systemic change needed for personalisation and self-directed support***

- 1.21 There are a number of cultural and organisational barriers to progress in local authorities making a universal offer of self-directed support to people using care and support. Reasons might include: perceived higher costs; low priority given to this principle by councils; inertia; vested interest; or the perception by individuals that a higher workload is required by a more responsive and flexible service.<sup>10</sup>
- 1.22 The current legal framework does not require councils to provide personal budgets. As the law stands, local authorities have had a power to offer direct payments since 1997, but individuals with eligible needs can only request, not demand them. If a local authority does not want to offer a direct payment, an individual can be refused. Personal budgets do not currently exist in law and the term currently only describes where a notional sum for care is allocated to an individual.
- 1.23 Individuals may therefore lack the knowledge, power or influence to encourage councils to change. Individuals may be put off by the perceived potential complexities of decision-making in relation to personal budgets and personalised support planning.
- 1.24 The absence of a clear statutory framework makes it difficult to set a consistent expectation of local authorities that all services should be personalised. Some are already making great strides in this area but legislation is required to make personalised care common practice.

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<sup>10</sup> Audit Commission reports, *Improving Value For Money in Adult Social Care*, June 2011 and its earlier report *Financial Management of personal budgets* which said that whilst personal budgets were unlikely to produce significant cash savings, satisfaction and outcomes were improved. Overall 'personal budgets offered improved outcomes for a similar or slightly reduced spend'.

- 1.25 Not all groups of users are able to access personal budgets and direct payments. Current regulations do not allow those in long-term residential care to access direct payments. This disparity in access to personalised support was highlighted during the *Caring for our future* engagement and chimes with the Law Commission's view that choice and control should not be limited only to people in community settings. Some local authorities have begun to introduce Individual Service Funds (ISFs) as a personal budget option for people in residential settings (mainly adults of working age with complex packages) who have some (limited) control over the delivery of their care and support, but progress has been slow.
- 1.26 Access to quality information and advice is crucial to support people to make informed choices both before and once they need care and support (this is explored in more detail below). This applies to both those receiving care and support from their local council and those funding their own care. However, evidence suggests that there is inadequate provision of information to both state-funded care users and in particular to people funding their own care.<sup>11</sup> Many self-funders do not access local authority information or take up assessments as they receive no support due to their financial position.
- 1.27 Evidence from the *Caring for our future* engagement, supported by research from the Personal Outcomes Evaluation Tool, showed that people were much more likely to take control of their care and support funding through a direct payment if they had received support with making choices about the care they wanted, and with articulating how that care should help them achieve their goals.<sup>12</sup> Such help might take the form of 'brokerage' or representation. However, the coverage of this type of support is variable across the country – and very often people who are funding their own care and support will not have access to it.

### ***Lack of provisions to support transition into adult care and support for children***

- 1.28 There are well-documented<sup>13</sup> issues associated with the transition between children's services and adult services. One such issue is a gap in provision often described as the 'cliff edge'<sup>14</sup>. An independent report commissioned by the Department of Health referred to the "considerable evidence from research that for most young people with disabilities the process of transition from child to adult services is problematic"<sup>15</sup>. Policy documents and guidance also refer to

<sup>11</sup> National Audit Office, *Oversight of User Choice and Provider Competition in Care Markets*, September 2011 - "...69 per cent of those funding their own care do not feel sufficiently informed about the financial implications of long-term care." and "Users report very different levels of support across local authorities, and best practice in implementing personal budgets is not as widely shared as it needs to be."

<sup>12</sup> In Control, *Personal Outcomes Evaluation Tool*, 2011.

<sup>13</sup> Including : Models of Multi-agency Services for Transition to Adult Services for Disabled Young People and Those with Complex Health Needs: Impact and costs (SPRU, 2010) P. Sloper, J. Beecham, S. Clarke, A. Franklin, N. Moran and L. Cusworth, University of York. <http://php.york.ac.uk/inst/spru/pubs/1888/>; Transition to Adult Services and Adulthood for Young People with Autistic Spectrum Conditions FINAL REPORT ( Bryony Beresford, Nicola Moran, Tricia Sloper, Linda Cusworth, Wendy Mitchell, Gemma Spiers, Kath Weston and Jeni Beecham, 2013) <http://www.york.ac.uk/inst/spru/pubs/pdf/TransASC.pdf> ; Don't Let Me Down: Ensuring a good transition for young people with palliative care needs. (Marie Curie Cancer Care and Together for Short Lives , 2012) <http://www.mariecurie.org.uk/Documents/press-and-media/News-Comment/Dont-Let-Me-Down.pdf>

<sup>14</sup> <http://www.mariecurie.org.uk/Documents/press-and-media/News-Comment/Dont-Let-Me-Down.pdf> (See p10)

<sup>15</sup> Transition to Adult Services and Adulthood for Young People with Autistic Spectrum Conditions FINAL REPORT ( Bryony Beresford, Nicola Moran, Tricia Sloper, Linda Cusworth, Wendy Mitchell, Gemma Spiers, Kath Weston and Jeni Beecham, 2013) <http://www.york.ac.uk/inst/spru/pubs/pdf/TransASC.pdf>

the issue<sup>16</sup> and individual stories, including those gathered by the Preparing for Adulthood programme,<sup>17</sup> provide an illustration of the importance of the transition process for young people and the benefits of planning and preparation.

## Policy objective

1.29 Our aims in reforming the law relating to care and support are to:

- *Modernise* the legal basis to reflect the Government's ambitions for personalised adult care and support:
  - Refocus the law around the person, not the service, by enshrining new statutory principles that place the wellbeing of the individual at the heart of individual decisions about care.
- *Simplify* the law into one single statute for adult social care, supported by clear regulations and a reformed bank of statutory guidance in one place:
  - Develop a more transparent framework, which simplifies practice for care professionals, reduces burdens, and empowers individuals to better understand their rights and responsibilities.
- *Consolidate* all existing legislation and repeal old statute dating back over 60 years:
  - Incorporate existing powers for local authorities where they fit with the modern service, whilst bringing the provisions up to date and creating a new statutory framework for adult safeguarding.
  - Rationalise and remove unnecessary top-down controls or restrictions to allow services to innovate and meet the changing needs of local populations.

1.30 The law should recognise that the guiding principle of care and support is to promote the wellbeing of the individual, with a focus on the person and their needs, choices and aspirations, rather than the service or the local authority.

1.31 The law should reflect the modern priorities and focus of care and support. In order to best aid implementation, the law must capture the key functions and responsibilities of local authorities, and support better understanding of individual entitlements. Our objective is to reform the entire legal framework to meet this challenge, and to put in place a sustainable framework which underpins the future of the system.

1.32 The Care Act, as well as the associated regulations and statutory guidance, has been the subject of robust consultation with local authorities, professionals, stakeholder groups and many others to ensure that the all impact of these reforms are assessed as robustly as possible and based on a thorough understanding of current practice. Many of the chapters of guidance and sets of regulations have had specific reference groups (including local Government representatives) to comment on drafts and eventually agree the final form.

## What policy options have been considered?

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<sup>16</sup> including: Valuing People, DH, 2001; the National Service Framework for Children, Young People and Maternity Services, DH/DfES, 2004; Better Services for People with an Autistic Spectrum Disorder, DH, 2006a; Aiming High for Disabled Children, HM Treasury/DfES, 2007; and Transition: Moving on Well, DH, 2008.

<sup>17</sup> See: <http://www.preparingforadulthood.org.uk/resources/stories>

### **Option 1: Do nothing**

- 1.33 This option would mean retaining the existing law relating to adult social care. There are currently over 30 Acts of Parliament dealing with adult social care. The law is also subject to further direction and approval, with the consequence that a statute by itself may not provide the answer to whether a local authority has a power or a duty to provide services. Further to this, the current statute does not provide a statement of fundamental principles on which legislation is based, to aid interpretation in the implementation and operation of the law.
- 1.34 Doing nothing would mean retaining a complex and confusing legal framework. This option will not support the current and proposed system of care and support, creating further unnecessary burdens on local authorities and people wishing to access care and support services.

### **Option 2: Consolidate and modernise the legal framework (preferred option)**

- 1.35 This option requires the creation of a new, single statute for adult care and support in England, which sets out the responsibilities of local authorities and entitlements of individuals. This new statute will consolidate and replace existing legislation where there remains a rationale for the provisions, and modernise the overall legal framework to reflect the priorities of today's care and support system.
- 1.36 Specifically, the table below this option entails the introduction of legal provisions intended to:

**Table 2: Policy proposals related to consolidation and modernisation of care and support law**

Ref	Policy area	Policy proposals	Section of Act
<i>Modernisation of the legal framework</i>			
1A	Well-being and preventing, reducing and delaying needs for care and support	<ul style="list-style-type: none"> <li>Create a new statutory principle to promote individual wellbeing when taking any step under Part 1 of the Act.</li> <li>Introduce a statutory duty on local authorities to take steps (including but not limited to providing or arranging services) intended to prevent, reduce or delay needs for care and support</li> </ul>	1, 2
1B	Cooperation and integration with other local organisations	<ul style="list-style-type: none"> <li>Place a general requirement on local authorities and relevant partners to cooperate in relation to care and support functions, and clarify local authority duty to cooperate with local service providers.</li> <li>Create an ability for the local authority or relevant partner to request cooperation in relation to an individual case.</li> <li>Place a duty on the local authority to promote integration of care and support services with health and other related services.</li> </ul>	3, 6, 7
1C	Information and advice on care and support	<ul style="list-style-type: none"> <li>Place a duty on local authorities to provide an information and advice service in relation to care and support.</li> <li>Clarify responsibility for supporting access to independent financial advice to enable people to plan for their care.</li> </ul>	4
1D	Promoting diversity and quality in the market of care and support providers	<ul style="list-style-type: none"> <li>Place a duty on local authorities to promote a market of diverse and high-quality range of care and support services in the local area, including a focus on sustainability of the market, local authority commissioning practice and workforce conditions.</li> </ul>	5

1E	Care and support planning, including personal budgets and direct payments	<ul style="list-style-type: none"> <li>Place a duty on local authorities to provide a care and support plan for all those whose needs it will meet.</li> <li>Require that a personal budget be included in such plans, unless specified otherwise.</li> <li>Consolidate rights to a direct payment, and include duties to review the care and support plan.</li> </ul>	24-27, 30-33
1F	Transition for children to adult care and support	<ul style="list-style-type: none"> <li>Provide a duty for local authorities to assess children, young people and young carers in advance of their transition to adult care and support, in order to consider their future needs and support transitional planning.</li> <li>Require local authorities to continue to provide children's services after the 18<sup>th</sup> birthday, where a transition assessment has not taken place and should have done.</li> </ul>	58-66
1G	Delayed discharges	<ul style="list-style-type: none"> <li>Replicate existing framework but with charges discretionary rather than mandatory</li> </ul>	74
1H	Charging and financial assessment	<ul style="list-style-type: none"> <li>Largely replicate existing framework but with a change in policy to more effectively target 12-week disregards</li> </ul>	14, 17
1I	Debt Recovery	<ul style="list-style-type: none"> <li>Provide powers for local authorities to recover debts, for instance where charges for care are not paid</li> </ul>	69-70
1J	Meeting Needs	<ul style="list-style-type: none"> <li>Provide a duty for local authorities to meet needs for care and support above the national minimum eligibility threshold, and a power to meet other needs</li> </ul>	18-20
<i>Consolidation of existing law</i>			
1K	<ul style="list-style-type: none"> <li>entitlements to care and support</li> <li>exceptions to entitlements</li> <li>ordinary residence</li> <li>debt recovery</li> <li>mental health aftercare</li> <li>registers of blind people</li> </ul>	Consolidate existing legal provisions and statutory requirements on local authorities – repeal existing law and re-enact effect of legislation, updating language as necessary.	21-23 39-41 69-70 75 77

1.37 Proposals 1A-1J above relate to the modernisation of the legal framework. These proposals are intended to bring into the statute existing practice and priorities which are not currently reflected in the law, for instance matters which have previously been required by statutory guidance rather than primary legislation.

1.38 Proposal 1K covers a number of issues and provisions related to consolidation of existing law. These matters are all intended to replace existing legal provisions with updated provisions that retain the same effect in law and in practice, and do not expand the statutory requirements or costs on local authorities.

### **Costs and benefits of option 1 (do nothing)**

1.39 The costs of doing nothing would be to perpetuate and exacerbate the issues caused by the existing statute. Without a more coherent, reformed legal framework, current shortcomings will be magnified as more people come into contact with a wide range of care and support services. This implies that without change, more care users will experience problems navigating a complex system, and more people will have unnecessarily poor outcomes. These costs cannot be easily monetised.

1.40 Option 1 (do nothing) would avoid any transitional costs associated with implementation of the new legal framework (see the section on implementation below).

### Costs and benefits of option 2 (preferred option)

1.41 The proposals outlined in option 2 codify existing good practice and therefore to give rise to additional recurring costs on local authorities.

1.42 All individual proposals are intended to either consolidate existing legislation (where provisions are to be replaced and their effect re-enacted in the Care Act) or to codify current local authority practice in the new statute. Some proposals are new to primary legislation, reflecting the fact that statute has failed to keep pace with policy development, but represent established practice which has been required of local authorities by statutory guidance<sup>18</sup>. Table 3 below gives examples of areas in which the law is being updated to capture requirements of statutory guidance, but where we do not expect additional recurring costs. The key pieces of statutory guidance noted are:

- Prioritising need in the context of *Putting People First: a whole system approach to eligibility for social care* (2010)
- Guidance on direct payments for community care, services for carers and children’s services (2009)
- Carers and people with parental responsibility for disabled children (2001)

**Table 3: Example of links to existing statutory guidance**

Policy area	Policy proposal	Existing requirement
Well-being and preventing needs	Duty to take steps intended to prevent, delay or reduce needs for care and support	<i>Prioritising Need...</i> paras 33-40, 112 and 118
Cooperation and integration	Duty to cooperate with relevant partners, and to promote integration with health and related services	<i>Prioritising Need...</i> paras 23, 36-37
Information and advice	Duty to establish information and advice service	<i>Prioritising Need...</i> paras 11, 36, 45, 80, 82, 104, 111, 143 <i>Guidance on direct payments...</i> paras 32-33, 71, 86 <i>Carers...</i> para 99
Market-shaping	Duty to promote diversity and quality in the market of care and support providers	<i>Prioritising Need...</i> paras 37 and 112-118
Care and support planning	Duty to provide care and support plan for those entitled to care and support	<i>Prioritising Need...</i> paras 119-121 and 129-132 <i>Guidance on direct payments...</i> paras 97-98 <i>Carers...</i> para 94
	Duty to provide written record of assessment for those ineligible for care and support	<i>Prioritising Need...</i> para 106
	Duty to provide personal budget for those entitled to care and support (regulations to exclude certain people)	LAC(2009)1: <i>Transforming adult social care</i> <i>Prioritising Need...</i> paras 119 and 127-128
	Duty to keep care and support plan under review (and power to revise)	<i>Prioritising Need...</i> paras 141-151

<sup>18</sup> “Statutory guidance” is that issued by the Secretary of State under section 7 of the Local Authority Social Services Act 1970

Transition to adult care and support	Duty to assess children and young people under adult care law in advance of 18 <sup>th</sup> birthday, and duty to continue children's services where a transition assessment has not taken place and should have done	<i>Prioritising Need...</i> paras 24-28 and 135-140
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1.41 The following paragraphs consider costs and benefits related to each of the proposals 1A-1H noted in Table 4 above.

**1A. Well-being and preventing, reducing and delaying needs for care and support**

1.43 The duty to take steps to prevent, reduce or delay care and support needs reflects established practice and existing statutory guidance, and codifies such practice in primary legislation, as opposed to extending the scope of local authority responsibilities. The duty to promote an individual's well-being when taking steps or making decisions about them also reflects current practice in local authorities.

1.44 The Secretary of State must have regard to local authorities' duty to promote wellbeing when making regulations or issuing statutory guidance under the new statute.

1.45 The duty on the Secretary of State (provided for in Section 78(3) of the Act) is not expected to give rise to new costs or burdens. When making regulations or issuing statutory guidance, the Secretary of State must in any event consider how those instruments will enable local authorities to meet their statutory requirements, and should not require any action which may lead to a contravention of those requirements. This duty gives statutory expression to this principle as it relates to the local authority duty to promote well-being and through this clarification should provide some small benefits in terms of greater understanding of the new statute, though these are not monetisable.

1.46 As part of the consultative process used to develop regulations and guidance, the Department of Health has satisfied itself that due regard has been given to local authorities' duty to promote wellbeing in all cases.

**1B. Cooperation and integration with other local organisations**

1.47 The Government is committed to encouraging cooperation, integration and joined-up working between local partners across health and social care, and placed a duty on clinical commissioning groups to promote integration of health services with social care and related services<sup>19</sup>. Section 3 of the Care Act places an equivalent duty on local authorities to promote integration of care and support with NHS and related services, to act as a partner provision and further incentivise integration between organisations. Sections 6-7 place duties on local authorities in relation to ensuring cooperation between departments within the authority, and with other public organisations. It also places a reciprocal duty on those "relevant partners" to cooperate in turn with the local authority,

<sup>19</sup> Section 14Z1 of the NHS Act 2006 (inserted by the Health and Social Care Act 2012)



and sets out a non-exhaustive list of other bodies with which local authorities should cooperate, such as providers of services.

- 1.48 The Act does not mandate a particular model of integration or cooperation, so benefits are not easy to estimate at individual level.
- 1.49 We expect that the coherent narrative for integration and partnership working will signal to providers, commissioners and the public that integration will be fundamental to the future of care. Moreover, we expect that taking action in the above-mentioned areas will encourage integration at a number of levels. It will encourage commissioners to source models of care that take their patients through a seamless journey. In turn, this will encourage health and care providers to cooperate across traditional organisational boundaries to offer integrated products.
- 1.50 Evidence from the Integrated Care Pilots (ICPs) evaluation report found no overall significant changes in the costs of secondary care utilisation. However, for case management sites, there was a net reduction in combined inpatient and outpatient costs (reduced costs for elective admissions and outpatient attendance exceeding increased costs for emergency admissions). The evidence from ICPs shows that integrated care can lead to improved quality of life if well led, well managed and tailored to local circumstances and patient needs.<sup>20</sup>
- 1.51 However, improvements are not likely to be evident in the short-term. Evidence from the ICPs supports conclusions made by Ovretveit that savings are not likely in the short-term and certainly not inevitable.<sup>21</sup> However, case management approaches used in the pilots could lead to an overall reduction in secondary care costs. The ICP findings also support the findings of Powell Davies and colleagues, in that the most likely improvements following integrated care activities are in healthcare processes.<sup>22</sup> Improvements are less likely to be apparent in patient experience or in reduced costs.
- 1.52 The duties of cooperation at Sections 6 and 7 are intended to supplement the focus on integration, and mirror similar legal requirements that place a duty to cooperate on certain local public bodies. Such duties are common in public law, and serve as an affirmation of expected practice between partners, without requiring any specific actions or processes to be followed. Consequently, we do not believe that the consolidated duties to cooperate give rise to any new costs or burdens on the local authority and “relevant partners” specified. The cooperation duties do not extend to private sector bodies, such as providers.

### **1C. Information and advice on care and support**

- 1.53 This proposal is focused on maintaining the current, underpinning duty on local authorities to provide information and advice on care and support services in their area. It involves a modernisation of the terminology and a more detailed explanation of what an information and advice service must cover, leaving sufficient leeway for authorities to vary their services based on the local needs

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<sup>20</sup> Department of Health, *National evaluation of the DH integrated care pilots*, 2012.

<sup>21</sup> Ovretveit, J., *Does clinical coordination improve quality and save money?*, Health Foundation, 2011.

<sup>22</sup> Powell Davies, G., Harris, M., Perkins, D., Roland, M., Williams, A., Larsen, K., et al. *Coordination of care within primary health care and with other sectors: a systematic review*, Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine, 2006.

of their population. The Care Act and associated Statutory Guidance modernises and draws together the long outdated duty from the Chronically Sick and Disabled Persons Act and makes connections to the more recent duty in the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012) This provides that local authorities are under a duty to work with their local CCGs, and other partners through the Health and Wellbeing Board to undertake Joint Strategic Needs Assessments for their areas and to develop Joint Health and well-being Strategies. Existing Statutory Guidance published in March 2013 makes clear that the Joint Strategic Needs Assessment and Joint Health and Well-Being Strategies must be published, and have specific regard to “what health and social care information the community needs, including how they access it and what support they may need to understand it”.

- 1.54 Independent Age published a report<sup>23</sup> based on data collected by the Care Quality Commission (CQC) in a review of English social services’ response to people’s ‘first contact’ for information, advice, help or support carried out between December 2009 and August 2010. 152 English social services authorities took part and it involved around 7,500 detailed “mystery-shopping” phone calls. While all authorities provided information and advice services it found a considerable variation in the quality of the information that was provided from area to area. This indicated that while it could be argued that all local authorities were meeting their duty to provide information and advice, the inconsistency of what was being provided and its quality was an issue.
- 1.55 During 2009, and in relation to developing personalisation and transforming adult social care the Putting People First (PPF) consortium, including the Association of Directors of Adult Social Care (ADASS) set out a number milestones<sup>24</sup> to assist Councils gauge both direction and required 'speed of travel' in relation to PPF transformation progress. This was supported by a framework of advice to help local authorities with self-improvement<sup>25</sup>. Putting People First Milestone 4 stated '*That citizens have access to information and advice regarding how to identify and access options available in their communities to meet their care and support needs.*'
- 1.56 Through 2013 wider work has been undertaken by the Think Local Act Personal (TLAP) partnership with local authorities. This has confirmed that authorities are already taking action to improve their local information offers and has resulted in publication of supporting documentation, including Principles for the provision of information and advice. Advice in information needs in adult social care, and thirty case studies of current local authority initiatives to deliver better information and advice. Additional work is being undertaken to support potential efficiencies in delivery through national and local digital strategies, in particular, the improvement of systems and tools for the reuse and automatic updating of national information at the local level.
- 1.57 Evidence also suggests that the quality of local authorities’ approaches to providing online information and advice services can improve outcomes for

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<sup>23</sup> Easterbrook, L., Getting over the threshold for advice: issues arising from the Care Quality Commission's unpublished review of English social services' response to people's 'first contact' for information, advice, help or support, 2011.

<sup>24</sup> <http://www.adass.org.uk/images/stories/Milestones%20for%20PPF%20-%20Final%209.09.pdf>

<sup>25</sup> [http://www.thinklocalactpersonal.org.uk/\\_library/Resources/Personalisation/Personalisation\\_advice/Milestones\\_Self\\_Improvement\\_Letter\\_to\\_Directors\\_16\\_11\\_09.pdf](http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/Personalisation_advice/Milestones_Self_Improvement_Letter_to_Directors_16_11_09.pdf)

people.<sup>26</sup> One example of an outcome which is contingent on the quality of advice is the ease with which people are able to navigate the system to access other forms of support, for instance independent financial advice which may help a person to plan for meeting the costs of their care and support.

- 1.58 As noted above, local authorities are already subject to broad duties to provide information and advice, which can be met through a variety of approaches adapted to local need. This includes information and advice on local care and support services, other community provision, and independent advice and advocacy services, including regulated financial advice. Since the provisions of the Act are intended to clarify and update these existing duties, rather than to expand their scope or place specific additional requirements on the local authority, on the evidence available, we do not expect the duty in itself to give rise to any significant costs.
- 1.59 We do know that information and advice currently provided is of variable quality and inconsistent across local authorities. The *Caring for our Future* White Paper therefore set out a range of national and local actions that should be undertaken to support improvements in information and advice services. This included:
- Introduce a new national care and support information portal including a directory of services;
  - Improve local authorities' web-based information and advice services;
  - Provide additional provision of advice and support to help people arrange care and support;
  - Make clearer the duty for local authorities to share information with individuals, carers and families;
  - Develop and disseminate best practice models for support and representation services.
- 1.60 Although the definition of "information and advice" is to be taken to include services such as brokerage and advocacy, the general duty set out in Section 4 of the Act is not specific as to how local authorities should meet the requirements and which types of service are to be provided. Local authorities should adapt their local information and advice offer to meet the needs of local people, and must ensure that the type and range of information provided is proportionate to those needs. However, the Act recognises that in specific circumstances, to support the involvement of the person in key care and support processes, the provision of an independent advocate should be required. This provision is considered separately, in section 2C below.

#### **1D. Promoting diversity and quality in the market of care and support providers**

- 1.61 We do not identify any significant risks associated with the new legal duty regarding market shaping, as this is intended to codify existing practice and provide further guidance for local authorities on the elements that they should consider when seeking to promote and facilitate a diverse and sustainable market, such as considering the workforce and the well-being of those using the services. This duty will clarify existing practice. Over 80% of care and support provision is now provided by the independent sector. There was a large growth

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<sup>26</sup> [http://www.socitm.net/info/214/socitm\\_insight/182/better\\_connected\\_2013/1](http://www.socitm.net/info/214/socitm_insight/182/better_connected_2013/1)

in private care homes starting in the 1980s, and the market was further stimulated by the Community Care Reforms in the 1990s. This means that for many years local authorities have been commissioning services from a range of providers.

- 1.62 There should be no additional resources required by local authorities, but rather a change in approach to improve commissioning. There may also be additional costs for some local authorities who do not already have in place measures for market shaping. We do not estimate these to be significant and there will be additional support in the form of the £700,000 “Developing Care Markets for Quality and Choice” programme to help local authorities enhance their capability to shape local markets, using local information to produce Market Positioning Statements.

### **1E. Care and support planning**

- 1.63 Under this proposal, legislation would set out that everyone eligible for care and support<sup>27</sup> would be provided with a personal budget as part of a care and support plan, giving them a clear allocation of resources so that they can control as much of their care and support as they wish.
- 1.64 Supported by the proposals on information and advice, these changes in the law, will help to deliver the vital step change required and reduce the scope for variation. A re-designed statute will ensure personalisation is one of the defining features of the care and support system.
- 1.65 Local authorities are already moving towards a more personalised system in line with the *Vision for Adult Social Care*, which set out an ambition for providing everyone eligible with a personal budget by April 2013. This was underpinned by £520m of funding to develop systems to deliver this. Therefore, this does not represent a new burden on local authorities.
- 1.66 A snapshot of local authorities that have fully embraced personalisation do not cite increased costs but highlight the benefit of improved outcomes for people needing care and support.<sup>28</sup> However, the provision of personal budgets varies widely, both geographically and by user group. This is exacerbated by personal budgets having no legal basis.
- 1.67 Perceptions of increased costs can be a barrier to local authorities making progress with personalisation. The IBSEN evaluation found the costs and complexities of implementing individual budgets (where a number of budget streams were brought together from across local and central Government) alongside traditional resource allocation systems and service provision were major challenges.<sup>29</sup> However, it is important to bear in mind not only that these were the experiences of the pilot sites who may have faced difficulties in terms of being early implementers, but also, that the individual budget pilots were dealing with six separate funding streams. Personal budgets involve only one funding stream for adult social care and are therefore much simpler to administer.

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<sup>27</sup> With the exception of emergency and end of life care, advice and one-off pieces of equipment, etc.

<sup>28</sup> Audit Commission, *Improving Value For Money in Adult Social Care*, 2011. Thirty-six per cent of councils cited personalisation as a driver of better value for money in 2009/10. This rises to 45 per cent for 2010/11. Better value came mostly from improved outcomes, not savings.

<sup>29</sup> Glendenning, C. et al, *Evaluation of the Individual Budgets Pilot programme*, IBSEN, York, 2008.

- 1.68 As personal budgets have been in existence since 2008, there is now a wealth of best practice guidance and information sharing on personal budgets for local authorities to access on the Think Local, Act Personal website that should negate these ‘early implementer’ costs. In a survey conducted in 2008 by LGA and ADASS, it was shown that 19 local authorities (13%) already had systems in place for all user groups to receive personal budgets and that 51 (34%) had a system in place only for some people.<sup>30</sup>
- 1.69 Since the survey was conducted in 2008, there has been wider roll-out of personal budgets. Table 4 below compares the extent to which local authorities have rolled out personal budgets in 2010/11 compared to 2008-09. This suggests that by 2010/11, the start-up costs of personal budgets had been borne by most local authorities.

**Table 4: Community based users:**

Proportion of community based users receiving self-directed support	Number of local authorities providing self-directed support to this proportion	
	2008/09	2011/12
5% or less	55	1
5% - 10%	70	0
10%- 20%	24	5
20% - 30%	1	15
30% - 40%		33
40% - 50%		45
More than 50%		50
<b>Total</b>	<b>150</b>	<b>149</b>

Source: Information Centre – National Indicator Set publication and Adult Social Care Outcomes Framework. In 2008/09, there were only 150 councils in total compared to 152 in 2011/12 following a local government reorganisation. Data are missing for three councils in 2011/12.

- 1.70 Where someone receives a personal budget the evidence base suggests they will accrue benefits. Results from a six-month follow-up undertaken by IBSEN with those offered individual budgets showed that 47% of people who had accepted the individual budget reported that their view of what could be achieved in their lives had changed a lot and 19% reported that it had changed a little. A third of this group reported that their view had not changed at all. Older people were significantly less likely than other user groups to report that the process had changed their view on what could be achieved.<sup>31</sup>
- 1.71 Using the social care outcome measure “ASCOT”<sup>32</sup>, IBSEN found that people in the individual budget group were significantly more likely to report that they felt in control of their daily lives (48%,  $p < 0.05$ ) compared with those in the comparison group (41%).
- 1.72 When looking at each user group individually, IBSEN found that although there were some differences between the individual budget and comparison groups for younger physically disabled people, none of them reached statistical

<sup>30</sup> LGA, ADASS, *Putting people first: measuring progress*, 2009.

<sup>31</sup> Please note that proxy interviews were used in 24% of the total cases as some respondents were unable to communicate.

<sup>32</sup> ASCOT (*Adult Social Care Outcomes Toolkit*) <http://www.pssru.ac.uk/ascot/>

Ascot is a measure developed in partnership by PSSRU which can be used to measure an individual's social care related quality of life (SCRQOL) and identify outcomes. A range of instruments and data entry tools are provided which measure SCRQOL and outcomes across 8 key domains (accommodation cleanliness and comfort; control over daily life; dignity; food and nutrition; occupation; personal cleanliness and comfort; safety; and social participation and involvement).

significance. The results suggest that people with learning disabilities in the individual budget group were more likely than those in the comparison group to feel they had control over their daily lives.

- 1.73 The Audit Commission has also recognised the wider benefits of personal budgets that are not confined to care and support outcomes (for example economic growth, increasing employment opportunities).<sup>33</sup>
- 1.74 In Control published the National Personal Budget Survey (also known as the Personal Outcomes Evaluation Tool (POET)) in June 2011.<sup>34</sup> This suggests that personal budgets are likely to have generally positive impacts on the lives of all groups of personal budget holders and the people who care for them. The likelihood of people experiencing a positive impact from a personal budget is maximised by a support process that keeps people fully informed, puts people in control of the personal budget and how it is spent, supports people without undue constraint and bureaucracy, and fully involves carers. Under these conditions, personal budgets can and do work well.
- 1.75 Alongside the findings from POET, the NAO commissioned Ipsos Mori to conduct consumer research, published alongside its report on Care Markets.<sup>35</sup> The evidence from this research supports the Government's policy to encourage more people to take their personal budget as a direct payment as this leads to greater choice and control for users as well as greater creativity.

#### *Impact of Care Act regulations – direct payments*

- 1.76 Direct payments have been around since the mid-1990s, and the Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009 currently provided the legislative framework for direct payments. These regulations will be replaced by the Care Act (Direct Payment) Regulations. The new regulations mainly reflect the current legal provisions of the 2009 regulations, with certain exceptions, outlined below.

#### a) Ability to pay family members living in the same household for administrative/management support

- 1.77 The 2009 Direct Payment Regulations excluded the payment from being used to pay for care from a close family member living in the same household, except in exceptional circumstances. While the Care Act (Direct Payment) Regulations maintains this provision regarding paying a family member living in the same household for care, it does allow for discretion to pay a close family member living in the same household to provide management and/or administrative support to the direct payment holder.
- 1.78 This is intended to reflect the fact that in some cases, especially where there are multiple complex needs, the direct payment amount may be substantial. The management and administration of a large payment, along with organising care and support can be a complex and time consuming task. This new discretion allows family members performing this task to be paid a proportion of the direct payment, similar to what many direct payment holders pay to third-party support organisations.

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<sup>33</sup> Audit Commission, *Financial Management of Personal Budgets*, 2010.

<sup>34</sup> <http://www.in-control.org.uk/media/92851/national%20personal%20budget%20survey%20report.pdf>

<sup>35</sup> Ipsos Mori, *Users of Social Care Budgets*, July 2011.

1.79 Given that direct payment users often contract with third party providers to purchase direct payments management and administration, this should not be an additional burden on local authorities to administer and review as part of their existing care planning and direct payment processes. The decision to pay a family member living in the same household for management of the direct payment should be recorded as part of the planning process.

1.80 This new discretion is not intended to replace the normal family bonds associated with caring. Authorities will need to make this clear to people so that they are aware of the distinction between receiving a nominal amount for providing administrative support and management of the direct payment, and the retained exclusion regarding family members in the same household being paid for care.

#### b) Restrictions on excessive monitoring and curtailment of choice

1.81 The Care Act (Direct Payment) Regulations sets out that the local authority must not design systems that place a disproportionate reporting burden upon the individual and must not limit how a person uses the direct payment. The reporting system should not clash with the policy intention of direct payments to encourage greater choice, autonomy, flexibility and innovation.

1.82 This reflects best practice and the established policy position on direct payments, Therefore, we do not think this reference in legislation creates any additional impacts for local authorities.

#### c) Review of direct payments

1.83 The 2009 Regulations set out that local authorities must also review the making of the direct payment within the first twelve months of making the payment. The Care Act (Direct Payment) Regulations proposes to reduce this period to six months.

1.84 This review is intended to be light-touch to ensure that the person is comfortable with using the direct payment, and experiencing no initial issues. It should be incorporated within the initial review of the care and support plan 6-8 weeks after sign-off. This review is not intended to be a full review of the person's care and support plan.

1.85 We heard through development of the draft guidance and regulations that many local authorities already operate in this manner, and were conducting initial reviews of direct payments much earlier than the previous twelve month limit, often shortly after sign-off of the payment. Therefore, given some of the other changes to direct payments we are proposing, such as the relaxation of the family member rule, we have decided to reduce the time period to conduct the initial review.

1.86 We think this represents current best practice and does not constitute an additional burden on local authorities.

#### *Impact of Care Act regulations – personal budgets*

##### a) Reablement/intermediate care costs excluded from the personal budget

- 1.87 The Care Act [Personal Budget] Regulations set out that the provision of reablement and/or intermediate care to meet eligible needs, must be excluded from the personal budget. This will mean that where reablement/intermediate care is being provided to meet eligible needs (i.e. needs under Section 18, 19 or 20 of the Care Act) the cost of this must not be calculated in the personal budget.
- 1.88 We have always set out that there may be some aspects of care and support provision where personal budgets are not appropriate. Reablement/intermediate care should usually be provided as a free, universal service under Section 2 of the Act, and therefore would not contribute to the personal budget amount (and in future to the cap on care costs). However, in some circumstances, a local authority may choose to combine reablement/intermediate care with aspects of care and support to meet eligible or ongoing needs, which would require a personal budget to be developed. Removing the cost of provision of these services from the personal budget in these scenarios ensures that the allocation of reablement/intermediate care is applied uniformly across all local authorities, and in future people progress towards the cap on care costs in a fair and consistent way.
- 1.89 This represents current practice. The ASCOF definition of personal budgets sets out the reablement should not be incorporated. Therefore, we do not view this as an additional impact on local authorities.

#### ***1F. Transition for children to adult care and support***

- 1.90 As noted at paragraph 1.27, there are well-documented issues associated with the transition between children's services and adult services, often the result of a lack of planning and engagement between different departments in the local authority and with the individual concerned, and their family.
- 1.91 The proposals will place a duty on local authorities to carry out an assessment where it appears that a young person, young carer or the child's carer is likely to have needs for care and support when the child becomes 18, and it would be of "significant benefit" to the person to do so. This will enable transition planning in advance of the young person's 18<sup>th</sup> birthday, if they are likely to need care and support as adults. The Act does not, however, allow for services to be provided to children before their 18<sup>th</sup> birthday.
- 1.92 "Significant benefit" refers to the timing of a transition assessment – it is a deliberately flexible term that avoids placing a prescription on local authorities as to the age at which they must conduct a transition assessment. This recognises the fact that the appropriate age for a transition assessment will vary from person to person. There is thus no burden on local authorities associated with undertaking transition assessments at a particular age and potentially having to reassess later.
- 1.93 We do not expect any additional cost to local authorities associated with this new duty, because it simply codifies best practice without changing the number of people who should be assessed and receive care and support compared to current practice. Assessments should be carried out to support transition to adult care and support in normal practice, as part of the process of transition between children's and adults' services in the local authority. Children already in receipt of services under the Children Act 1989 will already undergo



assessments and reviews as they approach the age of 18 years<sup>36</sup>; this duty is intended to confirm such practice and to allow the local authority to treat assessments undertaken before the 18<sup>th</sup> birthday for the purposes of adult care and support.

- 1.94 We do not expect any additional demand for services as a result of the provision because the cohort of people potentially transitioning to adult care and support will remain the same (allowing for normal fluctuation and demographic changes).
- 1.95 There should be no additional cost to local authorities to carry out assessments. These are not additional assessments. Local authorities are already under duties to carry out assessments of children and young people under children's legislation, and will also be under a duty to carry out an assessment under adult care and support law for those over 18 years with care and support needs. The duty to conduct transition assessments under adult law in the Care Act is to allow for earlier assessments, not additional assessments (i.e. conducted ahead of the 18<sup>th</sup> birthday rather than on or after it), and as such the costs should be the same but would be incurred earlier. It is possible that there will be savings associated with earlier consideration of young people's needs, allowing better planning and improved outcomes for the individual and their family; however such benefits will depend on how the provisions are implemented on a local level (which will be supported by statutory guidance). We are not prescribing the detail of this process, which we expect for many local authorities will not differ significantly from their current processes for communicating with people who request assessment.
- 1.96 A similar principle applies to the duty to provide information and advice following a transition assessment – this simply means carrying out somewhat earlier the duty to provide information and advice that would apply under the adult statute when the child in question turns 18, so this is not an additional burden.
- 1.97 It is possible that there will be savings associated with earlier consideration of young people's needs, allowing better planning and improved outcomes for the individual and their family; however such benefits will depend on how the provisions are implemented on a local level. We are not prescribing the detail of this process, which we expect for many local authorities will not differ significantly from their current processes for communicating with people who request assessment.
- 1.98 The benefits could not be monetised beyond those set out in the section covering Assessment and Eligibility. The primary benefit is to young people and their carers being able to better plan their futures and not experiencing gaps in the services they receive.
- 1.99 The Act also places a duty on local authorities to maintain children's services after their 18<sup>th</sup> birthday where a transition assessment should have taken place but has not. This again codifies best practice and so is not expected to be an additional burden on local authorities. Avoiding a "cliff edge" in services is

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<sup>36</sup> Under Section 17 of the Children Act 1989, assessments of children in need are carried out by a social worker. A child in need is defined under the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, or children who are disabled.

expected to lead to improved wellbeing for young people and carers, as they will avoid the potentially dangerous situation of suddenly being without care and support, along with associated stress and anxiety. There are also likely to be benefits to local authorities in avoiding expensive crisis management forms of care and support that could result from these cliff edges.

- 1.100 Local authorities will also have a power under the Act and associated regulations to meet the needs of a child's carer identified in a transition assessment, in advance of the child in question turning 18. Because this is a power rather than a duty, it will not lead to an additional burden on local authorities but could lead to benefits in allowing for earlier intervention in keeping with the overarching policy of the new care and support system.

### **1G. Delayed transfers of care**

- 1.101 We will be increasing the penalty amounts that may be paid by local authorities where they are responsible for a delayed discharge as a result of not fulfilling their obligations as set out in the Care and Support (Delayed Discharge) Regulations.
- 1.102 The proposed increase in costs is from £100 to £130 for local authorities outside London and from £120 to £155 in London for every reimbursable day that a delayed discharge continues. This increase is in line with inflation since 2003 (29.17%).
- 1.103 In line with the existing regulations, the primary purpose of these updated 2014 regulations is to promote joint working between local authorities and the NHS so that where appropriate people receive safe and timely transfers of care. In the current 2003 regulations, the use of these penalty amounts was mandatory. However, with the increased focus on joint working and in some cases even the pooling of budgets, in the vast majority of cases the NHS chooses not to invoke these penalty amounts and no charge is actually made to the local authority. There is no evidence that this non-use of the mandatory penalty regime has resulted in an incentive for local authorities to not fulfil their responsibilities under the regulations. The latest data shows that the proportion of overall discharge days attributed to social care has been stable and is now actually falling. There were 78,000 fewer bed days attributable to delays from social care in the 12 month period to January 2014 compared to the same period up to January 2012 (a decrease of 15%).
- 1.104 The 2014 regulations recognise the limited importance of penalty amounts as a basis for driving improvements in this agenda by moving them from a mandatory to a discretionary basis. This, taken with the fact that the integration agenda is now fully embedded at the heart of health and social care, with for example the establishment of the Better Care Fund will not only mean that there will not be an increased use of the penalty amounts, in fact there will be a reduction. For those few NHS organisations who do continue to use penalties, this in large part is because they are adhering to the letter of the 2003 Regulations which made their use mandatory. The move to a discretionary approach in these regulations will provide them with the flexibility to no longer use them and so we expect the use to further decrease.

- 1.105 In addition the amount of increase is in line with inflation since 2003, so this is not punitive and in most areas of activity inflation is something that local authorities would build into their expectations when planning.
- 1.106 Of course, in the very unlikely and limited circumstances that these penalty amounts were used, any cost to the local authority would need to be considered against the backdrop of its savings as a result of not providing the social care provision that is needed. In many cases, this social care will involve residential care provision where the costs in many cases would provide a significant offset against the cost of the reimbursement rate.
- 1.107 Other changes in the 2014 regulations as compared to the 2003 version are the mandated inclusion of the NHS number in assessment notices and basing delay counts on a seven-day week rather than five (both in line with broader policy).
- 1.108 Informal consultation indicates that inclusion of the NHS number creates no additional burden. Its inclusion in fact facilitates better joint working in terms of identifying people so should actually play its part in enhancing joint working and reducing delayed discharge days. Formalising the policy direction by making penalties discretionary (and so less likely) is expected to lead to modest cost savings (although these are not monetisable).
- 1.109 In practice, through wider Government initiatives and policy, in particular the Better Care Fund, both the NHS and local government are already required to have 7 day working arrangements in place by April 2015. Therefore, the extension of the days to which reimbursement applies to cover 7 days a week is not placing any additional expectations or burdens beyond what will be already existing practice.
- 1.110 The delayed transfers of care regulations therefore are not expected to constitute an additional burden on local authorities.

#### ***1H. Charging and financial assessment***

- 1.111 The charging regulations being consulted on within this package put the existing charging arrangements on a clearer statutory footing with common rules across all care settings.
- 1.112 They are intended to allow local authorities to continue their current charging practices, within the new legal framework. Wholesale reforms to what and how people pay for their care and support will be introduced in April 2016 and an impact assessment will be produced to accompany these subsequent regulations when published for consultation later in 2014.
- 1.113 We have taken this opportunity to make some minor adjustments to the way the charging system works, in particular the 12-week property disregard (see below). These changes are designed to be cost neutral for local authorities but to ensure that support is better targeted at those who need it.
- 1.114 In 2012/13, local authorities raised £2.5 billion through care and support charges. We do not expect these regulations to change this amount.

#### *Charging in care homes*

- 1.115 Currently local authorities are under a duty to charge for care in homes. Local authorities must charge according to the Assessment of Resources Regulations.
- 1.116 Under the new legal framework, local authorities will no longer be under a duty to charge but will have discretion to choose whether or not to charge. Where local authorities do charge they will have to charge an amount determined in accordance with these regulations.
- 1.117 Whilst we are giving local authorities a new flexibility to decide whether or not to charge for residential care we expect local authorities to continue to charge in the vast majority of cases and therefore to raise the same income as they do at present.

#### *Charging in other settings*

- 1.118 Currently local authorities have a broad discretion to decide how much to charge people in settings other than care homes. The department issues guidance to help local authorities determine how much to charge. This guidance is known as the Fairer Charging guidance.
- 1.119 We have engaged with local authorities in designing these regulations to ensure that they will enable current practice to continue whilst putting the existing rules on a more transparent and consistent footing by moving the key rules in to regulations.
- 1.120 It is important that local authorities are able to tailor their non-residential care charging policies to reflect different models of care and promote innovation and support local priorities. Over time, and as informed by the evidence, the Department will use regulations and guidance to promote greater local consistency where it is appropriate to do so. Decisions will be made on a case by case basis and informed by the evidence.

#### *12-week property disregard*

- 1.121 The charging framework for care and support sets out how a local authority must undertake a financial assessment, including how property should be treated. Under the current framework local authorities must disregard the value of a person's home for the first 12 weeks of local authority-supported residential care. This covers someone entering residential care for the first time if their non-housing assets are below £23,250 and those who are already in residential care, but whose non-housing assets fall below £23,250 at any point.
- 1.122 The intention behind this approach is to provide people with the space to decide how they wish to fund their care over the longer term. For those first entering residential care, the current approach meets the aims. However, those who are already in care and meeting their own costs due to the value of their property, the vast majority will remain self-funders and people should therefore be aware of how quickly their assets are being spent down and be able to plan and prepare for this eventuality. The Care Act introduces new duties on local authorities to provide people with information and advice which will further support people to plan and prepare and looking ahead, the introduction of Care Accounts from 2016 will further support this.

1.123 This disregard provides much needed protection and we intend to continue it. However, we have taken this opportunity to clarify its operation and make minor changes to ensure that it is focused on those most in need of its support.

1.124 The principle purpose of the 12-week property disregard is to protect people from being forced to sell their home through a distressed sale. It gives them the space they need to consider how they wish to fund their care over the longer term and to decide whether to choose to set up a deferred payment agreement or sell their home should they wish to do so.

1.125 We have analysed who is currently protected and who would benefit from protection through the disregard and this is set out below.

**Table 5 – Groups benefitting from property disregard**

	<b>Current Status</b>	<b>Recommendation</b>	<b>Cost of protection</b>
<b>Group 1: When people enter residential care</b>	Protected	Protect	£210 million <sup>37</sup>
<b>Group 2: When people already in residential care spend down their assets over time</b>	Protected in theory limited protection in practice	Protection not needed	Estimated around £5 million but uncertain and potentially up to £45 million
<b>Group 3: When people lose eligibility for a housing disregard due to the death or entry into care of a relative or spouse</b>	Not protected	Protect.	Estimated at around £5 million
<b>Group 4: When people suffer financial shocks such as a company they invest in going bankrupt.</b>	Not protected	Local discretion	Costs are likely to be small and discretionary.  <£1 million

1.126 Given these regulations provide support to group 1 and group 3 we believe that this will be broadly cost neutral for local authorities. During the consultation we would welcome further evidence to inform these estimates and ensure that the final regulations are designed with the best possible understanding of the costs.

## **11. Debt Recovery**

1.127 Sections 69 and 70 of the Care Act provide powers to enable local authorities to recover any debts that may have arisen as a result of non-payment of care and support fees. This replaces current legislation, including Section 22 of the Health and Social Services and Social Security Adjudications Act (HASSASSA) 1983.

<sup>37</sup> The cost of this protection is £202 million when strictly applied. However there are a small number of people who would be worse off once the extension to the upper capital limit is introduced in 2016. This approach accounts for this and therefore created an additional £8 million cost to ensure that people with low housing wealth and moderate non housing assets are not made worse off. This is likely a small over estimate.

- 1.128 The current legislation is essentially a unilateral power that allows local authorities to recover debts with very little oversight or due process and does not give the person from whom the debt is being pursued an opportunity to seek alternative means for payment. It is a power that no other body holds and that could lead to successful challenges under Human Rights legislation.
- 1.129 The Care Act therefore brings current practice up to the legal minimum expected in all other fields of debt recovery. The new provisions bring the balance of power more into line with other areas of law, protecting local authorities from potential lawsuits under Human Rights legislation while providing increased protection for the person through improved oversight and due process. This will be equivalent to provisions that already exist in other areas where a local authority may need to seek to recover a debt.
- 1.130 The statutory guidance sets out a full range of options to consider around debt recovery, placing a new emphasis on dispute resolution through negotiation and mediation wherever possible. Most notably, Section 69 of the Act sets out that a person must be offered a deferred payment agreement as a means of recovering the debt where they are eligible, either through meeting the nationally mandated eligibility criteria or through local authority discretionary powers.
- 1.131 This replicates existing powers. Although it is not possible to separate charges placed under Section 22 of HASSASSA from formal deferred payment agreements (DPAs) in the existing data, the total number of DPAs per year is around 4,300, only a small minority of which are likely to be related to debt recovery.
- 1.132 Although we do not have direct data on how often HASSASSA powers are used for debt recovery, given that DPAs are usually the first option considered, it seems reasonable to assume that HASSASSA powers are used less frequently (i.e. considerably less than the 4,300 DPA number).
- 1.133 Where other options are refused, the Act allows for the local authority to proceed to the County Court system as a last resort. All administrative and other costs are fully recoverable through the County Court and a local authority can apply to receive interest. The maximum amount of interest that can currently be applied is 8%, which is higher than the level of interest that may be applied for a deferred payment agreement or the current costs of debt financing. Section 70 sets out that in the case of deliberate deprivation, the debt can be recovered from a third party to the amount that they have benefited, providing further protection for local authorities where debts are incurred and someone has already passed on money (for example to their children). We would not expect the new powers for debt recovery to change individuals' behaviour, because they replicate the current powers and definition of what is and is not a debt.
- 1.134 The Act will ensure that local authorities can continue to recover debt, and importantly the administrative costs associated with doing so, whilst ensuring that a fair and transparent process is embedded in the system. The process should be viewed in terms of the reduction in risk of challenge to the fairness of the process itself.
- 1.135 Given the ability to recover costs associated with any extra administrative burden, there should not be a cost to local authorities arising from the change in debt recovery powers. Therefore the only potential area of cost would be if the increased due process around debt recovery were to influence local authorities to

pursue less of the debt owed to them. However, debts from care and support are very likely to outweigh by an order of magnitude the administrative costs of recovering them, so a short-term and ultimately recoverable administrative cost is extremely unlikely to change a local authority decision on whether to pursue a debt. Therefore this change is very unlikely to affect local authority behaviour.

## **1J. Meeting needs**

- 1.136 Section 18 of the Act (duty to meet needs for care and support) consolidates a number of existing duties to provide certain types of adult social care services. In doing so, it modernises the legal framework to remove historic anomalies between the way in which entitlements to residential care and to other types of care and support are established.
- 1.137 Section 18(3) provides a duty to meet eligible needs where an individual has financial resources above the limit set out in regulations, but asks the local authority to meet their needs. It is important to be clear that this would in no way change a local authority's responsibilities for funding the provision of care and support: such people would be required to pay for the costs of their care and support in full (and may pay an additional administrative charge to the local authority for making arrangement on their behalf), but the local authority would be required to meet their eligible needs, usually by directly contracting with a care provider to provide the necessary care and recovering the costs from the individual, or by making a direct payment to the individual for them to commission their own arrangements.
- 1.138 The purpose of this provision is to give people who are able to afford to pay for their costs of their care the ability to access the support of the local authority in finding the care they need. The care market is often difficult for individuals to navigate, and may be lacking in transparency, therefore many people without sufficient support find it difficult to judge different options or to arrange a contract with a care provider. As a result, some individuals may therefore make less optimal decisions for meeting their own needs than they may with better information and support. This provision's primary focus is to allow people who might struggle to arrange care on their own to access local authority assistance to do so.
- 1.139 In the consultation, some respondents have suggested that the provision in Section 18(3) of the Act may give rise to a risk of destabilising the care home market in particular, with consequent additional costs for local authorities. The contention is that some people who would otherwise arrange and pay for their own care may use the Act to access care which is arranged at a lower cost, because local authorities are often able to contract with certain providers at more favourable rates. If widespread, this could lead to a change from current purchasing practices as more wealthy individuals seek to use a local authority route to care at a lower cost.
- 1.140 As noted above, the Act requires the local authority to meet the eligible needs of the individual. The Act and supporting guidance set out a variety of ways a local authority could exercise the duty to meet needs to support self-funders, including arranging care directly for the individual, making a direct payment, or in some circumstances brokering arrangements on behalf of the person. It is not the case that the duty must be fulfilled through direct commissioning of care, or

that this must always be at a standard rate. Where the local authority does arrange (i.e. commission directly) care, there will be a range of providers available and these are likely to be on a range of rates.

- 1.141 There is a lack of robust empirical evidence to support analysis of any potential impact arising from this provision. Studies have shown that, on average, local authorities pay lower prices than self-funders for care packages, including accommodation and living costs. However, this does not represent a like for like comparison, since it cannot be shown that the care paid for is equivalent. Self-funders are often choosing to pay more to enter more expensive care homes, or choose a larger room, for instance. This will be reasonable in many instances, since many of these individuals have higher income and assets and are making a legitimate decision to enter a care home of their choice which may be more expensive than the local authority would usually pay. Moreover, local authorities can reasonably negotiate lower prices as a bulk purchaser, and given the lower risk of local authorities defaulting on payments.
- 1.142 These lower prices may reflect both the local authorities' ability to negotiate a better deal as a bulk purchaser but also the fact providers may face lower costs when contracting with a local authority. In particular there is a lower risk of local authorities defaulting on payments.
- 1.143 The scale of impact also depends on a local authority's current commissioning arrangements. One local authority is likely to have a number of contracts with different providers, and may have a range of different agreed rates within an individual contract. Such contracts and framework agreements will vary over time. It is therefore unlikely that a local authority will have a single rate for all care homes it arranges which can be compared with the market rate for self-funders.
- 1.144 In addition, it is not possible to demonstrate how the Care Act may change an individual's behaviour and their choices in relation to care. It is not possible to determine how likely it may be for a more wealthy individual to choose a different care home from their original preference, solely on the basis that one may be available at a lower cost. Evidence from different sources suggests that care home choices are usually made at a point of crisis, and cost is one of a series of considerations, alongside other matters such as perceptions of quality, amenities and location (e.g. access to family). Whilst on average 40,000 individuals per year will seek a new care home placement, it is not possible to estimate how many of that number may decide to limit their choice of care home to access lower prices, when other options are both available and affordable to them.
- 1.145 Based on the analysis above, we do not believe that there is sufficient evidence at this time to estimate what if any costs will occur, or to quantify those costs. It is therefore not possible, based on existing evidence, to accurately predict what the scale could be of any disparity between care costs paid by local authorities and self-funders and therefore what the impact of the Act may be.
- 1.146 Accordingly, we have decided to partially delay the implementation of Section 18(3) for one year, so that it only applies in relation to non-residential care, replicating the current situation and individual rights to care. This duty would therefore not apply in 2015/16 in relation to people whose needs are to be met in a care home; however, local authorities will retain powers to meet such needs, in keeping with current best practice. We intend to put in place a programme of research and activity over 2014/15 and 2015/16 to better



understand the potential scale of any impact, with a particular focus on the care home market. As further evidence becomes available, we will review our assessment and set out the expected impact of full commencement (i.e. including care homes for the first time) in the impact assessment which accompanies the 2016/17 Care Act guidance.

## 1K. Consolidation of other matters

1.147 Proposals related to consolidation cover a range of different areas, where the intent is to replace existing legislative provisions with new, equivalent provisions in the Care Act. The new provisions retain the effect of those which they replace, and therefore there are no new or additional costs arising from their inclusion in the Act.

1.148 In the process of consolidation, the language used to describe these provisions is updated or reframed as appropriate to fit within the context of the new statute. Whilst certain improvements are made to the drafting of provisions, and other anomalies rectified, these do not change the fundamental requirements or impact on local authorities. The specific areas covered within proposal 1I are noted in Table 6 below:

**Table 6: Areas of legal consolidation**

Policy area	Proposals	Replaces existing legislation	Sections of the Act
Exceptions to entitlements	<ul style="list-style-type: none"> <li>Prohibition on providing services required to be provided by NHS</li> <li>Prohibition on care and support for those subject to immigration control</li> <li>Prohibition on providing general housing</li> </ul>	<ul style="list-style-type: none"> <li>Sections 21(8) and 29(6) NAA 1948</li> <li>Section 49 Health and Social Care Act (HSCA) 2001</li> <li>Section 21(1A) NAA 1948</li> </ul>	21-23
Ordinary residence	<ul style="list-style-type: none"> <li>Provisions to "deem" ordinary residence when receiving accommodation in another area</li> <li>Power to resolve disputes between local authorities and recoup costs</li> <li>Powers to enable cross-border placements between administrations in the UK.</li> </ul>	<ul style="list-style-type: none"> <li>Sections 24 and 32 NAA 1948</li> <li>Section 56 HSCA 2001</li> <li>Ordinary Residence Disputes (National Assistance Act 1948) Directions 2010</li> </ul>	39-41, Schedule 1
Human Rights Act	<ul style="list-style-type: none"> <li>Clarification of implicit coverage of Human Rights Act as relates to provision of care and support</li> </ul>	N/A	73
Mental health aftercare	<ul style="list-style-type: none"> <li>Amendments to apply choice of accommodation, additional payments and ordinary residence to mental health aftercare</li> </ul>	<ul style="list-style-type: none"> <li>Amendments to section 117 Mental Health Act 1983 (not replacing existing legislation)</li> </ul>	75, Schedule 4
Registers of blind people	<ul style="list-style-type: none"> <li>Duty to hold registers of blind and partially sighted people, and powers to hold additional registers</li> </ul>	<ul style="list-style-type: none"> <li>Section 29(4)(g) NAA 1948</li> </ul>	77
Power to delegate functions	<ul style="list-style-type: none"> <li>Power to delegate specified care and support functions to a third party</li> </ul>	<ul style="list-style-type: none"> <li>Replicates effect of Section 70 Deregulation and Contracting Out Act 1994 (not replacing existing law)</li> </ul>	79

1.149 There will be some benefits arising from the process of consolidation, in terms of the additional clarity afforded by new legislation and consequent impact on ease of implementation. These benefits cannot be monetised.

## **Risks/sensitivities/issues**

- 1.150 The Care Act re-states and updates existing powers for local authorities and the power for the making of regulations. The detail across a number of themes fall out of scope of the impact assessment for this Act, and this risks issues impacting on implementation of the Act not being accounted for in this assessment. This impacts on the eligibility criteria, carer assessment and in determining ordinary residence. Impact assessments will be provided with the regulations, at the appropriate time.
- 1.151 In addition to the benefits of consolidation, there are some benefits, for example, associated with giving local authorities the powers to enable better coordination and more proactive, preventative measures. These are not readily quantified, but are not required in order to justify the costs.
- 1.152 Proposals requiring legislative enactment are assumed to be implemented from 2015/16 with other proposals that do not require enactment through primary legislation may be implemented earlier.
- 1.153 Work carried forward by local authorities will be in an environment of financial constraint and expenditure across a number of universal responsibilities is profiled into the next Spending Review round and so will be subject to change. Calculations have been based on the base year of 2010/2011 and will need revisiting during the next Spending Review in 2015.

## **Specific Impact Tests**

- 1.154 The paragraphs which follow consider further specific impact tests related to the range of proposals discussed in this assessment.

### *One-In Two-Out*

- 1.155 These proposals do not involve any additional regulatory measures that impose costs on business or civil society. The law considered in this Impact Assessment relates to the responsibilities of local authorities and other public sector partners for the planning and commissioning of adult social care services and for meeting the needs of their local population.
- 1.156 As a result, the proposals discussed within this Impact Assessment do not fall within the scope of the Government's "One-In Two-Out" (OITO) rule which states that "any regulatory measure that is expected to result in a direct net cost to business must be offset by deregulatory measures providing savings to business of at least double that amount."

### *Wider impact on business*

- 1.157 The primary objective of the proposals set out in the White Paper is to support people who use care and support and their carers to maintain their health, wellbeing and independence for as long as possible. As part of the overall objective of improving quality of care and experience, proposals are also intended to strengthen and enhance the social care market. The consolidation of existing legislation should make the system more transparent and reduce transactions costs of operating in the market, although these benefits cannot be monetised.

- 1.158 Actions to support personalisation may have positive implications for small businesses in that they could increase the number and range of small and micro providers. The development of personal budgets has led to an increase in the opportunities for micro-providers responding to niche markets as care becomes more personalised.<sup>38</sup>
- 1.159 The proposal to introduce a market shaping duty on local authorities and support them to understand their local market should help foster increased opportunities for small and micro enterprises. Just like large companies, small firms, who might want to expand or move into a new area, would be able to access more information about the local market. This is a result of the requirement on local authorities to have regard to market sustainability, be aware of current and future demand, and actively consider how service providers might meet that demand. Furthermore, smaller businesses should benefit from better, more strategic relationships between commissioners and all providers. For example, it may be the case that commissioners consider revising procurement arrangements after having completed a market position statement. A local authority may also decide to put in place extra support for small or micro businesses and social enterprises, in order to support the development of a more diverse market and specifically in the local authority requirement to encourage innovation.

#### *Carbon emissions*

- 1.160 The policies considered in this impact assessment do not affect any activity or sector that may have a significant impact on emissions of greenhouse gases, so a full carbon Impact Assessment has not been conducted.

#### *Competition*

- 1.161 We have not identified any specific impacts on competition. The proposals in the Care Act relate in the main to responsibilities of local authorities, and do not impact on business or civil society.

#### *Equalities and human rights*

- 1.162 We have not identified any negative impact on human rights as a result of our proposals. Several of the proposals are likely to have positive implications for human rights, in particular proposals to improve the quality and availability of information about the support on offer and proposals to extend and improve personalised care and support to care users and carers.
- 1.163 The Department of Health published a separate equality analysis to support the *Caring for our future* White Paper and draft Care and Support Act<sup>39</sup>. This equality analysis covered the areas of consolidation and modernisation of legislation proposed in the draft Act. Since the Care Act takes forward the proposals of the draft Care and Support Act without substantial amendment, we do not anticipate any additional impact on equalities and protected characteristics beyond those identified.

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<sup>38</sup> Community Catalysts - <http://www.communitycatalysts.co.uk/micro-enterprise-help-for-micro-providers/>

<sup>39</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/136452/2900021\\_Equalities-Assessment\\_acc2.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136452/2900021_Equalities-Assessment_acc2.pdf)

1.164A further detailed equality analysis is attached at **Annex A** to this impact assessment. This considers impacts on equalities and protected characteristics arising from law reform as a whole. The Department will continue to review and update this equality analysis in order to identify and mitigate any adverse impacts in relation to implementation of the new legal framework.

## 2A. ASSESSMENT, ELIGIBILITY AND CONTINUITY OF CARE

### Background – case for change

- 2.1 The current system of assessment and eligibility can be confusing, unfair and is unpopular with many care users and carers. Local authorities currently assess users and carers and set their eligibility criteria using guidance issued by the Department of Health.<sup>40</sup> Access to care and support varies across the country, with different authorities setting different thresholds for eligibility and very broad variations in how these thresholds are interpreted. Individuals who have the same needs can be eligible for care and support in one part of the country but not eligible in another part, even where the local authority nominally sets the same local threshold based on national guidance. Carers do not yet have the same entitlements to assessment and support as care users (see chapter 8 of this impact assessment, which considers carers).
- 2.2 This lack of consistency is one of the factors that act to prevent people moving between local authority areas, potentially to take up or remain in work, or be closer to their family. Users and carers primarily find it difficult to move around the country because their care and support is often interrupted until the new local authority carries out an assessment and arranges access to new personal budgets.

### *Variation in people's ability to access care and support*

- 2.3 Currently, individuals who develop a need for care and support approach their local authority to have an assessment. If their need is severe enough to meet the local authority's eligibility threshold for access to care and support, and their means are determined as not sufficient to provide it for themselves (as defined by the financial means test), the local authority will provide them with care and support.
- 2.4 Although assessment and eligibility operate within a broad national framework, local authorities are able to set their own eligibility thresholds in response to local needs and circumstances, resulting in variation in the access to care and support across the country. The system can seem opaque and inconsistent – users and carers do not know from local authority to local authority whether they will be eligible for care and support. This is compounded by a lack of clarity around the existing legislation and different legal entitlements based on the setting of the care provided.
- 2.5 The Fair Access to Care Services (FACS) framework sets out eligibility criteria against which local authorities assess an individual's need.<sup>41</sup> Local authorities are able to choose where they set their eligibility threshold and therefore the level of need at which they will offer support, based on one of the four levels described in the guidance. This results in variation in the levels of access to care and support offered, as demonstrated in Table 7 below which shows the

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<sup>40</sup> Department of Health, *Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care*, 2010.

<sup>41</sup> The current assessment framework is commonly known as *Fair Access to Care Services*. It is formally published as *Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care* (Department of Health, 2010).

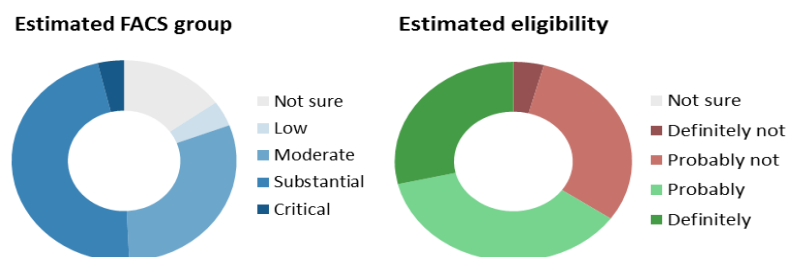
most recently published information on local authorities' thresholds for eligibility:<sup>42</sup>

**Table 7: Local authority eligibility thresholds**

FACS threshold for access to care and support	Number of local authorities setting their threshold at that criterion in 2012/13
Critical	3
Substantial	130
Moderate	16
Low	3

- 2.6 Differences in thresholds applied by local authorities are compounded by considerable variation in the way that they interpret the eligibility criteria set out in the FACS guidance. This variability was highlighted by the Personal Social Services Unit (PSSRU) report<sup>43</sup> which showed evidence of significant variation in patterns of categorisation both within and between local authorities. The research found that in local authorities with tighter eligibility criteria, there was a tendency for care managers to allocate the described cases to a higher banding. The proportion of the population with critical needs in authorities with “critical” thresholds is much greater than in other authorities.
- 2.7 The study showed major discrepancies in how individual cases are assessed by care managers. For example, in one case a user deemed to have “critical” needs by a care manager in one local authority was thought to have “low” needs by a care manager in another local authority, based on the same information.
- 2.8 The charts below show the findings of the first case study in the report and are representative of the findings from the case studies throughout the report. They demonstrate the variation in interpretation in a single case, considering which the FACS bandings would be most appropriate, and whether that individual would be likely to have eligible needs as a result:

**ESTIMATED FACS GROUP AND ELIGIBILITY (ALL LOCAL AUTHORITIES)**



<sup>42</sup> Based on data provided by ADASS in autumn 2012.

<sup>43</sup> Survey of Fair Access to Care Services Assessment Criteria Among Local Authorities in England. Economics of Social and Health Care Research Unit. 2012

- 2.9 A 2008 review of eligibility criteria by the Commission for Social Care Inspection (now part of the Care Quality Commission) flagged as two of its top findings:<sup>44</sup>

*“A lack of clarity and transparency in practice, particularly related to the complexity of the framework, so neither professionals nor people using services are confident of their understanding ...”*

*“A lack of fairness in the way criteria are applied, due to variations in professional judgements and different approaches taken by councils.”*

- 2.10 In addition, it is difficult to know what a particular threshold means in practice – meaning therefore that a comparison of thresholds across the country is not useful. The Commission on Funding of Care and Support found that:<sup>45</sup>

*“There are in effect 152 different systems across England – one for each local authority in England. This level of variability adds complexity and leads many to be confused about how the system works.”*

- 2.11 Stakeholders recognised the problem of variable access to care and support created by the current assessment and eligibility framework during the *Caring for our future* engagement and showed significant support for change in this area. For example, the MS Society said:

*“We strongly support recommendations for national eligibility criteria and portable assessments. These proposals have the potential to transform the lives of people with care and support needs, enabling them to access the same level of care, wherever they live in the country, and whatever their level of need.”*

- 2.12 The lack of a clear and consistent State offer also contributes to the inability of individuals and families to plan and prepare and take responsibility for their own care and support needs.

- 2.13 During the *Caring for our future* engagement, the financial services industry highlighted variations in eligibility and local authority practice as one of the key barriers to developing financial products to help people cover the costs of their care. Indeed, moving to a more consistent, national eligibility framework was one of the top five priorities for change identified by the financial services work-stream during the engagement.

- 2.14 The 1998 Modernising Social Services White Paper set out as its aim for the new FACS guidance that “Eligibility criteria should inform users about what sorts of people with what kinds of need qualify for what types of service... There has to be a greater level of consistency and fairness in social care.”<sup>46</sup> The evidence cited above suggests that this aim has not been fully achieved.

### ***Underlying causes of the problem***

- 2.15 The lack of clarity and consistency in access to care and support is largely due to local areas having significant flexibility over eligibility and assessment. The

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<sup>44</sup> Commission for Social Care Inspection, *Cutting the cake fairly*, 2008.

<sup>45</sup> *Fairer Care Funding, The Report of the Commission on Funding of Care and Support*, 2011.

<sup>46</sup> Department of Health, *Modernising Social Services White Paper*, 1998.

FACS statutory guidance on setting eligibility criteria and interpreting each threshold does not impose mandatory duties – this therefore results in local variation in people’s access to care. Indeed, existing legislation does not allow for mandatory duties to be placed on authorities which would reduce this variation.

- 2.16 Government is clear that some local variation is appropriate within a system that promotes local determination and personalised public services, and allows for a role for professional judgment in considering the individual case and the person’s own needs, outcomes and wellbeing.
- 2.17 Individual and family circumstances should be taken into account by a local authority in determining the size of a care and support package. For instance, factors such as the care that may be provided by a carer, the accommodation an individual or family lives in, their specific needs and the outcomes they want to achieve, could contribute to variation in the size of a care and support package provided to individuals and families with similar needs.
- 2.18 Local discretion on other variables such as overall local authority funding, resource allocation and the configuration of local authority markets and services, as well as variation in local needs will also rightly result in care and support packages being tailored to local need.
- 2.19 Finally, it needs to be recognised that within any framework for assessment and eligibility there will always be some differences in outcome given the element of subjectivity or professional judgement that is involved. In a person-centred approach, it will always be right that determinations are based on the individual and not fit around a restrictive eligibility tool that cannot adapt to the person’s needs and circumstances.
- 2.20 However, users and carers should be able to know whether they will be eligible for care and support and have a sense of the way in which their care and support needs will be assessed no matter where they live in the country. There is a clear distinction to be made between access to care and support, where we believe there should be more national consistency in provision, and the size and type of care and support package received which is determined by local decisions and individual circumstance.
- 2.21 What has emerged is not the locally led system within a nationally consistent framework which was Government’s intention, but rather a system with broad variation that can be opaque to users and carers. The view that Government needs to take action to address this was supported during the *Caring for our future* engagement.

### ***Barriers to continuity of care and support***

- 2.22 The Government set out its intended policy with regard to continuity of care in its *Vision for Adult Social Care* published in November 2010. It set out that:

*“The system should support rather than hinder people’s goals. People who want to pursue educational or employment opportunities, for example, should be able to move from one part of the country to another without having to go through unnecessary multiple assessments and uncertainty. We want to see greater portability of assessments, and will consider how to pursue this in the*



*light of the work of the Law Commission and the Commission on Funding of Care and Support.”*

- 2.23 There are several barriers to continuity of care in the current system. At present users and carers may face discontinuity of care and support when moving from one local authority area to another until they receive an assessment. Although we do not have a clear view on the numbers of people who do not move local authority area as a result of these barriers, stakeholders, in particular younger disabled adults, carers and their representative organisations, have been heavily critical of the current approach.
- 2.24 The lack of consistency of eligibility thresholds and the interpretations of those thresholds, the variance in care and support packages and charging arrangements also act as barriers to people moving area. Some of these differences are legitimate as part of a local system, such as the size of care and support package will vary from local authority to local authority depending on local decision-making.
- 2.25 However, others, such as eligibility thresholds and in particular the current discontinuity of care and support, affect access and can therefore present significant barriers to freedom of movement that need to be addressed. Individuals and families should have greater certainty over their ability to access care and support across the country, to enable them to move more freely between areas.
- 2.26 There was strong support to introducing a continuity of care process during the *Caring for our future* engagement. This supports the response to consultation by the Law Commission which found that:<sup>47</sup>

*“A large number of consultees argued that current arrangements for the portability of services are so confusing and uncertain that many service users feel unable to move from their area.”*

- 2.27 At present, the level of ‘portability’ in the system depends on voluntary information exchanges and agreements between local authorities and so is variable across the country.
- 2.28 RADAR summarise the problems well, setting out that:<sup>48</sup>
- “Currently, disabled people face very severe and unnecessary barriers when moving from one local authority to another. That is because they cannot be certain that they will receive equivalent levels of care and support in a new locality.*
- Even where people are already getting care and support in one authority they will often be unable to start the process of sorting out arrangements in a new location until they have moved, and they then have to negotiate a new care package from scratch. For many disabled people effective and timely social care is the difference between independence and entrapment.”*
- 2.29 Emerging findings from research being carried out by the University of Hull<sup>49</sup> show that the key messages to support people moving is that there is ongoing

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<sup>47</sup> The Law Commission, *Adult Social Care Consultation Analysis*, 2011.

<sup>48</sup> RADAR, *The Social Care and Portability Act Information Briefing*, 2011.

communication; that there is co-ordination between all parties involved; and that there is continuity of care to ensure the person's wellbeing.

### **Rationale for intervention**

- 2.30 Local authorities are responsible for the assessment of need, determination of eligibility and provision of care and support to meet eligible needs. It is the Government's view that local authorities should be able to exercise flexibility in the way in which they meet the needs of their local populations, according to local circumstance. However, evidence suggests that there is currently an unacceptable level of variation in access to care and support affecting care users, those with caring responsibilities and offenders with care needs. This is largely a result of variability in local interpretation of national legislation and guidance. Repeated attempts to bring more national consistency to the system have not had the desired effect.
- 2.31 Government intervention is therefore required to support greater equality and consistency of access to assessment and provision of support. Without reform through primary legislation, the level of variation will not be reduced and these aims will not be met.
- 2.32 A report on assessment and eligibility by the Social Care Institute of Excellence (SCIE) set out that:<sup>50</sup>
- "It is clear that despite the best intentions of revised guidance and continuing attempts to improve practice, the experience and consequences of assessment and eligibility determination are often unsatisfactory."*
- 2.33 The Commission on Funding of Care and Support recommended that the Government take action in this area and that in the longer term the future system should have a new, more objective assessment scale, with a simplified and clearer process. Until this is designed and implemented, the Commission recommended the introduction of a national eligibility threshold in the interim. The Commission felt that such changes would benefit both people with care needs and carers.
- 2.34 Reforming the law to create a clear single statute around assessment and eligibility also provides an opportunity to look again at how these policies interact with the rest of the system, and to ensure that going forward they are designed in such a way to support greater personalisation and self-directed support for care users, families and carers.
- 2.35 There are currently few incentives to ensure that a local authority provides continuity of care and support if an individual or family moves into their area, or even that they re-assess them promptly to ensure that any discontinuation of care and support is short. In practice, the cost of providing services to new users and carers moving into their local area may act as a disincentive to promptly putting in place a care and support package and there is anecdotal evidence from stakeholders that this may be the case.

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<sup>49</sup> Marsland, D. (2014) Portability of Social Care: messages for practitioners. *School of Social Care Annual Conference*. London, UK

<sup>50</sup> SCIE, *Crossing the threshold: the implications of the Dilnot Commission and Law Commission reports for eligibility and assessment in care and support*, 2012.

2.36 The Government believes that only through national action to give local authorities a legal duty to ensure continuity of care removing barriers to porting care and support packages; such action was recommended by both the Law Commission and the Commission on Funding of Care and Support. A duty, with additional funding for local authorities, to ensure continuity of care will incentivise prompt assessment. This is because local authorities would be responsible for providing an equivalent package of care and support based on the person's previous local authority's assessment until its own assessment of the needs of the user, and if appropriate the carer, who had moved into their area.

**Policy objective**

2.37 The overarching policy objective is to bring about greater clarity, consistency and equality of access to care and support both for people using care and support and for people with caring responsibilities. The Act includes a number of proposals to achieve this objective.

**Table 8: Assessment, eligibility and continuity of care:**

Policy Theme	Objectives	Policy Proposals
Assessment, eligibility and continuity of care	<ul style="list-style-type: none"> <li>• Create a more nationally consistent system for eligibility for users and carers which is understandable, transparent and outcome-focused, supports personalisation and prevention and continues to allow local authorities flexibility to reflect individual, family and local circumstance;</li> <li>• Provide continuity of care to users and carers when moving home from one local authority area to another.</li> </ul>	<ul style="list-style-type: none"> <li>A. Establish a national threshold for eligibility for care and support;</li> <li>B. Place a duty on local authorities to meet the needs of care and support for users and their carers who move into their areas, from the day of arrival until they undertake a new assessment.</li> </ul>

**What policy options have been considered?**

**Option 1: Do nothing**

2.38 As discussed above, the aspects of local variation in access to care and support which are seen as unacceptable would continue. The system would remain difficult to understand and individuals and families will continue to find it difficult to plan and prepare. Individuals and families would still be unable to move local authority area without facing the risk of discontinuity in their care and support package.

**Option 2: Implement the following proposals (preferred option):**

- A. Establish a national minimum threshold for eligibility for care and support;
- B. Place a duty on local authorities to meet the needs for care and support of users and their carers who move into their areas, until they undertake new assessments;

## **A. Establish a national minimum threshold for eligibility for care and support**

- 2.39 From April 2015, the Government will take forward the Law Commission recommendations and sets a national minimum eligibility threshold for adult care and support services. This requires new primary legislation with a corresponding impact on local authorities. The Care Act provides a power to set mandatory national eligibility criteria to which local authorities will have to adhere.
- 2.40 This would ensure that local authorities could not restrict their eligibility for care and support beyond the level set nationally and would bring greater consistency in access to care and support. Councils could choose to meet needs that are not considered eligible under the national criteria if they wished. Councils would however, retain control over how they interpret the threshold, overall budget setting, the size of individual care and support packages and the configuration of local services.

### **Costs of preferred option, proposal A**

- 2.41 The Act provides a power to set the national minimum eligibility threshold for adult social care in regulations. The national eligibility criteria for 2015/16 onwards have been set at a level where the adult's need has a significant impact on their wellbeing. This is a *minimum* threshold and local authorities can choose to meet needs that are not eligible.
- 2.42 The Department held an extensive engagement with stakeholders on the draft Eligibility Regulations. This included consultations on two versions of the draft Regulations, the first in June 2013, and the second in June 2014, with ongoing engagement with stakeholders throughout the period.
- 2.43 The aim of the regulations is to describe the threshold at a level which allows a similar level of access to continue when we move from the current to the new system in April 2015. As shown in table 7, the vast majority of local authorities currently set their threshold at 'substantial' according to current *Prioritising need in the context of Putting People First* Guidance. The Government's intention is that the national minimum threshold is set at a level which most closely matches the current average amongst authorities.
- 2.44 The Department also engaged the Personal Social Services Research Unit (PSSRU) at the London School of Economics to evaluate both drafts of the regulations against current practice. PSSRU asked local authorities to compare the regulations with the current guidance. This comprehensive engagement and research informed the final version of the regulations.
- 2.45 The policy intention is that the threshold describes a level that can maintain current practice. Three local authorities (see table 7) currently set their threshold at the 'critical' banding according to FACS Guidance. The 2012 PSSRU report showed that each local authority interprets the current guidance differently, and that those three authorities have a bigger proportion of people determined to have "critical" needs as compared with other authorities who nominally set their threshold at a lower level. This implies that they meet needs for people who, in other areas, would be determined to have needs other than "critical". Conversely, some authorities who currently set their local criteria at

“substantial” are likely to be interpreting this more restrictively than other authorities.

- 2.46 Due to this level of variation across authorities, it is not possible to estimate precisely what the possible impact might be on individual local authorities of introducing a national eligibility threshold. For the same reason, it is therefore also not possible to fully apply New Burdens principles; however our approach seeks to determine a reasonable proxy for the overall impacts on the local government system. We are committed to reviewing any potential impacts resulting from emerging evidence.
- 2.47 In determining a proxy for the likely overall costs to local government, we have used PSSRU’s estimates of the number of additional users who may become eligible, based on the national threshold being set at the current average position of “substantial” needs. The costs were estimated by PSSRU, who used a population-based approach, comparing levels of coverage and expenditure per capita between local authorities at different existing thresholds to estimate the costs. This method implicitly assumes that the overall level of need and the needs assessment is similar across local authorities, i.e. that there will be a similar proportion of the population assessed as critical and substantial in each local authority.
- 2.48 The PSSRU work estimated that an additional 4,000 adults would become eligible for care and support following the introduction of the national threshold. The report looked at the relative coverage in local authorities setting their eligibility threshold at ‘substantial’ versus those set at ‘critical’ in order to judge how many people might become eligible once the new national minimum threshold comes into effect. PSSRU estimated that 4,000 people would now become eligible for care and support, which would increase expenditure by £25.3m per year [15/16 prices].<sup>51</sup>
- 2.49 However, while it was concluded that this was a reasonable method to calculate the impact on authorities moving to the eligibility threshold overall, it was acknowledged that local authorities do not have a consistent approach to interpreting the current eligibility bandings (see findings from 2012 research by PSSRU), and this approach would not therefore reflect the expected impact on local authorities in practice. As above, this assumes that the proportion of people with assessed needs in each banding in different authorities is consistent, which other research and feedback demonstrates is not the case.
- 2.50 As noted, the evidence from the 2012 PSSRU report demonstrates that there is clear variation in how local authorities interpret the FACS guidance. This is supported by the response to the consultation on the draft eligibility regulations from one of the authorities who set their threshold at “critical” that their view is that *“our interpretation of “critical needs” does not differ in any clear way from the interpretation of “low needs” applied in”* authorities who set their threshold at “low”.
- 2.51 Data from the Adult Social Care Efficiency Index further support this position. If local authorities meeting only “critical” needs under the current system where restricting eligibility to fewer people, it might be expected that those local authorities would provide fewer services and spend less per head than other

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<sup>51</sup> This is based on 2010-11 RAP data and 2010-11 PSS EX1 returns and assumes that local authorities have similar proportions of residents with needs for care and support.

authorities. However, the Index, which makes comparisons based on “statistical neighbours” (i.e. those other local authorities with similar characteristics)<sup>i</sup>, shows that those three authorities’ spending on adult social care per head of population over 65 years is either close to or above the median of their statistical neighbours, and in some cases the proportion of services provided to over 65s is significantly above the median.

2.52 A combination of this evidence suggests that in practice there is little relationship between a local authority’s stated local threshold and how that authority is meeting needs. Our view therefore, based on the evidence above, is that the most likely scenario is that the additional cases arising from the national eligibility threshold will be spread across a much larger number of authorities.

2.53 The 4,000 adults identified in para 2.48 would all require an assessment in order to determine their needs and eligibility. In addition to these, we have assumed that a further 2,000 people may come forward for an assessment and be assessed as not having eligible needs and may receive other universal services. We have therefore assumed a need to carry out an additional 6,000 assessments in 2015/16. Taking an assessment cost of £500, these 6,000 assessments would represent a cost of £ 3.0 million in 2015/16. The costs of these assessments are transitional costs in 2015/16 only, in order to bring existing individuals with eligible needs into the system. While the individuals in question have a right to assessment under the existing system, they may have already had an assessment but need to be reassessed with the new eligibility threshold. Individuals approaching a local authority in future years are very unlikely to have been assessed previously and so assessing them does not represent an additional burden compared to the “Do Nothing” option. Hence this is a transitional rather than recurring cost.

2.54 The expected financial impact of the new national eligibility threshold is laid out in Table 9 below:

**Table 9: Costs of preferred option, Proposal A**

<i>£ millions, 15/16 prices</i>	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Implementation assessment costs	£3.0									
Cost of meeting needs for care and support	£25.3	£25.3	£25.3	£25.3	£25.3	£25.3	£25.3	£25.3	£25.3	£25.3

### **Benefits of preferred option, proposal A**

2.55 Proposal A would help set out a national minimum offer for access to care and support across the country, which should simplify the system and act to reduce some of the variation in access to care and support. It is also expected to release some peace of mind benefits, by reducing the anxiety caused within the current system that local authorities may change their local threshold, so potentially leaving people without the care they need.

- 2.56 Further, it should support continuity of care as users and carers will have greater certainty that they will still receive care and support should they move to a different local authority from their own, as all councils would offer care and support at a national threshold.
- 2.57 There would also be benefits in the form of improvements to wellbeing to individuals and their families from the additional expenditure on provision of care and support with potential small savings to the NHS from this new social care expenditure. These small savings would be as a result of the adult being better able to manage their overall health and care needs and have fewer visits to the NHS. General improvement in the adult's wellbeing could also see improvements for their carer and help address some of the pressures they face in their caring role, which can often result in visits to their GP.
- 2.58 However, without additional intervention, individuals and families would still face potential discontinuity of care and support when moving to another local authority area. We propose that in addition to Proposal A, we also take forward Proposal B, to place a requirement on local authorities to assess needs in a timely manner and to continue providing people with a package of care and support in the intervening period. This is discussed below. Benefits will be estimated in the Impact Assessment for the regulations, as noted in paragraph 2.41.

***B. Place a duty on local authorities to meet the needs for care and support of users and their carers who move into their areas***

- 2.59 Taken forward in addition to Proposal A, Proposal B ensures that users and carers do not face discontinuity of access to care and support when they move local authority area and before they are re-assessed by the receiving authority. This proposal requires new legislation with a consequential impact on local authorities.
- 2.60 Under the provisions of the Act, a duty would be placed on local authorities setting out that they must meet the assessed care and support needs of users and carers (where they are continuing to care for a user who is also moving) who move into their area, until they are able to re-assess them and potentially provide a revised care and support package. This duty would be further defined in guidance but in essence would equate to ensuring that a user, and if appropriate the carer, is able to receive care and support to meet the same assessed needs as in their previous local authority, from the day of arrival in a new local authority area, so that there is no gap in care. The Act also sets out new duties on the local authorities involved to share information to encourage a smoother transition between local authorities.

**Costs of preferred option, proposal B**

- 2.61 There would be costs associated with Proposal B both from providing care and support where there may have otherwise been discontinuity and also from additional assessments for users and carers who move local authority area as a result of this proposal.
- 2.62 There is very little data available for how many users and carers are prevented from moving local authority area as a result of the barriers to continuity. We consequently use ONS migration data as the basis of our estimates, supposing

that in the future, users and carers want to and would move with the same propensity as the wider population. We recognise that it may be unlikely that, given their circumstances, they will move as frequently as the rest of the population but it is important that this is catered for and we do not contravene the rights of users and carers to move by not making sufficient funding available for this proposal.

- 2.63 We also make assumptions, and vary these, on the split between:
- the proportion of the population that would have moved anyway, regardless of this change; and,
  - the proportion of the population that would now move as a result of the increased certainty of care and support.
- 2.64 We use an assessment cost of £500 [15/16 prices], which reflects the potential need for a full needs assessment, as an individual's circumstances will change when they move local authority area. Assuming that the vast majority of users who move would receive domiciliary rather than residential care, we assume an average weekly domiciliary care cost of £192 a week (12 hours per week at £16 per hour). Finally, we also make assumptions about the current discontinuity of care in the current system, using a higher and lower estimate. We perform a range of calculations using different variants on assumptions to produce an annual cost estimate of between £10 million and £15 million. We assume that this range would cover the costs of removing barriers to continuity of care for both users and carers.
- 2.65 However, it may take some time for individuals and families receiving care and support to move towards a level of migration that is similar to that of the general population, given the significant change in policy that is being introduced. Therefore, we assume that not until the third year after implementation will the full costs be potentially incurred, increasing by a third over the intervening years.
- 2.66 The indicative costs associated with Proposal B is set out in table 10 below:

**Table 10: Summary of costs of Proposal B (£m)\***

<i>£ millions, 15/16 prices</i>	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Ensure councils provide continuity of care for people moving into their areas until reassessment	£4.4	£9.9	£13.4	£13.4	£13.4	£13.4	£13.4	£13.4	£13.4	£13.4

### **Benefits of preferred option, proposal B**

- 2.53 Proposal B will break down the most significant barrier to continuity of care in the current system, which is the risk that an individual or family may lose vital care and support for a period of time until they are re-assessed. This proposal should therefore support individuals and families in being able to move from one local authority to another.
- 2.54 Proposal B would bring about significant welfare gain by enabling individuals to move closer to family and friends or into more suitable accommodation, which would have benefits in terms of improved outcomes and potential reductions in costs to the State. It would also help both users and carers to move in order to



take up or remain in employment, which would bring benefits to the wider economy from increased productivity and potentially a reduction in welfare benefits claimed.

### **Summary impact of option 2 (proposals A and B)**

- 2.55 Together these measures will act to clarify the State offer, create a more nationally consistent system for access to care and support and facilitate freedom of movement between local authority areas.
- 2.56 The Act sets out the principle of a national minimum eligibility threshold and to place a duty on local authorities to ensure that there is continuity in care and support for people who move areas. In terms of welfare gain, these proposals will widen access to care and support and reduce the uncertainty facing new users and carers, and those already receiving care and support who wish to move area.
- 2.57 Reducing the variation in access to care and support across England means users and carers will benefit directly from these proposals. They will create a clearer system where the processes and outcomes are more transparent for all involved, which in turn will support users and carers and potential users and carers in planning and preparing for their care and support needs.
- 2.58 Further, ensuring that people do not face discontinuities of care and support when moving local authority will provide users and carers with the ability to move without being unduly hindered by the care and support system. It supports the freedom of movement and may result in people moving to take up or remain in employment, be closer to family and friends or simply to improve their standard of living, all of which have benefits to individual and families as well as potentially to the State.

## 2B. ASSESSMENT AND PROVISION OF SUPPORT FOR CARERS

### Background – case for change

- 3.1 The 2010 Carers Strategy highlighted the crucial role of carers and the importance of a fair and transparent offer to both users and carers.<sup>52</sup> Carers do not yet have the same entitlements to assessment and support as the people they care for.
- 3.2 Carers' legislation has been introduced as Private Members Acts on an ad hoc basis, reflecting the changing attitudes towards carers over the last 25 years. Under current law, local authorities have a duty to undertake carers' assessments if certain conditions are satisfied. There is a lack of consistency and transparency in relation to how local authorities decide whether and how carers receive support. Local authorities currently have a power rather than an express duty to provide support to meet carers' needs identified through assessment. When exercising this power, local authorities can, but are not required to, apply an eligibility framework and criteria.

### Support for carers

- 3.3 Piecemeal legislation and guidance about carers' assessments has created a process that is confusing, prolonged and overly bureaucratic, both from the perspective of carers and those administering the process. The current processes tend to focus on supporting carers in their caring role and do not necessarily result in the provision of support to improve the health and wellbeing of carers and their quality of life.
- 3.4 Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes. These in turn can affect a carer's effectiveness and lead to the admission of the cared for person to hospital or residential care.
- 3.5 For example, the Carers, Employment and Services (CES) report by Carers UK and the University of Leeds 2007 found that only a minority (about a quarter) of carers believed they had adequate support from formal services – even though 42% were paying privately for these. Very few were getting carers' breaks or respite services and a large minority felt poorly informed about available support. Among 'new' carers in the CES study, 46% of full-time employees, and 62% of part-time employees felt they did not have adequate support to enable them to work.
- 3.6 H. Arksey et al found that carers' opinions on the quality and adequacy of support provided by local authorities varied widely, even within the same local authority.<sup>53</sup> Many carers (or care users) were unwilling to accept assistance from their local authority, and there was no evidence of a direct link between the number of hours that carers worked and the level of support received. They found that local authority support was generally not seen as essential to the

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<sup>52</sup> Department of Health, *Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own*, June 2008 and *Recognised, valued and supported: next steps for the Carers Strategy*, November 2010.

<sup>53</sup> Arksey, H. et al, *Carers' aspirations and decisions around work and retirement*, Department for Work and Pensions, Research Report 290, 2005.

ability of carers to undertake paid work, partly because it did not easily accommodate work patterns. Whilst local authorities could provide reasonably effective short-term solutions to help carers combine work and care, it was much harder to sustain this support in the longer-term. Services that carers felt would make it easier for them to work and care included childcare for disabled children, longer day centre hours, and practical help with domestic chores.

- 3.7 It is therefore important that care and support legislation supports families and carers to access timely information and advice and early interventions to enable them to care for as long as they wish and are able to and to have a life of their own alongside caring. The proposals for better access to quality information and advice set out in the paragraphs on *Information and Advice* will support carers as well as care users in this objective.
- 3.8 However, as set out above, there are still legislative barriers that can prevent carers from accessing assessment and support, which need to be addressed. Under current legislation, local authorities only have a duty to undertake carers' assessments if certain conditions are satisfied and only have a power not a duty to provide support to meet carers' needs identified through assessment. Carers therefore do not yet have the same entitlements to assessment and support as the people they care for. This Impact Assessment therefore considers the impact of provisions within the Care Act to address these legislative barriers.

**Policy objective**

- 3.9 The overarching policy objective is to bring about greater clarity, consistency and equality of access to care and support both for people using care and support and for people with caring responsibilities. To achieve this objective, the Government has set out a number of proposals to be taken forward listed below.

**Table 11**

<b>Policy Theme</b>	<b>Objectives</b>	<b>Policy Proposals</b>
Reforming legislation to provide better support for carers	<ul style="list-style-type: none"> <li>Ensure carers have the same rights as users with regard to access to assessments and support.</li> </ul>	A. Simplify the legislation in respect of carers' assessments; B. Introduce a new duty on local authorities to meet eligible needs for support.

**Summary of options**

**Option 1: Do nothing**

- 3.10 Other commitments set out in the Carers Strategy would still be taken forward but the inadequacies of the current legal framework would present barriers to their complete success. Existing legislation would be retained both in terms of carers' assessments and provision of support.
- 3.11 Local authorities would continue to have a duty to inform carers of their right to request an assessment, where the local authority believes the carer may be entitled to an assessment under either the Carers (Recognition and Services) Act 1995 or the Carers and Disabled Children Act 2000. Currently only carers providing a substantial amount of care on a regular basis would be entitled to a carer's assessment (2000 Act) and a carer's assessment could only be undertaken if requested by a carer (1995 Act).

- 3.12 Assessments would continue to take into consideration the carer's ability to provide and to continue to provide care for the person cared for. They would also continue to take account of whether the carer works or wishes to work or is undertaking or wishes to undertake education, training or any leisure activity. (Carers (Equal Opportunities Act) 2004).
- 3.13 Local authorities would continue to have regard to the ability of carers to continue to provide substantial care on a regular basis when assessing whether a disabled person's needs call for the provision of services (Disabled Person (Services, Consultation and Representation) Act 1986). They would also continue to take into account the results of a carer's assessment in making a decision about whether the cared for person's needs call for the provision of services (1995 Act).
- 3.14 Anyone providing care by virtue of a contract or as a volunteer with a voluntary organisation would continue to be excluded from the definition of a carer and thus eligibility for a carer's assessment (1995 and 2000 Acts).
- 3.15 Local authorities would continue to have a power to provide services to carers. They could, but would not be required to, apply an eligibility framework and criteria.

***Option 2: Implement the following proposals (preferred option)***

- A. Simplify the legislation in respect of carers' assessments;
- B. Introduce a new duty on local authorities to meet eligible needs for support.

***Proposal A: Simplify the legislation in respect of carers' assessments***

- 3.16 This option will entail a number of changes to be effected through legislation with a consequential impact on local government. These changes are firstly listed and then expanded on below:
- Consolidation of the fragmented legal framework that currently exists in relation to carers' assessments;
  - Removal of the current restriction that carers' assessments are limited to those carers who provide a substantial amount of care on a regular basis;
  - Assessment to be triggered where a carer appears to have, or will have upon commencing the caring role, needs that could be met either by the provision of carers' support or by the provision of support to the cared-for person;
  - Local authorities to have discretion to assess a carer who receives payment for some of the care they provide or is a volunteer worker, where the local authority believes the relationship is not principally a commercial or ordinary volunteering one;
  - Requirement on local authorities to apply eligibility criteria to carers in a similar way to care users and to meet the eligible needs of carers;

*Consolidation of the various duties about carer's assessment into a single duty.*

- 3.17 This would help to make a carer's entitlements much easier to understand. The overwhelming majority of responses to the Law Commission's consultation agreed that it makes sense to have a single duty.

*Removal of the 'substantial and regular' test.*

- 3.18 This would improve clarity and consistency of approach to assessment, remove the possibility of excluding some carers who care for people with unpredictable and fluctuating needs (for example those with mental health problems) and reduce complexity. This would also enable the assessor to focus on the impact of caring on an individual carer - for example 10 hours caring for someone with challenging behaviour may be far more emotionally and physically demanding than 20 hours caring for someone who is appreciative of all the support they are given. A large majority of Law Commission consultation responses agreed the test should be removed.

*Removal of the requirement that a carer must request an assessment before the duty to undertake an assessment is triggered.*

- 3.19 Again, this would simplify the process for both carers and local authorities, support a proportionate response and help local authorities to offer assessments to people who did not readily identify themselves as carers, despite carrying out significant caring responsibilities. The majority of responses to the Law Commission consultation agreed the request mechanism should be removed.

*Requirement that a carer's assessment considers the person's ability and willingness to provide and continue to provide care and whether the carer works or wishes to work or is undertaking or wishes to undertake education, training or any leisure activity.*

- 3.20 This would consolidate existing requirements from different Acts and guidance. It would help to ensure that due consideration is given to supporting carers to have a life of their own alongside caring as well as how they are coping with the caring role. In particular, it would help to ensure that consideration is given to supporting carers to remain in or return to work.

*Local authority discretion to assess a carer who receives payment for care they provide or who is a volunteer worker.*

- 3.21 This would enable local authorities to offer a carer's assessment to a carer who is paid for some of the care they provide or to a volunteer worker, when the authority believes the relationship is not principally commercial or volunteering. This proposal received a mixed response in the Law Commission consultation including concerns that this might erode the distinction between a carer and a paid employee and have resource implications. Making this a power rather than a duty would enable local authorities to decide whether to offer an assessment when the caring relationship appears not to be principally a commercial or volunteering arrangement and to control resource implications. It is not envisaged that this power would be used extensively and resource implications would therefore be minimal.

*Requirement through regulations that local authorities should take into account the results of the assessment of the person cared for in determining whether to provide support to the carer.*

- 3.22 This would support a more unified approach to carers' and users' assessments, which is likely to support better coordination and joint planning, while still

enabling carers to be separately assessed from the person they care for if they so wished. The regulations would also allow for the Secretary of State, if he so wished, to require local authorities to have regard to the family's needs as a whole when undertaking either a user's or carer's assessment. Neither of these proposals is likely to have cost implications.

***Proposal B: Introduce a new duty on local authorities to meet eligible needs for support***

3.23 In addition to the measures outlined under Proposal A, this would entail a new requirement on local authorities to determine whether a carer's needs are eligible needs using eligibility criteria and arrange for support to meet the eligible needs. This would require new legislation – the Care Act would place a new requirement on local authorities and remove the current ambiguity about how decisions are made regarding the provision of support to carers.

3.24 Local authorities are already required in law to provide support to some carers under existing community care legislation, for example, when a critical risk to the sustainability of the caring role is identified. Many authorities already use an eligibility framework in determining and providing support to carers. The resource implications of bringing the practice of all authorities up to this standard by the imposition of a new duty are considered below. Eligible needs for the carer could be met through support to the person cared for as well as support to the carer.

**Costs and benefits of option 2 (proposals A and B)**

*Costs of proposal A (Simplify the legislation in respect of carers' assessments)*

Number of assessments

***Total demand for carers' assessments***

3.25. We have considered two alternative methods of estimating the number of extra carers' assessments generated when the reformed care and support system has reached a steady state. These are:

- **Carer Allowance proxy.** Calculate the number of people receiving Carers Allowance who are caring 50+ hours a week, adjusting upwards to account for over-65s (who do not generally claim Carers Allowance because they are entitled to alternative benefits, usually pensions). Use this as a proxy for the people most likely to come forward (subtracting the number of assessments currently conducted).
- **Carers "known by association" proxy** (a carer "known by association" is someone caring for a person who is receiving local authority social care services). Calculate the number of carers known by association who have not received a carer's assessment – either by envisaging that all local authorities are able to achieve the current 90<sup>th</sup> percentile in terms of proportion of carers' assessments to number of users (39.3%), or by assessing the 35% of carers known by association who said they had not received an assessment in the most recent carer survey (2010).

- 3.26. There is likely to be significant overlap between the two groups – if a person is claiming Carers Allowance for 50+ hours of caring per week, it should be expected that the person cared for is likely to have needs which are eligible for local authority support, meaning that the carer should also be “known by association”. This means that these should be seen as alternative, rather than complementary, estimates.
- 3.27. It is important to emphasise that both methods are only a proxy – in practice it should be expected that not all of the carers in these groups will come forward, and other carers will. Given the inherent difficulty in predicting individual behaviour, no method can claim to be precisely accurate, much will depend on how receptive carers are to national and local communications campaigns. However, the methods above provide a reasonable estimate of the likely demand from carers from 2015/16 onwards.

#### Carers Allowance proxy

- 3.28. Just under 408,000 people were offered carers’ assessments in 2013-14. 38,000 declined – leading to 370,000 assessments being undertaken, with 210,000 having joint assessments with the adult needing care, and 160,000 separate carers’ assessments. This split varies dramatically from one authority to another – so in some local authorities 100% of the carers’ assessments are conducted separately, while in others over 90% of the assessments are joint.
- 3.29. In February 2013, 535,000 carers received the Carer’s Allowance (CA), which is paid to carers on low incomes who provide at least 35 hours of care per week. By February 2014, this number had grown to 565,000. This would suggest growth of at least 5% a year. This is confirmed by the figures for February 2012 – when the numbers receiving CA was 505,000 highlighting growth of 5% in that year. This increase shows a higher trend than the increase in the number of carers in the Census. The numbers of those providing care of over 50 hours a week grew by 25% in the ten years between 2001 and 2011. This may be due to an increased propensity of people to claim CA in part as they are encouraged and helped to do so by public and voluntary sector agencies.
- 3.30. The numbers of carers receiving CA is still well below the number of people providing more than 50 hours of care a week as identified in the Census – which was 1,360,000 in 2011. So for this exercise, we have assumed that the existing trend of 5% growth per annum will continue. To take an average mid-point estimate of the numbers of people likely to receiving CA during 2015-16, we have taken the assumed number at September 2015 (the mid-point of the year). This is 20 months from the February 2014 figure, and based on the same trend we would expect these numbers to grow by a further 8.3% to 610,000 carers.
- 3.31. Care should be taken in making use of the CA figure. Some people will only receive the benefit for a short period – 17.5% of claimants will receive the

allowance for 12 months or less. If carers only receive the allowance for 12 months or less, then they may be less likely to seek a carer's assessment. Applying this adjustment would give a figure for September 2015 of 503,000 individuals receiving CA of 12 months or more.

3.32. Those in receipt of a state pension will only rarely be entitled to receive CA, so the CA figure is likely to systematically underestimate the number of people above pension age who may seek a carer's assessment. This is illustrated in table x below. This table shows the proportion aged 65 and over in receipt of CA, compared to the proportion of those 65 and over providing 50 hours or more of care.

**Table: Carers Allowance and Intensive Caring By Age**

Age	Carer's Allowance		Carers 50+ Hours	
	Numbers (thousands)	Percentage	Numbers (thousands)	Percentage
18 -64	551	97.5	863	63.5
65 and over	14	2.5	497	36.5
<b>Total</b>	<b>565</b>	<b>100</b>	<b>1,360</b>	<b>100</b>

3.33. Table 2 considers the link between those providing 50 hours or more of care per week and those in receipt of CA. Taking the assumption of 503,000 carers in September 2015, we can make an adjustment for the under-representation of those aged 65 and over. If we assume the same proportions as for those aged 18 to 64, then this would give a total of 772,000. However, as people get older they have a greater propensity not to seek support from the State, and making a reasonable allowance for this would imply a potential cohort of 730,000 carers needing an assessment.

**Table: Carers Allowance and Intensive Caring By Age**

Age	Carer's Allowance		Carers 50+ Hours		
	Carers Allowance Numbers	Carers 50 Hours & More	Allowance as a proportion of 50 hours + care	"Carers Allowance" proxy 65 and over Numbers on a similar basis to 18-64	
18 -64	490	863	0.57	490	490
65 and over	13	497	0.03	282	240
<b>Total</b>	<b>503</b>	<b>1,360</b>		<b>772</b>	<b>730</b>

3.34. Having subtracted the existing number of assessments conducted from this total potential group, this would suggest a further 360,000 carers' assessments.



### Carers “known by association” proxy

- 3.35. Activity data (RAP) showed that in the 152 upper tier local authorities, the ratio of carers’ assessments to the overall number of service users ranged from a minimum of 6.9% to a maximum of 69.4%. The median was 25.0% and the 90th percentile was 39.3%.<sup>54</sup>
- 3.36. Our analysis looked at how many additional assessments would be required if those authorities with a proportion lower than the 90<sup>th</sup> percentile were to increase their proportion of assessments to this level. The analysis showed that the number of assessments would need to rise by 50% to enable all local authorities to reach the 90<sup>th</sup> percentile.
- 3.37. An alternative approach is to use data from the PSSRU survey of adult carers 2009/10. Analysis of the survey data from those local authorities that included data on carers “known by association” showed that 35% of those carers did not receive an assessment.<sup>55</sup> This equates to approximately 275,000 carers<sup>56</sup>. Providing them with an assessment would represent a 54% increase in assessments.
- 3.38. The table below summarises the additional assessment costs estimated using the two approaches:

**Table 12: Summary of additional assessment costs**

	<b>Matching the 90<sup>th</sup> percentile</b>	<b>Carers ‘known by association’</b>
Extra carers’ assessments	250,000	275,000
% increase	50%	54%

### **Time profile of demand**

- 3.39. The methods above both provide estimates of the potential group of carers who may benefit from the new rights in the Act, when the additional uptake reaches a steady state year-on-year. However, it would not be reasonable to assume that all of this group will approach the local authority for assessment in the first year (2015/16).
- 3.40. The implementation of similar rights in the past would support an assumption that it will take several years to reach the steady-state scenario discussed above. This is particularly true in relation to carers, who as a group have

<sup>54</sup> NHS Information Centre, Community Care Statistics: Social Services Activity England 2010/11 (Provisional release), November 2011. <http://www.ic.nhs.uk/pubs/carestats1011ssa>

<sup>55</sup> Survey data limited to the 41 councils that included carers known by association.

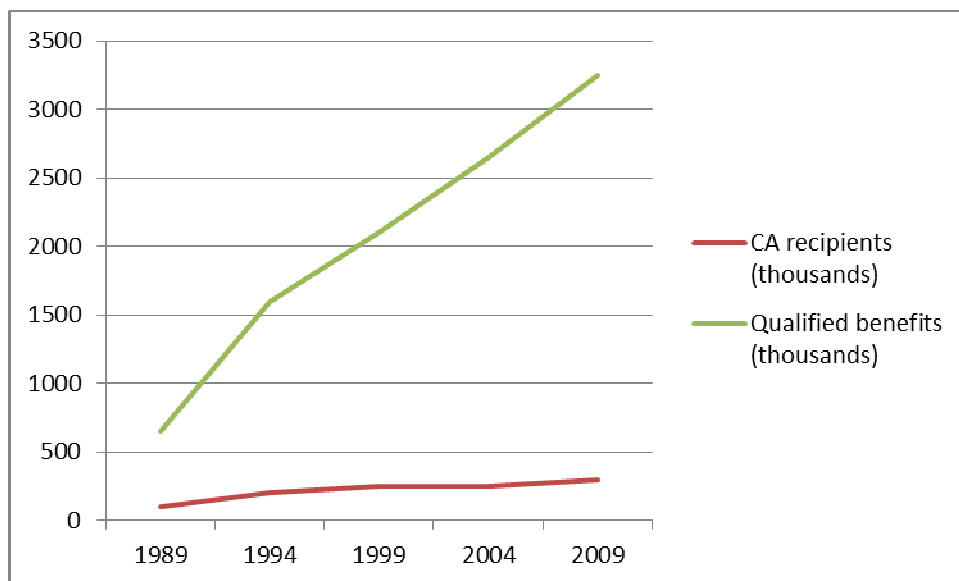
<sup>56</sup> NB: this has been updated to allow for likely increases in the number of carers since the original work

historically shown a marked reluctance to engage with the State. Examples of previous comparable scenarios are discussed below.

### Carers Allowance

3.41. The experience of Carers Allowance does appear to demonstrate that carers are less likely to come forward for support than other groups. A 2010 study by the Institute for Social and Economic Research (commissioned by DWP)<sup>57</sup> shows that the take-up of CA remained relatively static over the 20 years from 1990 – 2010, despite a dramatic increase in take-up of other benefits over the same period.

**Graph: take up of carers allowance v other qualified benefits<sup>58</sup>**



3.42. Some of this discrepancy can of course be accounted for by the fact that the main growth group, over-65s, do not generally claim CA because they have overlapping benefits. However, half of carers are under 65<sup>59</sup>, so a noticeable increase would still have been expected over this time period if carers were equally likely to come forward for support as those they care for.

3.43. Whilst the policy intention of the Care Act is to increase the number of carers coming forward for assessment over time, it is reasonable to assume that the current situation will not change in the first year, so this lack of engagement is an important factor when determining early year (as opposed to steady-state) demand.

<sup>57</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/207552/wp84.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207552/wp84.pdf)

<sup>58</sup> "Other qualified benefits" are Attendance Allowance and Disability Living Allowance – original graph p 23 of ISER study quoted above

<sup>59</sup> Personal Social Services Survey of Adult Carers - England, 2009-10, <http://www.hscic.gov.uk/pubs/psscscarersurvey0910>

3.44. This assumption is further supported by anecdotal evidence indicating that carers are more influenced by word-of-mouth signposting from fellow carers than by national or local communications campaigns. This indicates a “slow-burn” time profile as word of mouth spreads amongst local carers via carers’ centres and other informal contact over time, rather than a profile where steady-state demand occurs almost immediately due to national and local communications.

#### Free personal and nursing care (FPNC) Scotland

3.45. In July 2002, the Scottish Government introduced free personal and nursing care for all older people in Scotland, with the “personal care” element similar to the definition of “care and support” used by the Care Act<sup>60</sup>. The basic policy was to make care and support for older people free at the point of delivery.

3.46. This provides some comparison with the new rights for carers, in that it was a new right available based on meeting relevant criteria following an assessment. However, it would be reasonable to expect take up of free personal care to be higher than take-up of the new rights for carers, at least initially. This is because most of the people entitled to free personal care in Scotland were already receiving local authority services and in many cases were in a care home. This would have made it much easier to raise awareness of the new rights and also meant that the cohort of people targeted were already in contact with the State, which is much less likely to be the case with carers.

3.47. An independent review of FPNC commissioned by the Scottish Government shows that in the first year of introduction the extra spend associated with the FPNC policy was only 53% what it was in the fourth year of implementation<sup>61</sup>, demonstrating a clear “slow-burn” time profile even for a right that is universally available to an easily accessible group of people.

#### Local authority modelling work

3.48. The outputs of work with local authorities to model costs<sup>62</sup> locally indicated a total demand of 334,000 additional carers’ assessments<sup>63</sup>. Local authorities were asked to estimate take-up based on local knowledge, but were also supported to replicate the national steady-state estimates discussed above at a local level to inform this.

3.49. Partly due to uncertainty about the modelling used, many local authorities appear to have based their local estimates for 2015/16 on steady-state calculations. Feedback from conversations with some local authorities also

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<sup>60</sup> Chapter 4, para 25 *Independent Review of Free Personal and Nursing Care in Scotland*, April 2008  
<http://www.scotland.gov.uk/Publications/2008/04/25105036/0>

<sup>61</sup> Chapter 11, Table 7, *Independent Review of Free Personal and Nursing Care in Scotland*, April 2008  
<http://www.scotland.gov.uk/Publications/2008/04/25105036/0> - note that the costs of year one have been multiplied by 1.25 as they are only for nine months of the year.

<sup>62</sup> [Insert reference]

<sup>63</sup> Extrapolating the returns into a national figure for all 152 local authorities

suggests that in light of the uncertainty they have used estimates at the higher end of the range of possibility for 2015/16.

3.50. It has not been possible through quality assurance to verify to what extent the use of steady-state numbers was a deliberate commentary on the time-profile and to what extent it was based on generous estimates, but we do know that at least some of the discrepancy was accidental. In our view, this means that the total number is very likely to be somewhat inflated beyond what might reasonably be expected in the first year.

### Conclusion

3.51. The evidence above supports a range of estimates for the additional demand for carers' assessments, as well as giving some indication of the likely uptake in the early years.

3.52. In light of the local authority modelling work, we have taken a conservative approach and based our estimate for the first year on the Carers Allowance proxy rather than the carers known by association proxy. Taking the examples above which demonstrate slower than expected take-up with analogous reforms, we may make a conservative estimate that 75% of the total group may approach the authority in 2015/16. This equates to 270,000 additional carers' assessments.

3.53. This central estimate of 270,000 carers coming forward in 2015/16 equates to:

- Approximately a 20% percent reduction from the full value of the local authority modelling estimates (to allow for the likely inflation discussed above);
- Three-quarters of those currently entitled to or in receipt of Carers Allowance who are caring over 50 hours a week;
- The full steady-state estimate based on the carers known by association proxy.

3.54. These figures are likely at the generous end of the range of assumptions about time profile, based on past experience showing a significantly slower rate of take-up for more accessible groups. We then assume that this figure will increase over the following two years to a "steady-state" also based on the Carers Allowance proxy (360,000) by 2017/18.

<b>Central estimate of time profile</b>				
	2015/16	2016/17	2017/18	2018/19
Number of extra assessments	270,00	315,000	360,000	360,000

### *Costs of assessments*

3.55. DH had previously estimated the unit cost of a carer's assessment as approximately £100, from data gathered by Surrey County Council. (Costs were estimated between £90 and £120 - those at the higher end being

conducted by a qualified social worker). However, the much more extensive local authority modelling work explained above has produced a median unit cost of £116<sup>64</sup>. While some local authorities are likely to have considered the impact of the Care Act on unit costs (for example, where increased numbers of assessments may give opportunities for economies of scale or new delivery models), conversations indicated that most have simply given their current unit cost for carers' assessments.

- 3.56. The unit cost of any assessment will depend on the complexity of the needs assessed, and therefore the level and nature of professional input. It is also likely that carers "known by association" will require less time-intensive assessments, because they can be assessed at the same time as the person they care for is reviewed (essentially a joint assessment) and the background of the case will already be known to the local authority.
- 3.57. Given that the time profile assumptions discussed above are based on the theory that carers known by association are most likely to come forward first, it seems reasonable to assume that the unit cost of assessments in 2015/16 will be similar to current unit costs, which will largely be based on this scenario.
- 3.58. Over time, we might reasonably expect the average complexity of needs assessed to increase, as messages reach other groups of carers currently unknown to local authorities (and using the assumption that within these groups those with most complex needs are most likely to come forward).
- 3.59. However, both the significant variation in unit costs in the local authority returns and independent research<sup>65</sup> strongly indicate that there is considerable scope for efficiencies around assessment costs across the adult social care system. The Department of Health has committed to support this with comprehensive best practice guidance around effective and efficient interventions for carers, including carer assessment.
- 3.60. In the absence of any data with which to predict future trends, our provisional assumption is therefore that increased efficiencies will broadly balance out increased complexity of cases considered, maintaining a static national unit cost. The Department will be undertaking more detailed work with a group of councils to examine current and future carer unit costs in more detail, which will help to test this assumption. Any relevant outputs from this work will be included in future impact assessments.
- 3.61. Based on this assumption, the expected cost of carer assessments up to and including the steady state is set out below.

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<sup>64</sup> The median is weighted via the Area Cost Adjustment (ACA) methodology.

<sup>65</sup> Audit Commission, *Reducing the cost of assessments and reviews: An adult social care briefing for councils* <http://archive.audit-commission.gov.uk/auditcommission/nationalstudies/localgov/Pages/assessmentsandreviews.aspx.html>

<b>Cost of carer assessments</b>				
	2015/16	2016/17	2017/18	2018/19
Number of extra assessments	270,000	315,000	360,000	360,000
Cost	£31,320,000	£36,540,000	£41,760,000	£41,760,000

*Costs of proposal B (introduce a new duty on local authorities to meet eligible needs for support)*

3.62. The latest RAP data shows that 370,000 carers' assessments were conducted in 2013/14, of whom 172,000 received "carer-specific services" (i.e. support other than information and advice). This would imply an eligibility percentage of 46%, although it is problematic to translate current practice to that under the Care Act. We know that some local authorities provide personal budgets to carers as essentially a preventative or near-universal service, so they are likely to be providing these to at least some carers who may not meet the eligibility criteria under the Care Act. However, it is not possible to quantify this without further research, so we would not propose to adjust for this.

3.63. The returns from local authority modelling broadly replicated the RAP data in terms of eligibility for personal budgets (48%), with a significantly lower likelihood of eligibility for respite care (15%). The lower respite eligibility reflects the fact that most service users receive replacement care where appropriate, so support for their carers is unlikely to require additional respite care, even if they have not previously had a bespoke carer's assessment. In other words – more carers will receive respite care, but we do not need to double-count the cost of this as it is largely within existing provision.

3.64. We have also assumed an even distribution of people coming forward over the course of the year and that someone coming forward for an assessment three-quarters of the way through the year will receive one quarter as much support as someone coming forward at the very beginning of the year. This means that total in-year costs for a given local authority should be based on 50% of the number of people they will have assessed by the end of the year. However, personal budgets tend to be one-off payments that do not vary significantly depending on what part of the year they are given, so the same assumption cannot be made for personal budgets as for respite care.

3.65. In their modelling work, local authorities have also raised the specific point that in the first year there is likely to be a backlog of people waiting for the new rights to come into force, so we might expect a different distribution. We have therefore assumed that 75% of full-year costs will be realised in the first year. However, we believe that this will revert to a standard 50% part-year adjustment in subsequent years.

**Table: New carers coming forward per year**

		2015/16	2016/17	2017/18	2018/19
Number of extra assessments		270,000	315,000	360,000	360,000
<b>Personal budgets</b>	Eligibility	47.85%	47.85%	47.85%	47.85%
	Number	129,195	150,728	172,260	172,260
<b>Respite Care</b>	Eligibility	15.46%	15.46%	15.46%	15.46%
	Number	41,742	48,699	55,656	55,656
	In-year adjustment	75%	50%	50%	50%
	Full-year equivalent number	31,307	24,350	27,828	27,828

3.66. The average duration of a caring spell has been estimated at between 2 to 3 years, informed by the findings of a survey by The Princess Royal Trust for Carers. This would imply that any person assessed in a given year should have the full provision for the following two and a half years (on average). If we were to apply this to the number of new carers receiving support set out above, we would have total numbers of extra carers supported in each given year as below.

**Table: Total extra carers each year based on average 2.5-year caring stint**

		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
<b>Personal budgets</b>	Number	129,195	150,728	172,260	172,260	172,260	172,260
	Including provision from previous years	N/A	279,923	387,585	419,884	430,650	430,650
<b>Respite Care</b>	Total number	41,742	48,699	55,656	55,656	55,656	55,656
	Full-year equivalence	31,307	24,350	27,828	27,828	27,828	27,828
	Including provision from previous years	N/A	66,092	97,398	107,834	111,312	111,312

3.67. For unit costs of personal budgets and respite, we again have the weighted median of local authority returns, which again are likely to represent current practice rather than estimates of the cost of provision under the Care Act. These are £333 for personal budgets and £967 for respite care<sup>66</sup>.

3.68. However, estimating the scale and nature of any such change is very difficult. The only direct work on this comes from a small-scale review by the Personal Social Services Research Unit (PSSRU)<sup>67</sup>, who reviewed the current FACS criteria relating to carers against the draft carer eligibility criteria under the Care Act regulations, and concluded that:

<sup>66</sup> The medians are weighted via the Area Cost Adjustment (ACA) methodology.

<sup>67</sup> [insert reference]

...care package costs under the draft regulations would be very similar to the care package costs under the current regulations for currently eligible carers.

3.69. While this cannot be treated as conclusive evidence, in the absence of any evidence to the contrary we have therefore assumed stable unit costs going forward. As with assessment costs, the Department will be undertaking more detailed work with a group of councils to examine current and future carer unit costs in more detail, which will help to test our assumptions. Any relevant outputs from this work will be included in future impact assessments.

3.70. Assuming stable unit costs and the eligibility proportions discussed above, the full costs of provision would be:

**Table: Total cost of provision**

		2015/16	2016/17	2017/18	2018/19	2019/20
<b>Personal budgets</b>	Numbers	129,195	279,923	387,585	419,884	430,650
	Cost (£333 unit cost)	£43,021,935	£93,214,193	£129,065,805	£139,821,289	£143,406,450
<b>Respite care</b>	Numbers	31,307	97,398	107,834	111,312	111,312
	Cost (£967 unit cost)	£30,273,386	£94,183,866	£104,274,995	£107,638,704	£107,638,704
<b>Total</b>		<b>£73,295,321</b>	<b>£187,398,059</b>	<b>£233,340,800</b>	<b>£247,459,993</b>	<b>£251,045,154</b>

*Cost savings of option 2 (proposals A and B)*

3.71 Improved identification of needs and support for carers resulting from option 2 are likely to lead to savings in terms of public expenditure costs avoided. A study by NIHR School for Social Care Research (Linda Pickard et al)<sup>68</sup> has estimated that the public expenditure costs of working age carers leaving employment as a result of their caring role are £1.3 billion per year in England, comprising:

- additional payments of Carers Allowance of £0.3 billion per year (assuming £2,600 per year for 115,000 carers); and,
- foregone tax revenue of £1.0 billion per year (i.e. revenue lost as result of carers giving up employment).

3.72 It is not straightforward to link this research to the impact of provisions for carers in Part 1 of the Care Act. However, as a result of improved access to assessment of need (without any restriction based on quantity of caring provided), and new rights to support to meet eligible needs, it can be assumed that a proportion of carers who might otherwise have given up paid work will in the future be supported to maintain employment.

<sup>68</sup> <http://blogs.lse.ac.uk/healthandsocialcare/2012/04/25/dr-linda-pickard-public-expenditure-costs-of-carers-leaving-employment/>



3.73 If the provisions in the Act prevent 20-40% of carers currently in employment from giving up work over time as the system reaches a steady state, based on the study above cost savings to the public purse would be in the region of £260m-£520m per year). Using a central estimate of 30% of carers remaining in employment, this would equate to savings of £390 million per year –£429.3 million in 2015/16 prices.

*Summary of costs of option 2 (proposals A and B)*

3.74 We estimate that implementing these proposals would generate additional assessments at a cost rising to £41.8 million by 2017/18, and demand for support for carers would correspondingly increase. Costs arising from provision of support further to the extra assessments are estimated to rise to £251 million by 2019/20. Cost savings arising from public expenditure avoided through improved support to carers to remain in employment are estimated at £390 million.

3.75 We envisage that the demand for assessment and support will increase gradually once new legislation comes into effect and therefore we estimate that the associated costs and savings are likely to increase as follows:

**Table 14: Estimated costs associated with increased demand for assessment and support**

<i>£ millions, 15/16 prices</i>	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Support for carers assessments	£31.3	£36.6	£41.8	£41.8	£41.8	£41.8	£41.8	£41.8	£41.8	£41.8
Support for carers services	£73.3	£187.4	£233.3	£247.5	£251.0	£251.0	£251.0	£251.0	£251.0	£251.0
Recurring Savings	£154.7	£196.3	£282.1	£355.7	£429.3	£429.3	£429.3	£429.3	£429.3	£429.3

3.76 The Care Act will include an enhanced duty to co-operate between the NHS, local authorities and others. It is possible that some of the costs of support for carers might fall to the NHS rather than to councils. It is also possible that improved care and support for carers will reduce their need to use NHS services. These interactions are difficult to predict, and have not been quantified. However, resources have been provided to the NHS to support carers and which may be used to meet additional demand.

3.77 Following a carer assessment, care and support to meet eligible needs (such as respite care) could be subject to means testing as it is now and we estimate this could potentially reduce the costs of support by some 5%. Local authorities would also retain the power to charge carers for support directly provided to them, although we anticipate that, as now, they would use this power sparingly in recognition of the significant contribution that carers make both in terms of the value of the care they provide and because that care can avoid or delay a user’s need for long-term nursing or residential care.<sup>69</sup>

3.78 The extra numbers of carer assessments and carer support services that might result directly from these changes to legislation are inevitably uncertain. We believe that our estimates are plausible, but clearly there is a risk that they could prove to be under-estimates or over-estimates. If our estimates of take up prove to be under-estimates, councils may need either to limit the amount of support that they offer to each carer or to change local priorities between support for carers and other services.

<sup>69</sup> Wanless, D., *Securing Good Care for Older People: Taking a Long Term View*, King's Fund 2006.

3.79 We might also expect that proposals relating to assessment and support for carers, in conjunction with proposals for improved information and advice could increase awareness of and have a consequential effect on the number of people applying for Carer's Allowance and any linked benefits or services. An increase in the number of assessments over the current level could lead to an increase in the number of people claiming Carer's Allowance. The size of this impact will depend upon the characteristics of the people who claim – for example, an individual's age, whether they are in paid employment and the extent of their caring role will all affect whether they are eligible to receive Carer's Allowance. It is not possible to estimate this cost robustly at this stage and we will look to gather further evidence via the consultation in order to do so.

*Benefits of option 2 (proposals A and B)*

3.80 The impact assessment that accompanied publication of the updated Carers Strategy in November 2010 identified a number of benefits to be gained from strengthening support for carers, particularly in terms of preventing carer burn-out, early interventions that maintain or improve carers' health and greater choice and control for individual carers.<sup>70</sup>

3.81 The PSSRU Survey of Adult Carers 2009/10 was based on 35,000 responses from carers over 18 years of age who were in touch with social services either through having been assessed or reviewed themselves, or named on the file of a care user assessed or reviewed in the previous 12 months.<sup>71</sup> This indicates that most of those receiving carer support, including breaks, were very satisfied:

- 54% of carers reported they were extremely or very satisfied with support or services - of those 54%, 45% said they had as much control over their daily lives as they wanted;
- 61% of carers accessing breaks of more than 24 hours were either extremely or very satisfied.

3.82 The Survey of Carers in Households 2009/10, based on just over 2,000 responses, gives an indication of the low proportion of carers in the population who are currently assessed and the potential unmet need for support (though it does not go into the level of support that might be needed):<sup>72</sup>

- 6% of carers were offered assessment and 4% had been assessed. 67% of those assessed had received some sort of service;
- 66% said someone else would need to look after the person they cared for if they wanted a break from caring for a couple of days. 16% said there was no one they could rely on to provide care.

3.83 The Survey of Carers in Households also shows the adverse effects of caring that we expect to alleviate through reform of the law:

- Among working age carers, 26% felt caring had affected their ability to stay in employment, and of these, 39% had left work altogether, 32% had reduced their employment hours and 18% had agreed flexible employment arrangements;

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<sup>70</sup> Impact Assessment for *Recognised, valued and supported: next steps for the Carers Strategy*, Department of Health, 2010.

<sup>71</sup> NHS Information Centre, *Personal Social Services Survey of Adult Carers in England 2009-10*, 2011.

<sup>72</sup> NHS Information Centre, *Survey of Carers in Households 2009-10*, 2011

- Around half (52%) of carers said that their health had been affected because of the care they provide (39% of those caring for less than 20 hours and 66% of those caring for 20 or more hours);
  - Around two in five carers (42%) said their personal relationships, social life or leisure time had been affected because of the assistance they provided.
- 3.84 The independent evaluation of the Carers Strategy Demonstrator Sites published in November 2011 reports potential benefits from improving both assessment and support for carers including:<sup>73</sup>
- Preventing or delaying hospital or residential care admissions for care users;
  - Sustaining the caring role;
  - Improved health and wellbeing of carers;
  - Assisting carers to remain in or return to work;
  - Access to peer support networks.
- 3.85 Particular points to note from the evaluation of the demonstrator sites are:
- Carers valued different ways of accessing support including self-assessment. Assessments focusing on carers identifying their own support needs rather than a range of services offered by the local authority often resulted in low cost solutions and/or support from family and friends.
  - Breaks from caring and practical support have the potential to prevent carer burnout and health deterioration and to sustain the caring role. A minority of carers reported that taking a break from caring or practical support had improved how they cared for themselves, their ability to cope and deal with stress and how they felt about life.
  - Carers who did not receive a break were more likely to show deterioration in wellbeing scores.
  - In three sites, alternative care for the user was offered as well as a personal budget to enable carers to undertake an activity to give them a break from caring. However, few carers took up the offer of paid alternative care because having the flexibility to tailor a break to their choice and time enabled them to arrange replacement care informally with friends and family - and many understandably said they preferred this.
  - Positive health and wellbeing outcomes for a substantial numbers of carers can be maintained when carers are facing particular challenges including when the caring role begins, when carers experience strain and when they have intense or long-term caring roles.
- 3.86 There is a lack of quantitative evidence about the impact on carers' welfare of carer assessments and support. We would expect care support to have an impact on carer stress, anxiety and morale. If carer support improved carers' state on the EQ5D anxiety/depression dimension from moderate anxiety/depression to no anxiety/depression this would constitute a gain of 0.071 quality-adjusted life years (QALYs) per year.
- 3.87 The Department of Health values a year of life at perfect health (a quality adjusted life-year or QALY) at £60,000 when being compared to the opportunity cost of health care expenditure, or £25,000 when costs are expressed in

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<sup>73</sup> CIRCLE, *New Approaches to Supporting carers' Health and Well-being: Evidence from the National Carers Strategy Demonstrator Sites*, University of Leeds, 2011.

financial terms. This estimate is calculated using the societal value of a statistical life estimated to be £1.8 million, based on evidence from the Department for Transport. When health benefits, improved quality-of-life or lives saved are a likely outcome of a policy initiative, quantifying and monetising benefits in this way enables comparisons with costs, to understand whether the likely benefits of a policy will outweigh the costs.

3.88 If a QALY is valued at £60,000 as above, an improvement of 0.071 QALYs per year over 3 years would be worth almost £12,800 over 3 years. Using the same assumption as to the number of additional carers who may receive support (see above) as a result of the new legal provisions, this gives a basis for estimating benefits which may arise. If all of these additional carers experience a significant improvement in anxiety/depression as a result of support provided by the local authority, benefits would be in the order of £2.3 billion per year in a steady state.

3.89 These illustrative benefits are set out in the table below. As with our approach to costs, we assume that benefits will increase gradually as more carers undergo assessments and receive support over time.

**Table 15: Summary of monetised benefits for carers**

	2015/16	2016/17	2017/18	2018/19	2019/20
Personal budgets number	129,195	279,923	387,585	419,884	430,650
Respite number	31,307	97,398	107,834	111,312	111,312
Total carers supported	<b>160,502</b>	<b>377,321</b>	<b>495,419</b>	<b>531,196</b>	<b>541,962</b>
Monetised quality of life benefits	<b>£683,736,390</b>	<b>£1,607,385,330</b>	<b>£2,110,482,810</b>	<b>£2,262,893,895</b>	<b>£2,308,758,120</b>

3.90 These illustrative estimates of the value of the gain from carer support are well in excess of the assumed costs above. Even if care support had a lower impact, so long as the impact was over 20% of a move from moderate to no anxiety/depression, it would still be cost-effective. This suggests that, although there can be no certainty without robust evidence, the proposed expansion of carer assessments and support is highly likely to be cost-effective. Robust quantitative research on the impact of carer support on carer welfare would be valuable.

#### *Non-monetisable benefits*

3.91 The new rights for carers are also very likely to lead to significant financial benefits for both councils and the NHS in terms of:

- Savings to councils from increased ability of carers to meet eligible needs. Increased support is very likely to prevent carers from reaching crisis point and no longer being able to care, which would require the council to meet eligible care and support needs themselves, usually at a much greater cost.
- Savings to the NHS from increased ability of carers to meet health needs. Carers also meet a variety of low-level health needs that the NHS would

otherwise be required to meet, so support would generate similar savings to the health system.<sup>74 75</sup>

3.92 It is not possible to robustly monetise these benefits, because there is no clear link between those carers who are likely to receive support and the extent to which they fulfil these roles, but the benefits are likely to significantly outweigh the costs set out above, separately to the monetised QALY benefits discussed above.

### ***Summary of proposals in respect of carers***

3.93 The Information Centre surveys cited above show the low level of carers who currently receive assessment, the potential unmet need for support and that the majority of those receiving carer support from local authorities were very satisfied. It is not easy to make a direct link between investment in support for carers and cost savings or costs avoided. Evidence collected from the demonstrator sites identified a number of potential cost savings to be obtained from supporting carers as well as evidence of improvements in carers' health and wellbeing and ability to continue with a caring role. Further research is needed to strengthen the evidence base on the impact of carer support on carers' health and wellbeing.

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<sup>74</sup> For example, work for Surrey County Council indicates that a spend of £5m on carers saves £14.7m-£29.5m, with two thirds of the savings to adult social care and one third to the NHS.

<sup>75</sup> A separate study by Carers UK and the University of Leeds suggested that carers save the NHS £119bn a year [insert link]

## **2C. ACCESS TO INDEPENDENT ADVOCACY**

### **Background – case for change**

- 4.1 At present there is no duty on local authorities, beyond that provided by the Mental Health Act 2007 and the Mental Capacity Act 2005, to provide independent advocacy services to support people to have full involvement in care and support processes conducted by the authority – including safeguarding enquiries, assessments of need, care and support planning, and reviews. The availability of independent advocacy is spasmodic and varies across England from authority to authority, dependent on local priorities and decisions<sup>76</sup>.
- 4.2 Practice and evidence suggests that, although the system can be complicated to navigate and understand, the majority of people can be supported appropriately through these processes by local authority care and support staff (social workers, social work assistants etc.), and with support and help from family and friends. Particularly since the introduction and development of personalisation, there is growing evidence that people benefit from independent and peer support to help guide them through the process – enabling them to think and articulate their own needs and the life outcomes they want their care to support them achieve. Increasingly, local authorities are commissioning independent services particularly to support people to develop and put in place their own care and care and support plans.
- 4.3 For some people, there is a need for the services of an independent advocate to support them to make decisions through the care and support processes<sup>77</sup>. This will, for example, include those who may have particular difficulties in understanding or retaining information or in communicating or articulating their wishes. This will include some people with learning difficulties, autism and those who have mental health and neurological conditions, often multiple conditions that make communications problematic.

### **Policy objective**

- 4.4 Our aim in reforming the law is to support equality of access, and ensure that all people can be fully involved in the key processes to which their input is essential – including safeguarding enquiries, needs assessment, care and support and care planning and any subsequent review of their care and support needs.

### **Summary of options**

#### ***Option 1: Do nothing***

- 4.5 Doing nothing would mean that the responsibilities for provision of any advocacy services locally would remain at the discretion of each individual local authority. The provision would remain inconsistent across England, and there would be a number of related consequences:

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<sup>76</sup> Research Report 67: Advocacy in social care for groups protected under equality legislation, Equality and Human Rights Commission 2010

<sup>77</sup> Closer to Home: An inquiry into older people and human rights in home care. Equality and Human Rights Commission 2011

- i. a lack of support for some people to be adequately involved in the assessment of their care and support needs and the development of their own care and support or support plan. This may result in care being provided which does not meet a person's needs, with a higher cost to both the individual and to the state than would have been the case had the person been properly involved;
- ii. confusion for individuals who would not know when the services of an advocate may be available to them;
- iii. the risk of litigation under the Equality and Human Rights Act; and,
- iv. variability in access to advocacy services from one area to another.

***Option 2: Access to advocacy to support involvement in care and support 'process' for a defined range of people – (preferred option)***

- 4.6 This proposal places a duty on local authorities to provide an independent advocate to assist defined individuals (adults, carers and children in transition and their carers) in their involvement during a safeguarding enquiry, needs or carer's assessment, care and support plan or support plan, and review process.
- 4.7 This will be confined to advocacy to support a person's *involvement in these specific processes*, and not in relation to the services of an advocate that may be included as a means of meeting any on-going need that may be included in their care and support plan.
- 4.8 The services of an independent advocate should be available to those without family or friends willing or able to act on their behalf, where the local authority considers that without the assistance of an advocate the adult will experience substantial difficulty in relation to one or more of the following:
  - understanding, retaining, using or weighing the information relevant to the process of assessment, care and support planning or review; or,
  - expressing or communicating their own views or wishes and feelings.
- 4.9 This will also need to be available to carers going through the assessment and support planning process, and in the circumstances when a young person or their carer requires an assessment of needs prior or as part of the transitional arrangements to adult care and support.
- 4.10 Regulations and statutory guidance (published for consultation) under the Care Act provide additional explanation of the requirements for the availability of independent advocates. In particular they cover:
  - local authorities' responsibilities to provide independent advocacy;
  - matters which a local authority must consider in deciding whether an individual would experience substantial difficulty in engaging with care and support 'process';
  - circumstances in which an advocate must be provided; and,
  - role of advocate and how independent advocates are to carry out their functions.

- 4.11 The advocacy requirements build on the wider duties of local authorities to involve people in decisions made about them and their care and support. People should be active partners in the key care and support processes of assessment, care and support planning and review. The requirement is that local authorities arrange an independent advocate to facilitate the involvement of a person in their assessment, in the preparation of their care and support plan and in the review of their care plan, if two conditions are met. The aim is to provide assistance; first, to people who have substantial difficulty in being fully involved in these processes and second, where there is no one appropriate available to support and represent the person's wishes. The role of the independent advocate is to support and represent the person, and to facilitate their involvement in the key processes and interactions with the local authority.
- 4.12 This duty applies to all adults, as part of their own assessment and care planning and care reviews, as well as to those in their role as carers. It also applies to children who are approaching the transition to adult care and support, when a child's needs assessment is carried out, and when a young carer's assessment is undertaken.

### **Costs and benefits of Option 1 (do nothing)**

- 4.13 Currently people are not adequately and appropriately involved in the assessment of their needs and care planning and access to advocacy services is variable across different areas. Failing to sufficiently involve people in decisions about their own care and support may result in services being provided which do not meet the person's requirements, which are more likely to breakdown, leading to high cost or emergency placements. It may also limit the potential to develop alternative community based support at lower cost than conventional services. The costs of the consequence of this cannot be easily monetised.

### **Costs and benefits of Option 2 (preferred option)**

#### *Costs*

#### *During assessment and review*

- 4.14 Data published by the HSCIC suggest that in 2012-13, 405,000 people were assessed and went on to receive a service, and 870,000 people were reviewed. The introduction of care and support funding reforms means there will be additional assessments and reviews from April 2016. In addition there is a transitional period over 2015/16 and 2016/17, where the current stock of individuals self-funding their care and support will need to be assessed. To manage this spike in assessments, these 460,000 assessments will be spread out evenly around the implementation date, 50% in 2015/16 and 50% in 2016/17. The estimated number of additional assessments and reviews, for those who are expected to be deemed eligible, as a result of funding reforms are set out below.

**Table 16: Additional assessments/reviews arising from funding reform proposals**

	2015/16	2016/17	2017/18	2018/19	2019/20
<b>Additional assessments</b>	230,000	435,000	210,000	216,000	224,000
<b>Additional reviews</b>	0	255,000	495,000	512,000	530,000



- 4.15 Of those that are assessed or have a review, we estimate that about 10% of people would not have family or friends willing or able to act on their behalf, and would therefore be eligible for independent advocacy under this Option. This estimate is based on evidence from the experience within IMCA services where individuals are eligible for advocacy support in making key decisions if they do not have family and friends. Advice from those working in the sector supports this estimate.
- 4.16 Of this group, we have assumed that some people will not take up this service as they will have the capacity to, and want to, advocate for themselves. Advice from experts suggests that the proportion of take up at assessment stage is likely to be high, it has been assumed that 70% of those that are eligible will take up the offer of advocacy. We have also been informed by organisations currently delivering advocacy support that on average this group of users will require 17 hours of advocacy support at a cost of £30 per hour (in 2012-13 prices). Therefore our best estimate related to all assessments (baseline plus additional assessments arising as a result of the funding reforms) is that the additional costs would be around £23m by 2018/19 (as set out in table 16).
- 4.17 At the review stage of the process, advocacy services suggest that take up of advocacy is likely to be lower. It has been assumed that between 25% to 50% will need support at review stage and again based on advice from providers of advocacy that on average they will require 8 hours of advocacy support at a cost of £30 per hour (in 2012-13 prices). Therefore our best estimate related to all reviews (baseline plus additional reviews resulting from the funding reforms) is that the additional costs would range from £9m to £18m (mid-point £13m) by 2018/19 (as set out in table 16).

### *Carers*

- 4.18 Some carers who receive a service – there were 169,000<sup>78</sup> in 2012-13 – are likely to require advocacy support, but the proportion requiring support and the average level of support required is likely to be lower than for users of adult care and support. Based on discussions with carers and advocacy organisations, it has been assumed that 10% of carers receiving a service will require advocacy support, and that on average they will require 5 hours of support at a cost of £30 per hour (in 2012-13 prices). Therefore our best estimate is that the additional costs would be around £3m.

### *Safeguarding*

- 4.19 In 2012-13, there were 112,000<sup>79</sup> safeguarding referrals. However, we know that some referrals do not constitute a full safeguarding case. Based on discussions with experts in the field, it has been assumed that this accounts for two-thirds of referrals, and we have therefore excluded them. Of the remainder it has been assumed that about two-thirds of people would take up an offer of independent advocacy – about 25,000 people. Based on discussions with those that provide advocacy services the number of sessions required on average per case is assumed to be 22, which includes some time for training and awareness raising. It has been assumed the cost per hour of advocacy is

<sup>78</sup> Social Services Activity England 2012-13 (provisional) (HSCIC)

<sup>79</sup> Abuse of vulnerable adults in England 2012-13 (provisional) (HSCIC)

£30 (in 2012-13 prices). Having taken account of demographic growth, this gives an overall cost of £16m in 2015-16. However we know that true safeguarding cases are under reported. If this position were to improve and we assume that there would be an additional 50% of referrals, costs would rise to £26m. Therefore our best estimate is that additional costs would be between £17m and £26m (midpoint £22m).

4.20 We have assumed that take up of advocacy services for assessments, reviews, carers and safeguarding will build up over time. Therefore we have assumed that in the first year 25% of the total costs are incurred, rising to 50% in year 2, 75% in year 3 and 100% in year 4. This is based on the fact that assessments related to funding reform will naturally increase over time as set out above, that reviews will by definition increase over time as more people come into the system each year and that safeguarding enquiries will increase as the system beds in and becomes more efficient at identifying risks.

4.21 In summary the additional costs of advocacy, and expected numbers of recipients of independent advocates, under option 2 (shown in 2015/16 prices) are:

**Table 17: Costs of advocacy (option 2)**

<i>£ millions, 15/16 prices</i>	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Assessments	£5.6	£15.2	£18.7	£25.4	£25.4	£25.4	£25.4	£25.4	£25.4	£25.4
Reviews (mid)	£2.4	£6.0	£10.4	£14.2	£14.2	£14.2	£14.2	£14.2	£14.2	£14.2
Carers	£0.8	£1.5	£2.4	£3.0	£3.0	£3.0	£3.0	£3.0	£3.0	£3.0
Safeguarding (mid)	£5.8	£11.8	£18.0	£24.5	£24.5	£24.5	£24.5	£24.5	£24.5	£24.5
<b>Total recurring costs</b>	<b>£14.5</b>	<b>£34.6</b>	<b>£49.5</b>	<b>£67.1</b>	<b>£67.1</b>	<b>£67.1</b>	<b>£67.1</b>	<b>£67.1</b>	<b>£67.1</b>	<b>£67.1</b>

**Table 18: Summary of numbers of people receiving advocacy (option 2)**

<b>Proposal</b>	<b>Year1 2015/ 16</b>	<b>Year2 2016/ 17</b>	<b>Year3 2017/ 18</b>	<b>Year4 2018/ 19</b>	<b>Year5 2019/ 20</b>
Assessments	10,300	28,200	34,500	46,900	46,900
Reviews (mid)	9,300	23,700	41,000	55,700	55,700
Carers	4,500	8,900	13,400	17,900	17,900
Safeguarding (mid)	8,200	16,500	24,700	33,000	33,000
<b>Total</b>	<b>32,300</b>	<b>77,300</b>	<b>113,600</b>	<b>153,500</b>	<b>153,500</b>

## Benefits

4.22 The Law Commission's *Adult Social Care* report (May 2011)<sup>80</sup> recognised that "The evidence presented by consultees<sup>81</sup> makes clear that advocacy services play an essential role in assisting people to make and communicate decisions, safeguarding people from abuse and neglect and helping people to enforce their rights, secure access to justice and obtain an effective remedy".

<sup>80</sup> The Law Commission: *Adult Social Care* (May 2011) pg. 185 paras 12.2 to 12.9  
[http://lawcommission.justice.gov.uk/docs/lc326\\_adult\\_social\\_care.pdf](http://lawcommission.justice.gov.uk/docs/lc326_adult_social_care.pdf)

<sup>81</sup> Law Commission, *Adult Social Care: Consultation Analysis* (2011) paras 14.2 to 14.19.  
[http://lawcommission.justice.gov.uk/docs/ASC\\_Consultation\\_Analysis\\_full-version.pdf](http://lawcommission.justice.gov.uk/docs/ASC_Consultation_Analysis_full-version.pdf)

- 4.23 Independent advocacy can be particularly valuable when the relationship between the person being supported and the social worker has eroded (Featherstone et al, 2012)<sup>82</sup>. In such cases, the advocate can act as an important bridge between both parties and can help to repair damaged relationships.
- 4.24 The EHRC<sup>83</sup> has shown that “Independent advocacy has a central role to play in promoting people’s safety and security without compromising their personal autonomy through supporting decision-making and communication, removing the undue interference of others and in enabling individuals to recognise the strengths and weakness, opportunities and threats of different options available to them”.
- 4.25 SCIE’s publication *Prevention in Adult Safeguarding* (May 2011)<sup>84</sup> concludes, “Advocacy can make a significant contribution to prevention of abuse through enabling adults at risk to become more aware of their rights and able to express their concerns”.
- 4.26 Advocacy can help to empower people in these circumstances and working alongside other services, it can also help to identify when harm is occurring and ensure that appropriate action is taken.
- 4.27 Some research has been undertaken of the cost effectiveness of advocacy services. These are described below. In interpreting them, we need to bear in mind that the context of the advocacy support being provided in each study is different and is not directly comparable to those services being proposed in this option. However, they do give an indication that advocacy services in some circumstances may be cost effective.
- 4.28 One study<sup>85</sup> looked at the economic case for advocacy interventions for parents with learning disabilities whose children are going through child protection proceedings. It suggests investing in advocacy for parents with learning disabilities is likely to offset costs in the short term and bring a positive return on investment from a wider public sector perspective. Furthermore, the research findings suggest that there could be additional quality of life improvements to the parent due to reduced anxiety, stress and depression. In addition, there may be some productivity gains from a few parents who seek and find employment as a result of the advocacy intervention, possibly due to an increase in confidence and skills in communicating with professionals. The researchers note that there are limitations to the study and therefore the results should be seen as tentative in nature, but highlight the potential of advocacy services for this group. Advocacy can help to empower people in these circumstances and working alongside other services, it can also help to identify when harm is occurring and ensure that appropriate action is taken.
- 4.29 Evidence from wider forms of advocacy is beginning to emerge, such as the Scottish Independence Advocacy Alliance advocacy project with Older People

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<sup>82</sup> Featherstone B and Fraser C (2012) I'm just a mother. I'm nothing special, they're all professionals: Parental advocacy as an aid to parental engagement, *Child and Family Social Work*, 17(2), 244-253

<sup>83</sup> From Safety Net to Spring Board; EHRC (Feb 2009)  
[http://www.equalityhumanrights.com/uploaded\\_files/safetynet\\_springboard.pdf](http://www.equalityhumanrights.com/uploaded_files/safetynet_springboard.pdf)

<sup>84</sup> SCIE's publication *Prevention in Adult Safeguarding* (May 2011)  
<http://www.scie.org.uk/publications/reports/report41/files/report41.pdf>

<sup>85</sup> *Investing in Advocacy Interventions for Parents with Learning Disabilities: What is the economic Argument* (PSSRU/LSE April 2013) <http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/DP2860.pdf>

in Glasgow. Results from a project to look at the Social Return on Investment have not yet been published, but they have reported early findings<sup>86</sup> indicate that for every £1 invested in older people's advocacy, a social return of investment of £8.00 is returned.

- 4.30 In addition to the evidence from research studies, descriptive benefits of advocacy services from providers of advocacy support and those reported as a result of the IMCA services are:
- People have improved outcomes and experiences of care and support as advocacy services mean that more people are listened to and are in control of their lives.
  - As a result of being able to express their wishes and influence the process of assessment and planning, more people with complex needs receive more appropriate care and support arrangements. Evidence from the introduction of personalisation in the form of personal budgets suggests this would result in improved outcomes for individuals<sup>87</sup>.
- 4.31 Where appropriate advocacy support has not been provided, this can sometimes result in a breakdown of relationships and or the care package. Where relationships break down, the additional time required to resolve and rebuild relationships is longer than if an advocate had been involved from the beginning. Where the care package breaks down, this could result in the use of expensive emergency care provision resulting in higher costs.
- 4.32 In addition, a Voluntary Organisations Disability Group (VODG) report<sup>88</sup> makes the case for better planning resulting in better value support through a range of case studies.
- 4.33 We do not attach a monetary value to the increased advocacy service, but the evidence cited above suggests significant welfare gains and reductions in administrative costs required to resolve complex cases that have broken down or proved unsustainable.

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<sup>86</sup> Scottish Independent Advocacy Alliance - the SROI project Pg6/7  
[http://www.siaa.org.uk/images/siaa\\_magspring13.pdf](http://www.siaa.org.uk/images/siaa_magspring13.pdf)

<sup>87</sup> See section 1E of the Care Act 2014 for benefits of personalisation via personal budgets.

<sup>88</sup> *Advocacy – a voice for our future: VODG*  
[www.vodg.org.uk/news/203/111/New-report-shows-that-after-Winterbourne-advocacy-is-a-voice-for-our-future.html](http://www.vodg.org.uk/news/203/111/New-report-shows-that-after-Winterbourne-advocacy-is-a-voice-for-our-future.html)

## 2D. CARE AND SUPPORT FOR PEOPLE IN PRISON

### Background – case for change

- 5.1 At present, a lack of clarity in legislation means that the majority of local authorities do not consider they have a responsibility for the provision of care and support to people in prison. Evidence suggests that uncertainty about responsibilities for assessment and provision with regards to prisoners means that care needs are often not assessed, identified or provided for, both in prison and possibly on return to the community.<sup>899091</sup> If care needs are identified by the prison, they are unlikely to be met by a local authority.
- 5.2 A Prison Governors Association survey, for example, found that 40% of respondents said prisoners themselves provided care and support in their prison. Half of prison governors said care was provided by prison staff who were not part of healthcare services, while just 4% said local authorities provided staff to provide care and support.
- 5.3 Some prisoners may have had care needs before they entered prison. Provision can sometimes be discontinued once an individual enters a prison setting, which may impair rehabilitation and consequently increase the risk of re-offending upon release.
- 5.4 Some prisoners may develop needs after they enter prison. As for individuals within the community, local authority specialist expertise should be available to undertake assessment and facilitate the provision of care in order to minimise disability, support rehabilitation and ensure satisfactory supported return to the community or transfer, if appropriate, to a residential or nursing home.
- 5.5 There has been recent criticism of the quality of care and support provision in prisons from such bodies as Her Majesty's Chief Inspector of Prisons<sup>92</sup>, the Prison Probation Ombudsman prison Independent Monitoring Boards in their annual report to the Secretary of State for Justice, coroners and prisoner advocacy organisations such as the Prison Reform Trust.<sup>93</sup>
- 5.6 There are considerable risks resulting from the current lack of legal clarity regarding care and support provision in prisons:
- Care needs may not be assessed, identified or provided for, which can have negative effects on health and wellbeing outcomes for individuals.
  - If prisoners' needs are unmet or inadequately catered for, there is a risk of litigation. Prisoners who have not had their needs appropriately assessed, or been provided with the appropriate aids and adaptations, and or for whom the prison failed to make reasonable physical and regime adjustments have successfully sued the Ministry of Justice for lack of care and there are currently several ongoing cases.

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<sup>89</sup> The Law Commission, *Adult Social Care*, May 2011

<sup>90</sup> Her Majesty's Chief Inspectorate of Prisons, *Old and Quiet*, 2004

<sup>91</sup> Her Majesty's Chief Inspectorate of Prisons, *Older prisoners in England and Wales: a follow-up to the 2004 thematic review by HM Chief Inspector of Prisons*, 2008

<sup>92</sup> Her Majesty's Chief Inspectorate of Prisons, *Old and Quiet*, 2004 and *Older prisoners in England and Wales: a follow-up to the 2004 thematic review by HM Chief Inspector of Prisons*, 2008

<sup>93</sup> Prison Reform Trust Press briefings, December 2010

- Similarly, there is a risk that litigation may be initiated by prison officers or other prisoners who undertake care and support activities for which they are inadequately trained.<sup>94</sup>
- In the absence of care and support provision in prison, some prison *healthcare* providers give personal care.<sup>95/96</sup> As this should not ordinarily be a healthcare responsibility, this can be a source of local conflict. Moreover, it represents an inappropriate use of healthcare resource.
- Lack of portability for care within the prison system can hamper a prisoner's rehabilitation. A prisoner's journey throughout the prison system is guided in part by their sentence plan, which addresses their offending behaviour. The lack of clarity regarding responsibilities for care and support can be a barrier when attempting to transfer a prisoner to another prison. The receiving prison may claim it is unable to meet this prisoner's needs because the local authority in whose area the prison is situated does not perceive the prisoner's care to be their responsibility. Consequently, some prisoners do not progress satisfactorily through the prison estate as required by their sentence plan. This can increase the length of time spent in prison, increase the risk of re-offending and place an additional burden on criminal justice system resources.
- In some instances, unmet care and support needs may be manifested by poor or disruptive behaviour that can affect other prisoners and compromise control and order in the prison.

5.7 In contrast, responsibilities for healthcare are clearly defined. In 2000, the Department of Health became responsible for prison healthcare, initially on a shared basis with HM Prison Service. Financial responsibility transferred to the Department of Health in 2003. Responsibility for prison healthcare now lies with the NHS and operates on the principle of equivalence. This means that prisoners are entitled to the same standard of healthcare in prison as they would expect in the community. Similarly clarifying the position regarding care and support would enable this principle of equivalence to be extended, would promote consistency and equality and enable health and care and support to be aligned, as they are in the wider community.

### **Policy objective**

5.8 To provide better access to assessment and provision of care for people with care needs in prison, improving their health and wellbeing, reducing unmet need and the risk of litigation and supporting better use of public resource in meeting those needs

### **Summary of options**

#### ***Option 1: Do nothing***

5.9 Doing nothing would mean that responsibilities for prisoners' care and support will continue to be unclear with the following consequences:

- The current confusion regarding responsibilities for care and support needs will continue;

<sup>94</sup> Her Majesty's Chief Inspectorate of Prisons, *Old and Quiet*, 2004

<sup>95</sup> Her Majesty's Chief Inspectorate of Prisons, *Older prisoners in England and Wales: a follow-up to the 2004 thematic review* by HM Chief Inspector of Prisons, 2008.

<sup>96</sup> Mottram, P.G., *HMP Liverpool, Styal and Hindley Study Report*, University of Liverpool, 2007.

- The current risk of inappropriate use of healthcare resources and related costs will not be addressed;
- There is a risk of litigation if prisons are deemed to fail in their responsibilities under the Duty of Care, Equality Act and Human Rights Act, as outlined above.

***Option 2: Clarify in legislation the responsibility between prisons and local authorities for the assessment and provision of prisoners' care and support***

*Assessment*

- 5.10 Under this option, the Act clarifies that responsibility for the assessment of prisoners' care and support lies with local authorities. It would also place a duty on prisons to cooperate with local authorities in the undertaking of assessment.
- 5.11 In order to identify a prisoner's care and support needs, an assessment will be required. This will be the responsibility of the local authority of the area in which the prison is situated. However, as prisons will provide some level of care and support there will need to be a duty on prisons to co-operate with assessments. Department of Health will work with the National Offender Management Service (NOMS) to produce guidance on how appropriately trained prison officers could complete assessments, notwithstanding the local authority duty to assess where it appears that the individual may have needs for care and support.

*Provision of care and support to prisoners*

- 5.12 Under the provisions of the Act, responsibility for providing prisoners' care and support would rest with prisons up to a specified threshold. Above this threshold, the responsibility for provision of care would rest with the local authority. This threshold would be the same eligibility threshold for people who live in the community and require care and support.
- 5.13 The Act clarifies that the local authority in which lies the prison or approved premises where the individual is allocated to will be responsible for assessment and provision of care and support.

**Costs and benefits of option 2**

*Costs*

- 5.14 Note that all prices in this part of the impact assessment are in 10/11 prices unless otherwise stated.
- 5.15 We estimate that once fully implemented, the additional costs to local authorities as a result of Option 2 will be £9.4 million per year, comprising £7.4m for over 50s and £2m for those below 50 years, with an additional one off cost of approximately £0.8m in Year 1, to assess existing long-term prisoners (i.e. for over a year) in the system. This comprises the costs of assessment and the costs of providing care.
- 5.16 Previous calculations for the White Paper IA (February 2012) estimated the cost to be £8.6m in total (2010 prices) per year, comprising £6.4m for over 50s

and £2.2m for those below 50 years. The basis for the revised calculation is outlined below.

### Prison population

- 5.17 For prisoners aged 50 and over, NOMS provided three pieces of data on the prisons population in September 2013, the number of prisoners aged 50+ entering into custody in the year to September 2013 and projections of the number of older prisoners between November 2013 and December 2019.
- 5.18 This showed a population of prisoners aged 50+ years of 10,400 in September 2013, of whom 7,072 entered within the year. This population was estimated to grow by 0.95% between the period Nov 13 and Nov 15 and this growth was applied to estimate a prisons population of 10,500 in September 2015. This population is expected to grow by approximately a further 100 prisoners per year thereafter.
- 5.19 For the under 50 year prisoner population, the September 2013 NOMS estimate of 74,000 prisoners has been used. No growth in population to September 2015 is assumed for this age group. In fact prisoner numbers have dropped in the past years.

### Assessments and reviews

- 5.20 The cost of an assessment in the community is estimated at £450 and been used in the revised calculations. Additional costs in a prison setting arising from time to clear security could be off-set by having a standing security clearance for the assessment team, delegating to health partners or covering a number of assessments in one visit, offsetting the allowance for travel costs in the community.
- 5.21 The cost of a re-assessment is estimated at £250 and are based on costs in the community.
- 5.22 All prisoners over 50 years old are unlikely to need an assessment on entering custody, just as over 65 year olds in the community are only assessed when they report a need. We have assumed that 54% of all new prisoners could be considered to have a disability and therefore in need of an assessment. This estimate is taken from the MOJ 2014 SPCR survey<sup>97</sup>, but is likely to be an over estimate of assessment needs.
- 5.23 It is based on a much wider definition of disability compared to the levels of disability which require LA care support in the community. For example prisoners receiving treatment or counselling for any health or medical problem in the last 12 months were included in the estimates as well as those with anxiety and depression.
- 5.24 Of the additional 100 prisoners entering the system each year due to growth in 50+ prisoner numbers, 54 will need an assessment costing approximately an additional £24,000 per year. This small additional cost is contained within the rounding of the cost estimates below.

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<sup>97</sup> Older Prisoners: Surveying Prisoner Crime Reduction (SPCR) survey – MOJ 2014



- 5.25 We have assumed that new prisoners requiring care would receive a full assessment. In addition, we assume that those prisoners, approximately 3,000, who have been in the system before September 2014 (i.e. for over a year) would also need an assessment, as their needs will not already be adequately identified by prison authorities.
- 5.26 We also assume that these assessments for continuing prisoners would only be needed in the first year the responsibility for social care in prisons transfers to local authorities, as in subsequent years all continuing prisoners will have been assessed. This is likely to cost an additional £0.8m in Year 1.

### Turnover

- 5.27 Information from NOMS suggests an average of 1.02 inter-prison moves per prisoner per year take place. Each prisoner in receipt of social care support would need a re-assessment on transfer to a new prison, in addition to a full assessment on first entering custody. We have continued to use the 54% disability estimate used previously to estimate the number of prisoners over 50 years requiring a re-assessment on transfer.

### Social care provision – prevalence of need

- 5.28 Data from the 2014 pilot questionnaire to prison governors was used to estimate the number of prisoners needing care. So far 5 prisons have provided data. The proportion of prisoners over 50 needing care is estimated at 8.28% and 0.5% for prisoners below 50 years.

### Social care provision – cost of care

- 5.29 The average annual cost of social care per prisoner over 50 is based on data from the 2014 pilot questionnaire to prison governors. This showed average costs from two prisons of £4,760pp and £5,385pp and an average of the two deflated to 2010 prices (£4,786pp) is used in the recalculation.
- 5.30 Of the additional 100 prisoners entering the system each year, due to growth in 50+ prisoner numbers, 8 will need care costing approximately an additional £38,000 per year. This small additional cost is contained within the rounding of the cost estimates below
- 5.31 The cost of providing social care for prisoners below 50 years is assumed to be the same as the cost for prisoners over 50 years and is based on data from the 2014 pilot questionnaire to prison governors. This showed an average annual cost of £4,786pp, deflated to 2010 prices.

**Table 19 – Prevalence of need and potential costs of social care for people in prison over 50 yrs**

Assessment	
No of people over 50 in English prisons	10,501
No entering system each year	7,139
Proportion of prisoners likely to have some form of disability requiring an assessment/review	54%
Unit cost of 1 assessment (£)	£450
Cost of 1 assessment / year for new prisoners with disability over 50s	£1,734,822
Turnover (number of transfers per year)	1.02

Unit cost of 1 re-assessment (£)	£250
Prisoner transfers - cost of re-assessments/ year for over 50s with disability	£1,445,963
Total cost of assessments and re-assessments (on transfer)	£3,180,784
Number of prisoners in system for over a year	3,362
Unit cost of 1 assessment (£)	£450
Cost of 1 assessment for longer term prisoners (1+ years) with disability over 50s	£816,877
Social care provision	
% Prisoners 50+ needing care	8.28%
Number of prisoners over 50 who require care	870
Average annual cost of social care per prisoner (2010 prices)	£4,786
Estimated cost of providing social care	£4,163,810
TOTAL provision and assessment costs for people over 50 yrs in prison (after Y1)	£7,344,594
Additional cost in Year 1 to assess existing long term prisoners	£816,877

**Table 20 – Prevalence of need and social care costs for people in prison aged less than 50 yrs**

Assessment	
Total population under 50 in English prisons	74,083
% Prisoners under 50 needing care	0.5%
Possible number of people in prison aged 18-59 year olds requiring assessment	371
Unit cost of 1 assessment (£)	£450
Cost of 1 assessment / year for 18-49 year olds with PD	£166,950
Turnover (number of transfers per year)	1.02
Unit cost of 1 re-assessment (£)	£250
Prisoner transfers - cost of re-assessment/ year for 18-49 year olds with PD	£94,605
Total cost of assessments and re-assessments (on transfer)	£261,555
Social care provision	
Average annual cost of social care per prisoner (2010 prices)	£4,786
Estimated cost of providing social care £s	£1,775,602
TOTAL provision and assessment costs for people aged less than 50 years	£2,037,157
TOTAL COST CARE AND SUPPORT FOR OLDER PEOPLE AND ADULTS WITH PHYSICAL DISABILITY	£9,381,751

5.32 Upating the costs into 2015/16 prices means that the total costs are £11.2 million in 2015/16 and then £10.3 million in subsequent years.

**Table 21**

<i>£ millions, 15/16 prices</i>	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Assessments	£0.9	-	-	-	-	-	-	-	-	-
Over 50s	£8.1	£8.1	£8.1	£8.1	£8.1	£8.1	£8.1	£8.1	£8.1	£8.1
Under 50s	£2.2	£2.2	£2.2	£2.2	£2.2	£2.2	£2.2	£2.2	£2.2	£2.2
<b>Total</b>	£11.2	£10.3	£10.3	£10.3	£10.3	£10.3	£10.3	£10.3	£10.3	£10.3

5.33 Clarifying where responsibility lies for the care of people in prison will result in the identification of previously unmet need. Local authorities are currently responsible for meeting the care and support needs of their residents, including recently released prisoners. As a result of these proposals, it may be that an individual's need is identified during their time in custody and that the individual will therefore be eligible for ongoing support following their return to the community. This could involve an additional cost for the individual's home local authority. It is estimated that 25% of prisoners are released each year; therefore as an indicative cost, we estimate that the care and support costs of recently released prisoners may be in the region of £1.5 million per year.

#### *Benefits*

- 5.34 The clarity provided by the Act will ensure that the respective responsibilities of prisons and local authorities for the care and support of individual prisoners are clearly set out. This should bring significant welfare gain for people with care and support needs in prisons.
- 5.35 Greater clarity in guidance on movement across local authority boundaries will make explicit the responsibilities regarding both the assessment and provision of care and support. This should make compliance with the prisoner's sentence plan simpler and better enable them to address their offending behaviour.
- 5.36 These changes will ensure continuity of care for people leaving prison, thereby making their transition back to the community easier. Anecdotal evidence from prison governors and others suggests there are also potential benefits in terms of reducing re-offending, through improved planning and partnership working for resettlement.

## **2E. SAFEGUARDING ADULTS FROM ABUSE AND NEGLECT**

### **Background – case for change**

6.1 Government and public services have a responsibility in ensuring people in the most vulnerable situations are safe. The consultation on *No Secrets* and the Law Commission's report indicated a common consensus that legislation is required in order to provide a clear framework for organisations and their responsibilities regarding adult safeguarding. Also apparent was the view that Government should provide direction and leadership, ensuring that the law is clear, proportionate and effective, providing the right powers and duties for the right organisations. Lack of such co-ordination has been found to be a significant problem in cases where safeguarding has failed.

### **Policy objectives**

6.2 The overarching policy objective is for local organisations to understand their role, work together, support each other and share expertise to deliver better safeguarding outcomes for adults in vulnerable situations.

6.3 Quality care also means ensuring that people in vulnerable situations are appropriately protected from harm. Safeguarding is built upon the promotion and protection of people's human rights will lower the risk of people experiencing neglect and abuse – specifically Articles 3, 4, 8 and 14 of the European Convention on Human Rights. The objective is to provide a clear framework for organisations so they undertake their distinct roles to safeguard vulnerable adults from abuse and harm. That direction and leadership is provided with a legislative framework providing the right powers and duties for the right organisations to ensure the implementation of the following outcomes:

- Ensure local agencies collaborate in the best interest of adults in vulnerable situations and that they remain accountable for their respective roles;
- Local organisations with an interest come together as Safeguarding Adults Boards;
- Local authorities act as the lead coordinating body for adult safeguarding.

### **Summary of policy options**

6.4 Experts within and outside the Department of Health were consulted with regard to the policy proposals presented in this Impact Assessment. Consultation took the form of one to one meetings, group discussions and workshops. Experts included care users, commissioners, providers and academics. In these discussions, the merits of the policy proposals were discussed in terms of effectiveness and associated costs and benefits. Alternative options were also discussed.

6.5 As is made clear in discussion below, some of these proposals will be taken forward in legislation via the provisions of the Care Act. However, many of the proposals discussed below can be taken forward in collaboration with local government and the wider care sector and do not require new legislation to be implemented. For reasons of clarity and completeness, the Safeguarding

element of the Impact Assessment of the Care Act discusses all proposals with significant impact, whether or not they are regulatory in nature. Proposals have been listed under relevant objectives in the table below, although the overall package of proposals should also be seen as interdependent and mutually reinforcing.

**A. Clarify through legislation the core membership, roles and responsibilities of Safeguarding Adults Boards (SABs)**

6.6 Two options have been considered to take forward this proposal: Firstly, to do nothing; secondly to take an approach which specifies core membership with additional flexible local appointments and high-level strategic responsibilities. The second option is the preferred option. Analysis of both options is provided below.

**Option 1: Do nothing**

- 6.7 Under a “do nothing” option the statutory No Secrets guidance would still remain extant, requiring local authorities to consider establishing a non-statutory multi-agency management committee for safeguarding and for various agencies concerned to consider whether they should be involved in its work.
- 6.8 In relation to the work that SABs undertake, under a ‘do nothing’ option No Secrets would again remain extant. This requires local social services authorities to coordinate local policies and procedures for the protection of adults at risk of abuse by establishing local “inter-agency” mechanisms for investigating individual cases. The guidance also suggests that social services authorities should consider establishing a multi-agency management committee as a standing committee of lead officers. These arrangements are only binding on local social services authorities, not other bodies such as NHS organisations and the police, although these bodies do have relevant powers and duties, for example, as to the quality and safety of services, to reduce crime and so on.
- 6.9 Doing nothing would therefore mean that the variable range of functions for local multi-agency safeguarding arrangements would continue. Evidence and assumptions about current provision and membership of SABs and associated costs is provided below. This forms a baseline to analysis of the costs and benefits of establishing SABs in legislation.
- 6.10 Braye et al demonstrate there is considerable variation in the operation of existing non-statutory SABs.<sup>98</sup> Estimates of current ongoing costs are therefore based on assumptions about the activities of an “average” board (for example the number and length of meetings).
- 6.11 Based on a survey from 2007, around 96% of local areas had a multi-agency adult protection committee, and a further 2% of local areas were planning to establish one imminently.<sup>99</sup> This was based on a survey of 144 local authorities in England and Wales, of which 133 responses were suitable for analysis.

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<sup>98</sup> Braye, S., Orr, D. and Preston-Shoot, M., *The governance of adult safeguarding: Findings from research in Safeguarding Adults Boards*, Adult Services Social Care Institute for Excellence Report 45, final report to the Department of Health, published September 2011.

<sup>99</sup> Penhale, B., Perkins, N., Pinkney, L., Reid, D., Hussein, S. and Manthorpe, J., *Partnerships and Regulation in Adult Protection: Final Report*, Sheffield: Univ. of Sheffield, 2007.

- 6.12 If the 98% of the 133 authorities who reported having or planning to have a form of non-statutory safeguarding partnership in place were representative of the 152 local authorities with adult safeguarding responsibilities, then approximately 149 of these local authorities would have arrangements in place. If we assume that there is some selection bias in the responses (i.e. those authorities that responded are more likely to have boards in place), then 88% of areas have boards in place (133 out of 152). This would be a conservative estimate as discussions with experts in the field of safeguarding conclude that all areas have some arrangements in place.
- 6.13 Therefore, for the purpose of this Impact Assessment, we estimate that NHS and local authorities are currently involved in SABs in between 133 and 149 of a possible 152 areas.
- 6.14 Evidence from a survey of Police Force Areas (PFAs) by the Association of Chief Police Officers (ACPO) and the Home Office, suggests different levels of current safeguarding board attendance or activity among police forces. This found 86 boards in operation in 22 PFAs that responded to this question in the survey. These PFAs contain 91 local authorities. Assuming the same level of activity (around 95%) in the 17 PFAs that did not respond to the survey, this gives an attendance of an additional 58 boards. Therefore the baseline estimate of the number of boards in which police are involved is 144 boards (86 + 58), or approximately 95% of local authorities.
- 6.15 If we allow for selection bias in survey responses (it is possible that those PFAs that responded to the survey are more likely to be involved in boards), then we can derive a lower bound of SAB police attendance in which no boards are attended amongst the 22 PFAs which did not respond. This would imply that police would be represented on 86 of 152 boards, giving a lower bound estimate of involvement in boards of 57%.
- 6.16 This gives a range for current police involvement in SABs of between 57% and 95%. Home Office estimates suggest the true proportion lies towards the top of this range.
- 6.17 In 2011, Braye et al. found membership of between 10 and 47 agencies on existing boards. However, given it is not clear what the average number of board members is, or the number of boards with very low or high levels of membership, for the purpose of this analysis we use the mid-point estimate of this range as the best estimate of the average number of members currently on the boards.
- 6.18 Based on the evidence available we have estimated that:
- the mid-point of the current membership of boards is 29;
  - 98% of local authorities have boards currently in place;
  - police are represented on 95% of boards.
- 6.19 For the purpose of costing an “average” board both for current costs and any possible additional costs of options, a number of further assumptions are made regarding the operations of boards. These assumptions are presented in Annex A, as well as the hourly and daily costs of the members of boards.

6.20 There are currently around 80 serious case reviews per year, according to the NHS Information Centre. The cost of a serious case review is estimated to be approximately £48,000.<sup>100</sup> This data is used to inform the baseline costs of existing boards.

*Current costs of membership and responsibilities of boards*

6.21 The current costs of boards, based on the evidence and assumptions are presented in Table 22 below.

**Table 22: Current costs of SABs**

<b>Estimate of baseline costs of SABs (£m, minimum and maximum costs based on 88% and 98% of local authorities having boards respectively)</b>						
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
<b>Real costs</b>						
Chair	4	4	4	4	4	4
Administration	3	3	3	3	3	3
<b>Total real costs</b>	<b>7</b>	<b>7</b>	<b>7</b>	<b>7</b>	<b>7</b>	<b>7</b>
<b>Opportunity costs - members</b>						
NHS commissioner member	2	2	2	2	2	2
NHS provider member	2	2	2	2	2	2
Local authority member	1	1	1	1	1	1
Police member	2	2	2	2	2	2
Other board members	13-15	13-15	13-15	13-15	13-15	13-15
<b>Opportunity costs – responsibilities</b>						
Serious case reviews or equivalent	4	4	4	4	4	4
<b>Total opportunity costs</b>	<b>22-25</b>	<b>22-25</b>	<b>22-25</b>	<b>22-25</b>	<b>22-25</b>	<b>22-25</b>
<b>Total real and opportunity costs</b>	<b>29-33</b>	<b>29-33</b>	<b>29-33</b>	<b>29-33</b>	<b>29-33</b>	<b>29-33</b>
<b>**Numbers rounded so may not tally</b>						

***Option 2: Specify core membership with additional flexible local appointments of members and confer strategic responsibilities on SABs (preferred option)***

6.22 This option would involve specifying in legislation a core membership for SABs of local authorities, NHS commissioners and the police, in line with the Law Commission’s recommendations. Local authorities would be given powers to add to the membership as appropriate for the local situation. This is the preferred policy option for membership.

6.23 Under this option, the high-level objectives of the SAB would be described in legislation, focussing on outcomes. The primary objective for SABs would be to protect adults in vulnerable situations by providing leadership, ownership and co-ordination of multi-agency working at local level, reducing the risk of significant abuse and neglect. The statute should clarify this objective for SABs. This is the preferred policy option for strategic responsibilities.

6.24 Under this option, local authorities and other SAB members/local public services partners working collaboratively at a local level, would determine the

<sup>100</sup> This estimate is based on information from the Social Care Institute for Excellence (SCIE), *Learning Together for Adult Pilots*. They estimate a range of costs for reviews, from around £18,000 for focussed reviews to around £48,000 for full reviews. There is likely to be variation in the costs of reviews depending on their scope. A review of serious case reviews for children, *Learning from Past Experience – A review of Serious Case Reviews – June 2002*, found a range of costs from approximately £3,000 to £70,000, ten years ago. Therefore it seems reasonable to use the upper end of the SCIE estimates in the calculation of the potential additional costs of serious case reviews.

means by which SABs achieve these goals i.e. the specific functions that SABs should carry out.

6.25 The high level strategic responsibilities to be conferred upon SABs in legislation would be:

- That SABs must agree and publish a Strategic Plan, which discusses the outcomes SAB members are going to focus on and how SAB members are going to work together.
- That SABs must publish an annual report on the exercise of their functions and their success in achieving the outcomes described in the Plan. The link between plans and annual reports would provide clear objectives for the SAB and an assessment of whether the Board had met those objectives.
- That SABs must commission Safeguarding Adults Reviews and members should have a duty to contribute to such reviews, in order that member agencies learn lessons to improve services and prevent abuse and neglect taking place.
- That SABs to show what actions they have taken to implement recommendations of any previous year's Safeguarding Adults Reviews, and to provide an explanation as to why they have not adopted any recommendation.

6.26 This option empowers the local SAB to carry out the sorts of functions recommended by the Law Commission, with the precise approach taken to be determined by the local authority and its statutory partners. These in turn would be held to account by senior members of the organisations involved and the local population for whether or not they have achieved their locally specified outcomes.

### Costs of preferred option

6.27 We estimate that the effect of specifying a core membership and strategic responsibilities for SABs, with flexibility for local decision making, is to raise the number of boards, but leave the mid-point estimate of the number of members the same. The estimated additional costs of Option 2 are approximately £7m per year.

6.28 Strengthening boards through legislation is likely to confer upon them an increased ability and desire to learn from safeguarding incidents. Consequently, there may be a very slight increase in the number of reviews taking place. We estimate one per local authority per year, or 152 per year.

**Table 23: Cost of Option 2**

Costs of Option 2 (£m, additional to current baseline costs described in Table 20 above)						
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
<b>Real costs</b>						
Chair	0.09 – 0.5	0.09 – 0.5	0.09 – 0.5	0.09 – 0.5	0.09 – 0.5	0.09 – 0.5
Administration	0.06 – 0.4	0.06 – 0.4	0.06 – 0.4	0.06 – 0.4	0.06 – 0.4	0.06 – 0.4
<b>Total real costs</b>	<b>0.15 – 0.9</b>	<b>0.15 – 0.9</b>	<b>0.15 – 0.9</b>	<b>0.15 – 0.9</b>	<b>0.15 – 0.9</b>	<b>0.15 – 0.9</b>
<b>Opportunity costs - members</b>						
NHS commissioner member	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2
Local authority member	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2
Police member	0.11 – 0.9	0.11 – 0.9	0.11 – 0.9	0.11 – 0.9	0.11 – 0.9	0.11 – 0.9
Other Board members	0 – 2	0 – 2	0 – 2	0 – 2	0 – 2	0 – 2



<b>Opportunity costs – responsibilities</b>						
Serious case reviews or equivalent	3	3	3	3	3	3
<b>Total opportunity costs</b>	<b>4-7</b>	<b>4-7</b>	<b>4-7</b>	<b>4-7</b>	<b>4-7</b>	<b>4-7</b>
<b>Total real and opportunity costs</b>	<b>4-8</b>	<b>4-8</b>	<b>4-8</b>	<b>4-8</b>	<b>4-8</b>	<b>4-8</b>
<b>**Numbers rounded so may not tally. The number of decimal places varies in relation to the precision of the estimates</b>						

6.29 The effect of specifying a core membership and strategic responsibilities for boards, with flexibility for local decision-making, is to raise the number of SABs from the currently estimated 88% to 98% of boards to 100%, but leave the mid-point estimate of the number of members at 29.

6.30 The fact that boards are currently widespread and vary in their membership indicates that there is already some degree of local determination of the make-up of SABs. Option 2 would therefore formalise these arrangements but ensure that the mandatory core members from the social services authority, the NHS and the police are fully involved in the board's operations.

6.31 Uprating the costs to 2015/16 price.

**Table 24**

<i>£ millions, 15/16 prices</i>	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Min	£4.5	£4.5	£4.5	£4.5	£4.5	£4.5	£4.5	£4.5	£4.5	£4.5
Max	£8.3	£8.3	£8.3	£8.3	£8.3	£8.3	£8.3	£8.3	£8.3	£8.3
<b>Central Estimate (real and opportunity costs)</b>	<b>£6.4</b>	<b>£6.4</b>	<b>£6.4</b>	<b>£6.4</b>	<b>£6.4</b>	<b>£6.4</b>	<b>£6.4</b>	<b>£6.4</b>	<b>£6.4</b>	<b>£6.4</b>

### **Benefits of preferred option**

6.32 We expect the following welfare benefits from effective safeguarding arrangements:

- A reduction in the number of people subject to abuse; and
- Where abuse does occur, it is detected and stopped earlier.

6.33 These benefits could affect population health and wellbeing in two ways:

1. Reduction in the number of deaths that result from abuse; and
2. Positive impact on individuals' quality of life.

6.34 SABs will provide leadership and co-ordination of multi-agency working at a local level, driven by the local social services authority, thereby reducing the risk of abuse and neglect. The legislation on statutory SABs will allow for flexibility in how arrangements for safeguarding are set up locally with an emphasis on encouraging a focus on outcomes rather than process and prescription. SABs will work closely in partnership with local communities to set local priorities - representing the need to reflect the voice of people they will work with to keep safe. In developing strong local safeguarding arrangements, SABs should be empowered to take on board the voice of those affected by safeguarding concerns.

6.35 Expert opinion from safeguarding children work cautions against creating "A defensive system that puts so much emphasis on procedures and recording that insufficient attention is given to developing and supporting the expertise to

work effectively with children, young people and families”.<sup>101</sup> Instead of “doing things right” (i.e. following procedures) the system needs to be focused on doing the right thing (i.e. checking whether children and young people are being helped).” These considerations also support the approach proposed for adult care and support where local agencies are allowed to craft local adult safeguarding priorities in line with local need.

## **B. Local Authority function to make enquiries**

6.36 Two options are considered for this proposal: Firstly to do nothing; and secondly, to confer a local authority function to make enquiries.

### ***Option 1: Do nothing***

6.37 In certain circumstances, it is possible to argue that local authorities have an existing legal duty to investigate actual or possible abuse. In particular, Section 47 of the NHS and Community Care Act 1980 places a duty on local authorities to carry out an assessment of the need for community care services. In practice, this may require a local authority to conduct safeguarding enquiries, but it does not amount to a comprehensive duty to do so. Moreover, the emphasis of such an enquiry is to investigate the facts and establish the validity of an allegation, rather than to determine the need for specific services to prevent adverse events happening in the first place. Doing nothing therefore presents costs in terms of missing safeguarding needs and having to undertake a response to a safeguarding incident after the event. The current legal framework is also confusing for local authorities and other relevant authorities.

6.38 The NHS Information Centre estimated that there were 94,510 adult referrals in 2010-11.<sup>102</sup> The costs of undertaking adult enquiries are unknown, however Holmes et al (2009) estimate a range of costs for contacts, referrals and initial assessments for children.<sup>103</sup> These are therefore used as an indication of the amount of resource required for adult enquiries.

6.39 Using data collected the authors estimate that:

- The average social worker time spent on initial contacts is 49 minutes;
- Team leaders spent on average 30 minutes on initial contacts;
- Referrals took on average 4 hours and 40 minutes.

6.40 Using these estimates of referral numbers and the time involved, together with PSSRU estimated unit costs of adult social care workers and team leaders’ time<sup>104</sup>, we estimate the current cost of enquiries to be approximately £30 million.

### ***Option 2: Place a duty on local authorities to make enquiries (preferred option)***

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<sup>101</sup> *The Munro Review of Child Protection: Final Report*, Munro, 2011

[http://www.education.gov.uk/munroreview/downloads/8875\\_DfE\\_Munro\\_Report\\_TAGGED.pdf](http://www.education.gov.uk/munroreview/downloads/8875_DfE_Munro_Report_TAGGED.pdf)

<sup>102</sup> The NHS Information Centre, *Abuse of Vulnerable Adults in England 2010-11: Final Report, Experimental Statistics*, 2012.

It should be noted that this data collection is still very new and might be subject to issues around definitions of safeguarding alerts and referrals which vary across councils and impact on data quality.

<sup>103</sup> Holmes, L., Munro, E. and Soper, J., *Calculating the cost and capacity implications for local authorities implementing the Laming (2009) recommendations*, Centre for Child and Family Research, 2010.

<sup>104</sup> <http://www.pssru.ac.uk/uc/uc2011contents.htm>

Team leader unit cost = £67 per hour (page 155) of client related work;  
Adult social worker £53 per hour (page 156) of client related work.

- 6.41 This proposal introduces in legislation a function requiring local authorities to make enquiries. Legislations will clarify (but not change) the scope of adults who might be at risk. No additional statutory duties are put on any organisations.
- 6.42 This approach empowers professionals to take action when they judge necessary. To support professionals in this, guidance could be provided on the factors to be taken into account when conducting enquiries, and the kind of enquiry process that could be used. This does not remove the responsibility of individual health and care organisations for dealing internally with incidents as appropriate.

### **Costs of preferred option**

- 6.43 A proxy of the current level of safeguarding boards provision is used to estimate the impact on local authorities, as described above. This could lead to an increase of between 2% and 14% in the referral activity<sup>105</sup> at an additional cost of between £600,000 and £4.2 million per year [10/11 prices]. However, these are costs of fully meeting existing duties following increased focus on the policy area rather than additional costs imposed by the Care Act, so they are not in the scope of this impact assessment.

### **Benefits of preferred option**

- 6.44 It is anticipated that introducing a function for local authorities to make enquiries would have the following benefits:
- Improved quality of life for individuals who are able to explore what services they might need to access to improve their situation;
  - A reduction in the number of deaths from abuse as a result of consideration by individuals and local authorities of the actions that could be taken to reduce risk.

### **Costs and benefits of proposals A and B**

- 6.45 In summary, we propose that legislation should:
- Specify that core membership for SABs should comprise the local social services authority, NHS commissioners and the police, with flexible local arrangements for additional appointments of members.
  - Set out strategic responsibilities for SABs focussing on outcomes. The primary objective should be to protect adults in vulnerable situations by providing leadership and co-ordination of multi-agency working at local level, reducing the risk of abuse and neglect.
  - Confer on local authorities a function enabling them to make enquiries.
- 6.46 We believe that this approach provides for proportionate risk-based regulation, while ensuring that local boards are able to determine their activities and priorities, based on the needs of the local population.
- 6.47 A statutory but flexible approach should strengthen the governance of local safeguarding practices and facilitate improvement in weaker areas, without undermining areas where effective partnership working is already in place.

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<sup>105</sup> Note this is the range of raising the upper bound of this is the % increase required to raise 88% to 100% (i.e.  $100\% - 88\% / 88\% = 14\%$ ).

- 6.48 Requiring SABs to set out a plan for achieving local safeguarding outcomes, and then to report on how successful they were in achieving these outcomes, will support local transparency and accountability, devolving power and financial autonomy to local government and community groups.
- 6.49 By strengthening the statutory safeguarding arrangements, we expect that there will be a reduction in the number of people subject to abuse and, where abuse does occur, for it to be detected earlier.
- 6.50 There is evidence to suggest that those who suffer abuse have a lower health-related quality of life, compared to those who do not. A small study from Norway found that women who had suffered threats of and actual physical and psychological abuse had statistically significant lower scores than women in the general population, across all domains of the SF-36, a widely used health-related quality of life measurement tool.<sup>106</sup>
- 6.51 Another study of older women finds they are significantly more likely to report physical and mental health problems if they have suffered abuse than if they have not.<sup>107</sup>
- 6.52 Using a systematic review of the prevalence of abuse in general populations<sup>108</sup> it can be estimated that around 6% of people aged 65 and over suffer significant abuse per annum. Using ONS population data<sup>109</sup> this means approximately 480,000 older people are subject to abuse each year. Experimental “Abuse of Vulnerable Adults” data from the Information Centre estimates that there were around 46,000 “completed referrals for abuse” among those aged 65 and over in 2010-11.<sup>110</sup> At a maximum, this equates to 65,000 people, but is likely to be less. Therefore, it is likely that there is a large amount of undetected abuse among older people. In addition, this does not include undetected abuse among adults aged 18 to 65.
- 6.53 The Department of Health values a year of life at perfect health (a quality adjusted life-year or QALY) at £60,000 when being compared to the opportunity cost of health care expenditure, or £25,000 when costs are expressed in financial terms. This estimate is calculated using the societal value of a statistical life estimated to be £1.8 million, based on evidence from the Department of Transport. When health benefits, improved quality-of-life or lives saved are a likely outcome of a policy initiative, quantifying and monetising benefits in this way enables comparisons with costs, to understand whether the likely benefits of a policy will outweigh the costs.
- 6.54 The net additional costs of the preferred option is approximately £7m per annum. If between 3 and 5 additional lives were saved per annum as a result of the new arrangements, this would offset the additional costs. Equally as quality-of-life is between 1/5 and 3/5 lower for those who suffer from abuse, taking people out of abuse would save between 160 and 240 QALYs. Given

<sup>106</sup> Alsaker, K. et al, “Low health-related quality of life among abused women”, *Quality of Life Research* 15: 959 – 965, 2006.

<sup>107</sup> Fisher, B. and Reagan, S., “The Extent and Frequency of Abuse in the Lives of Older Women and Their Relationship With Health Outcomes”, *The Gerontologist* 46: 2 200 – 209, 2005.

<sup>108</sup> Cooper, C. et al, “The prevalence of elder abuse and neglect: a systematic review”, *Age and Ageing* 37: 151 – 160, 2008.

<sup>109</sup> <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-229866>

<sup>110</sup> The NHS Information Centre, *Abuse of Vulnerable Adults in England 2010-11: Final Report, Experimental Statistics*, 2012.

the potential level of undetected abuse, it seems reasonable to expect more effective safeguarding arrangements to offset these additional costs.

## Summary impact

### *Need for improved inter-agency collaboration on safeguarding*

- 6.55 Abuse is never acceptable but where abuse does take place, it needs to be addressed quickly and effectively. There have been several examples across the health and care system of individual and institutional failures in safeguarding adults in vulnerable situations. Abuse against adults affects a significant proportion of the adult population. A study carried out by the National Centre for Social Research and King's College London reported that 342,400 older people (aged 66+) in the community had been subject to abuse (about 4%).<sup>111</sup> As the proportion of older people in the population increases, in the future potentially a higher proportion of the population will be at risk.
- 6.56 Abuse can significantly affect other groups. In March 2012, the NHS Information Centre published a provisional report 'Abuse of Vulnerable Adults in England 2010/11'.<sup>112</sup> The data showed that 61% of safeguarding referrals related to people aged 65 and over. 49% of the referrals reported were related to adults who were classified as having a 'physical disability', 23% were for adults classified as client type 'mental health', 20% were for adults classified as client type 'learning disability' and 7% of referrals reported were for 'other vulnerable adults'.
- 6.57 One of the key challenges around effective safeguarding work is the high number of different organisations and agencies involved. The data from the NHS Information Centre also gives an overview of the range of settings where abuse is found. The majority of referrals cited the adult's own home (41%) or a residential care home (34%) as the location where the alleged abuse took place.<sup>113</sup>
- 6.58 A strong multi-agency and multi-disciplinary approach is therefore essential, as many agencies potentially hold information about adults in vulnerable situations and they each have different roles in preventing or protecting against abuse and neglect. A theme from many reported cases of abuse is that there can be a lack of effective coordination and cooperation of the different agencies involved in safeguarding. More effective coordination and cooperation between the agencies involved could have prevented, or reduced the impact, of some of the abuse. However, a multi-agency approach can be challenging to coordinate, as it requires a shared sense of objectives across organisations with different sets of priorities, structures, ways of working, personnel, and skills.
- 6.59 No Secrets is the basis for current adult protection arrangements. As statutory guidance, it is binding on local authorities. *No Secrets* policy guidance requires local authorities with social services responsibilities to lead and coordinate

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<sup>111</sup> National Centre for Social Research and King's College, *UK study of abuse and neglect of older people: qualitative findings*, August 2007.

<sup>112</sup> The NHS Information Centre, *Abuse of Vulnerable Adults in England 2010-11: Final Report, Experimental Statistics*, 2012.

It should be noted that this data collection is still very new and might be subject to issues around definitions of safeguarding alerts and referrals which vary across councils and impact on data quality.

<sup>113</sup> This sums to greater than 100% as some referrals involved multiple locations of alleged abuse.

multi-agency involvement in safeguarding adults, and encourages the formation of multi-agency management committees. These arrangements have become non-statutory 'safeguarding adults boards' in most areas. Based on the most recent quantitative study, in 2007 around 96% of local areas had a multi-agency adult protection committee, and a further 2% of local areas were planning to establish one imminently.<sup>114</sup>

- 6.60 However, beyond the general legal duties for cooperation between local authorities, the police and the NHS, there is no other legislation that makes No Secrets binding on other identified key partner agencies. This represents one way in which the 'patchwork' of adult safeguarding legislation and guidance has created an unclear picture as to the roles and responsibilities of individuals and organisations working in adult safeguarding.
- 6.61 The Law Commission endorsed the findings of the Commission for Social Care Inspection (the predecessor organisation to CQC), that 'the existing legal framework for adult protection is neither systematic nor coordinated, reflecting the sporadic development of safeguarding policy over the last 25 years.' Instead, there is a wider range of law, including general community care legislation and guidance, the Mental Health Act 1983, the Mental Capacity Act 2005, the Safeguarding Vulnerable Groups Act 2006, the inherent jurisdiction of the High Court and the civil and criminal justice system.
- 6.62 In the Report on the Consultation on the Review of No Secrets, 68% of the respondents to the question 'do we need new legislation' supported the need for new legislation.<sup>115</sup> 92% of respondents who replied to the question 'should Safeguarding Boards be placed on a statutory footing' wanted statutory safeguarding boards. In the report, the need for new legislation and statutory safeguarding adults boards was reinforced by examples from respondents - for instance:
- current arrangements meant that adult safeguarding was given low prioritisation and agencies were not cooperating effectively;
  - staff were not attending safeguarding meetings or were fielding junior staff who could not make decisions;
  - organisations were not sharing information and working in silos; and
  - agencies were shifting responsibility to other agencies, or were not contributing towards the cost of the safeguarding system.

### **Key Assumptions/Sensitivities/Risks**

- 6.63 Keeping SAB functions at a high level may result in variation in the performance of safeguarding boards across the country. We know that there is some variation in how safeguarding boards have set up and run 'multi-agency management committees' for adult safeguarding. However, we anticipate that any shortfall in performance will be addressed through the SAB's annual report. This will be a key mechanism by which the local SAB is held to account by the local community for the safeguarding outcomes it delivers. These annual reports will describe delivery against the SAB's business plan. They should reference how effectively the SAB believes it has delivered against the outcomes SAB members have agreed and worked together to achieve. The link between business plans and annual reports would provide clear objectives

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<sup>114</sup> Penhale, B., Perkins, N, Pinkney, L., Reid, D., Hussein, S. and Manthorpe, J., *Partnerships and Regulation in Adult Protection: Final Report*, Sheffield: Univ. of Sheffield, 2007.

<sup>115</sup> Department of Health, *Safeguarding Adults: Report on the consultation on the review of 'No Secrets'*, 2009.

for the SAB and an assessment of whether the Board had met those objectives.

6.64 Set out below are the detailed assumptions regarding the operations of Board, based on Department of Health estimates with involvement of Adult Safeguarding experts

Assumptions based on DH estimates and discussions with experts in Adult Safeguarding, regarding the operations of boards

- The board requires a chair, which is a real cost as the chair would be employed by the local authority.
- The chair would work for 40 days per year (10 days at meetings, 15 days at sub-groups, 6 days at events such as conferences, 3 days working with the police, 3 days with local authorities and 3 days with the local NHS).
- Other agencies represented on the boards would require 25 days of work per year (10 days for meetings and 15 days for sub-groups), except the NHS, police and local authorities who would require an additional 3 days to work with the chair, so a total of 28 days of work per year.
- These costs are a mixture of real and opportunity costs. Some could involve additional responsibilities for individuals already employed by an organisation, so would represent an opportunity cost as it could displace other activities. Others may involve expenditure, e.g. travel costs and are therefore considered to be real costs.
- All costs are discounted using the HMT Green Book discount rate of 3.5%, which means equivalent costs will be lower in future years.

6.65 We are not proposing to set out how many meetings the SAB must have every year. The costs above are based on an assumption of a reasonable number of meetings a year for the board to carry out its work and some additional time for work outside of meetings and for meetings of sub-groups. We have assumed that the SAB itself may meet approximately once per quarter, but that meetings of other groups and members may occur at the rate of approximately once per month, with additional meetings and work for any sub-groups that may take place (discounting August and December).

Estimated unit costs of those involved in safeguarding boards

(As discussed above there is evidence of a range of safeguarding arrangements in local areas, so the unit costs and associated staff grades are intended to represent an average.<sup>116</sup>)

- NHS costs per day – provider and commissioner – Agenda for Change Band 8b<sup>117</sup>, estimated at around £390 per day.
- Local authority member estimated at £311 per day.
- Cost of chair – assumed to be equivalent cost to a Director of Adult Social Services, estimated at £747 per day.
- The cost per hour of a senior police officer (including on-costs) is estimated to be £60.15. This is an uprated calculation of the cost of police time, estimated in 2008 using the ASHE (Annualised Survey of Hours and

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<sup>116</sup> All estimates of the daily cost of time are based on annual salaries, with geographical allowances added and averaged and 30% is added to cover on-costs. Annual salaries are then converted into daily costs on the basis of approximately 210 working days per year (52 working weeks, multiplied by 5 working days = 206 working days, minus annual leave (25), statutory leave (8), sickness leave (12) and training days (5))

<sup>117</sup> <http://www.nhs Careers.nhs.uk/details/default.aspx?id=766>

Earnings) and CIPFA (Chartered Institute of Public Finance and Accounting). This estimate is widely used in Impact Assessments of policies with impacts on the police. This hourly rate is equivalent to approximately £480 per day.

- Administration for the board is undertaken by a third of a whole-time equivalent administrative member of staff, estimated salary per annum including on-costs is £45,000. So cost of staff for admin of the board is £15,000. Additional non-workforce administrative costs of £5000 are added.
- An estimate of £160 per day is used for the cost of other agencies represented on the boards.
- Travel and subsistence is estimated at around 5% of the running costs of the boards.

6.66 For the purposes of this analysis, the start date for board implementation is assumed to be 2015/16. The start date for board implementation is dependent on the legislative timetable.

## **2F. IMPLEMENTATION OF LEGAL REFORM**

### **Background – case for change**

- 7.1 As noted in the first section of this impact assessment (paragraphs 1.1 to 1.27), the legal framework for adult care and support is in need of major reform.
- 7.2 The section outlines specific issues, costs and savings arising from implementation of a new legal framework.

### **Policy objective**

- 7.3 As previously discussed in earlier sections.

### **Summary of options**

#### ***Option 1: Do nothing***

- 7.4 This option would mean retaining the existing law relating to adult care and support. There is not one unified adult care and support statute to which Local Authorities and care users can refer to see what services can or should be provided. There are currently over 30 Acts of Parliament dealing with adult care and support. The law is also subject to further direction and approval, with the consequence that a statute by itself may not provide the answer to whether a local authority has a power or a duty to provide services. Further to this, the current statute does not provide a statement of fundamental principles on which community care legislation is based, to aid interpretation in the implementation and operation of the law.

#### ***Benefits***

- 7.5 In the short-term, doing nothing will avoid the transitional costs of reform, which comprise costs to Local Authorities associated with training of social workers and other local authority staff.



## **Option 2: Consolidation and reform of the law**

- 7.6 As outlined above, the legal framework for adult care and support consists of a patchwork of legislation, which makes interpretation and application of the law complex and time consuming. Consolidation and simplification would be best achieved by establishing a unified statute for care and support.
- 7.7 The intended effect of reform is to create a clear, cohesive, modern and accessible scheme for adult care and support, which sets out the responsibilities of Local Authorities and the rights of individuals.
- 7.8 These aims will be achieved by addressing a number of shortcomings of the existing law relating to adult care and support, which have given rise to the problems identified earlier. Through this impact assessment, we are assessing the impact of changes to the adult care and support statute per se; as set out in the Care Act that takes forward a number of policy initiatives. Further details of the policy proposals are set out in the preceding sections 1 through 15 of this impact assessment.

### **Benefits**

- 7.9 Consolidation of the law will produce a variety of cost savings to Local Authorities and the Local Government Ombudsman (LGO). Details are set out below. Creating a clearer and simpler statute, with clearer and simpler practice guidance, will mean that fewer mistakes are made and will prevent wrong advice being given, which will improve the outcomes and experiences of service users, carers and their families.

### **Everyday activities of social workers**

- 7.10 We assume that simplifying the law will reduce the administrative burden on social workers, as they will spend less time interpreting legal issues.
- 7.11 There is little data that expressly covers the time spent by social workers considering legal issues, but research does indicate that they currently spend a great deal of time on administrative work and less time on face-to-face contact with care users. In fact, a 2009 UNISON survey indicated that 73% of the social workers that were surveyed felt that they had either “insufficient” or “very insufficient” time available to spend with care users.
- 7.12 In addition, evidence in literature also suggests that social workers are generally lacking in legal knowledge and that they do not devote much of their time to legal matters.<sup>118</sup> The Law Commission highlighted one survey that suggests that many social workers do not use the law at all in practice. It reports that law has a “low profile in daily practice” and that there is a lack of “overt use of the law to inform practice.” This results in a dependency on policy and procedure rather than professional discretion.<sup>119</sup> Some researchers have suggested that this lack of legal knowledge, along with the uncertainty created by the complexity of the law, may cause more defensive administrative practices in response to the threat of litigation.<sup>120</sup>

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<sup>118</sup> Law Commission, *Adult Social Care Law Reform Impact Assessment*, 2011

<sup>119</sup> Braye, S. et al., “Beyond the Classroom: Learning Social Work Law in Practice”, *Journal of Social Work* 332, 330, 2007.

<sup>120</sup> Postle, K., ‘Between the Idea and the Reality: ambiguities and tension in care managers’ work’, *British Journal of Social Work* 335, 2002.

- 7.13 The Law Commission concluded that this lack of legal knowledge results in delays to processes. Evidence suggests that these delays may be due to a social worker's lack of knowledge of potential alternative solutions, or may be the result of social workers lacking the confidence in their knowledge to assert themselves when consulting with other professionals.<sup>121</sup>
- 7.14 The Law Commission acknowledged that it would be artificial to single out particular elements in social workers' daily tasks, rather it proposed that a certain percentage of time spent on that task will henceforth be saved as a result of a reformed legal framework. Therefore, the Commission attempted to quantify the savings in social workers' daily tasks by making a global estimate of the sort of overall time savings brought about by a clearer and simpler legal structure. Its assumptions were tested through consultation and, although no written responses dealt with the accuracy or otherwise of this approach, in consultation meetings with social workers and social worker managers, it was broadly accepted as reasonable.
- 7.15 Acknowledging that it is comparatively crude, the Law Commission assumed that social workers will save between 20 and 45 minutes a week on average and that this equates to between 0.68% and 1.54% of their time annually.<sup>122</sup> The Law Commission believes that the time savings for frontline social workers might be towards the bottom of this range, whereas it might be higher for more senior managers. Once the system reaches a steady state, this will produce savings to Local Authorities of between £7.6 million and £17.1 million per year. As set out in Table 25 below, our mid-point best estimate of these savings is £12.4 million.

**Table 25: every day activities of social workers [10/11 prices]**

	Low	Best	High
Number of full-time equivalent (FTE) social workers working in adult care and support		21,240 <sup>123</sup>	
Average total salary to employer (including on costs)		£52,363 <sup>124</sup>	
Time savings	0.68%	1.111%	1.54%
Annual savings	£7,562,893	£12,345,310	£17,127,728

- 7.16 However, in further work with local authorities, we have come to the conclusion that these savings are unlikely to be fully realised in the early years of implementation as the system beds down and local authorities get to grips with the new framework. We have therefore assumed a ramp up in savings, from £0 in 2015/16 to full realisation from 2018/19.

## Complaints

<sup>121</sup> McDonald, A. et al., "Barriers to Retaining and Using Professional Knowledge in Local Authority Social Work Practice with Adults in the UK", *British Journal of Social Work* 1370, 1379, 2002.

<sup>122</sup> Law Commission, *Adult Social Care Law Reform Impact Assessment*, 2011.

<sup>123</sup> Skills for Care, *We gather information about the social care sector: the state of adult social care workforce in England*, 2010.

<sup>124</sup> This is the average salary of social workers in 2010/11 plus direct overhead costs – PSSRU, *Unit Costs of Health and Social Care*, 2011

- 7.17 It is reasonable to assume that a more modern legal structure will reduce the number of complaints, and therefore the cost to Local Authorities to investigate them, and the Law Commission agrees with this.<sup>125</sup> It is not expected that the reduction in complaints will occur as a result of a significant difference in the decisions made about service provision in the new system, but rather, because there will be fewer mistakes. Clearer and simpler law will mean that better decisions are made with fewer mistakes, which will in turn result in fewer complaints.
- 7.18 According to estimates from the National Audit Office, in 2006/07, adult care and support complaints cost Local Authorities in England approximately £14.4 million (at 2010/11 prices).<sup>126</sup> This figure relates to the internal costs to Local Authorities of dealing with complaints, excluding the costs of complaints to the LGO.
- 7.19 The reduction in complaints is likely to be modest. Reductions are most likely to occur in relation to complaints about inaccurate advice, lack of information or expenses/costs. Such complaints account for approximately 21% of complaints to Local Authorities.<sup>127</sup> Based on this figure, the Law Commission assumed a saving of between 5%-15% of complaints with a best estimate of 10%. This would result in savings of between £0.7 million and £2.2 million per year, based on the calculated 2010/11 figures. As set out below, our mid-point best estimate of these savings is £1.45 million.
- 7.20 In addition to the costs to Local Authorities, there are also costs of complaints to the LGO. The Law Commission noted that in 2009/10 the LGO considered 836 complaints relating to adult care and support and estimated that almost £0.5 million was spent investigating these complaints.
- 7.21 The Law Commission estimated that there will also be reductions to the number of complaints that the LGO receives. This is likely to be a smaller reduction than the one seen to Local Authorities, as it is likely that complaints involving mistaken decisions are resolved earlier in the complaints process when the local authority is still investigating it. The Law Commission estimated that there would be a reduction of between 2.5%-7.5%. Based on this, the saving to the LGO would be between £0.01 million and £0.04 million per year (see table 22 below).
- 7.22 The total annual savings relating to complaints would be between £0.71 million and £2.24 million per year – mid-point best estimate £1.475 million – comprising £1.45 million to Local Authorities and £0.025 million to the LGO. Local authority complaints processes are often lengthy, with a number of escalation stages and individuals do not always submit their complaints immediately after an incident has occurred. As a result, we assume that these savings will not start to be realised until 2016/17, assuming the provisions of the reformed law come into effect in 2015/16.

**Table 26: Savings from fewer complaints [10/11 prices]**

	Low	Best	High
<b>Reduction in complaints to local authorities</b>	5%	10%	15%

<sup>125</sup> *Ibid*

<sup>126</sup> National Audit Office, *Feeding Back? Learning from Complaints Handling in Health and Social Care*, 2008. This figure has been calculated using the GDP deflator of 2.71%.

<sup>127</sup> *Ibid*

Spending on complaints by local authorities in England		£14,000,000 <sup>128</sup>	
Savings to local authorities	£720,000	£1,440,000	£2,160,000
Reduction in complaints to the LGO	2.5%	5%	7.5%
Spending on complaints by LGO		£539,816	
Savings to the LGO	£12,495	£26,991	£40,486
Annual savings	£733,495	£1,466,991	£2,200,486

## Litigation

- 7.23 We believe that simplifying the law will lead to a reduction in the level of litigation that Local Authorities face, as fewer mistakes will be made as a result of misinterpretation. This will result in savings to Local Authorities of the direct costs of litigation (including counsel's fees and court costs) together with savings in legal advisors' time.
- 7.24 In its consultation Impact Assessment, the Law Commission suggested that between 30% and 40% of the time spent by lawyers working on adult care and support would be saved by simpler law.<sup>129</sup>
- 7.25 In order to make a more accurate assumption, the Law Commission conducted research on the care and support workload of the higher courts to establish the proportion of issues litigated that would not have been litigated if the system that it proposed was introduced. This was a small-scale study, which took account of care and support cases in the Court of Appeal and Administrative Court for the year from July 2009. There were twelve adult care and support cases in this period and it was concluded that in eight of them their proposals for law reform would have made no difference. Of the remaining four, one would not have been litigated at all, and it was estimated that a third of the issues in the other three cases would not have to be litigated.<sup>130</sup> This gives a figure of 16.67%.
- 7.26 The Law Commission therefore revised its original assumption and suggested that between 10% and 20% - best estimate 15% - of the time spent by lawyers working on adult care and support would be saved by simpler law, although this is assumed to be a modest estimate. However, the Commission did note that this potentially underestimates the savings, as where litigation would still have been necessary consolidation and clearer provisions would have made the process quicker.
- 7.27 Based on the Law Commission's estimates, this would result in savings of between £0.8 million and £1.7 million per year for Local Authorities. Our mid-point best estimate of these savings is £1.25 million.
- 7.28 It is estimated that around £3.8 million per year is spent on the direct costs of litigation, which includes counsel's fees, court costs and other disbursement, and time spent by non-legal staff on the litigation.<sup>131</sup> Assuming that litigation is reduced by between 10% and 20%, the savings would be between £0.4 million

<sup>128</sup> National Audit Office, *Feeding Back? Learning from Complaints Handling in Health and Social Care*, 2008. This figure has been calculated using the GDP deflator of 2.71%.

<sup>129</sup> Law Commission, *Adult Social Care: A Consultation Paper*, 2010

<sup>130</sup> Law Commission, *Adult Social Care Law Reform Impact Assessment*, 2011.

<sup>131</sup> *Ibid.*

and £0.8 million per year. As set out below, our mid-point best estimate of these savings is £0.6 million.

- 7.29 As the litigation process is lengthy and it takes a long time for cases to be referred to court, we assume that the savings in relation to reduced litigation will not start to be realised until 2016/17, assuming provisions of the reformed law come into effect in 2015/16.
- 7.30 A recent report by Counsel and Care found that one of the top three issues that older people, their families and carers contacted Counsel and Care's advice service about in 2010 was concerns about being given incorrect and often illegal advice by their council.<sup>132</sup> It has also been suggested that social workers' lack of confidence in applying the law can result in delays to the assessment and care planning processes.<sup>133</sup> Similarly, a lack of legal knowledge can lead to an over-reliance on limited statutory powers or local authority policies, meaning that individuals do not always get the most appropriate support to meet their needs.
- 7.31 Creating a clearer and simpler statute with clearer and simpler practice guidance will mean that fewer mistakes are made and will prevent wrong advice being given. This will not only result in fewer complaints and less litigation, as outlined above, but will also improve the outcomes and experiences of care users, carers and their families.

**Table 27: savings from less lawyers' time required (in England) [10/11 prices]**

	Low	Best	High
Number of FTE lawyers working on adult care and support		182 <sup>134</sup>	
Median salary (excluding on-costs)		£45,400 <sup>135</sup>	
Time savings	10%	15%	20%
Annual savings	£823,280		£1,652,560

**Table 28: savings from lower litigation costs (in England and Wales)[10/11 prices]**

	Low	Best	High
Costs met by public funds		£2,480,000 <sup>136</sup>	
Costs agreed and met by opponents		£746,000 <sup>137</sup>	
Social workers		£570,000 <sup>138</sup>	
Time savings	10%	15%	20%
Annual savings	£379,600	£569,400	£759,200

## Costs

- 7.32 There will be some transitional costs resulting from the changes to the legal framework and these mainly relate to the training of professionals in adult

<sup>132</sup> Bernard, C., *Care Concerns 2010: "No Help Here"*, 2011

<sup>133</sup> Law Commission, *Adult Social Care Law Reform Impact Assessment*, 2011

<sup>134</sup> In 2009, there were 3,072 FTE lawyers working for local authorities in England and Wales. About 5% of the workload of lawyers in local authorities relates to adult social care. The proportion of the population of England and Wales residing in England is 94.6% and it has been assumed that the proportion of lawyers is the same.

<sup>135</sup> Law Commission, *Adult Social Care Law Reform Impact Assessment*, 2011.

<sup>136</sup> *Ibid.*

<sup>137</sup> Legal Services Commission, *Statistical Information 2009-10*, 2010

<sup>138</sup> Law Commission, *Adult Social Care Law Reform Impact Assessment*, 2011

social care. A range of professionals work in this area, including social workers, occupational therapists, rehabilitation officers and those with relevant NVQs. However, the most accurate data available is for registered social workers and so in order to gain an estimation of training costs we used this information. Social workers were also the focus of the Law Commission's *Adult Social Care Law Reform Impact Assessment* so they have been highlighted here. This is for the purpose of estimating costs and it is recognised that local authorities take their own approaches to staffing. See table 28 for further calculations on the costs of in-house training for other members of staff.

- 7.33 It will be necessary to train existing social workers in the new law and on assessment practices and the determination of eligibility under the new national threshold. The Law Commission suggested that there would be a requirement of four days of training per adult social worker in the first year and a further two days in the second year.<sup>139</sup> From then onwards, normal continuing training requirements would fulfil any ongoing need.
- 7.34 Assuming that an external trainer conducted the training and that Local Authorities used their own premises and therefore incurred no costs for venue hire, the total cost for training would be between £4.2 million and £8.5 million over the two years. Broken down, this would mean costs to Local Authorities of between £2.8 million and £5.7 million in the first year and between £1.4 million and £2.8 million in the second (see Table 29 below). As set out in table 25 below, we have used midpoint best estimates of £4.25 million in the first year and £2.1 million in the second. These costs would be reduced considerably if the training were to be conducted in-house.

**Table 29: costs of training social workers (in England)[10/11 prices]**

	Low	Best	High
Number of qualified social workers (headcount) working in adult care and support		23545 <sup>140</sup>	
Number of days training (year 1)		4 <sup>141</sup>	
Number of days training (year 2)		2	
Costs of trainer (per day) <sup>142</sup>	£600	£900	£1,200
Training costs (year 1)	£2,825,400	£4,238,100	£5,650,800
Training costs (year 2)	£1,412,700	£2,119,050	£2,825,400
<b>Total training costs</b>	<b>£4,238,100</b>	<b>£6,357,150</b>	<b>£8,476,200</b>

- 7.35 The opportunity costs of social workers' time whilst completing this training would be £25.1 million in the first year and £12.5 million in the second (see Table 30 below). Local authorities should be able to manage these costs as part of normal business planning so these costs are not funded – in line with standard methodology whereby opportunity costs are only included if they have a consequent specific cost (e.g. hiring locum staff).
- 7.36 Note that there will also be training costs associated with funding reform to be implemented from 2016/17, but these will be considered by a separate impact assessment.

<sup>139</sup> *Ibid.*

<sup>140</sup> Skills for Care, *We gather information about the social care sector: the state of adult social care workforce in England*, 2010.

<sup>141</sup> Law Commission, *Adult Social Care Law Reform Impact Assessment*, 2011

<sup>142</sup> Assumes that there will be approximately 20 social workers per training session.

**Table 30: opportunity costs of training social workers (in England)[10/11 prices]**

Number of qualified social workers (headcount) working in adult care and support	23,545
Hourly cost of social workers	£38 <sup>143</sup>
Number of days training (year 1)	4
Number of days training (year 2)	2
Opportunity costs (year 1)	£25,051,880
Opportunity costs (year 2)	£12,525,940
Total opportunity costs	£37,577,820

7.37 One issue that needs to be taken into consideration is that social work students generally study the legal framework during either the first or the second year of their degree. This will mean that for the first year or two of the new system newly qualified social workers will need to be retrained. The Law Commission suggested that it would be prudent to allow an extra two days of training for two years for these individuals and estimated that this would mean that approximately 750 individuals require additional training.

7.38 There will be some additional opportunity costs associated with the training of other local authority staff, such as those who work in call centres. This training would only be required on a one-off basis and it is reasonable to assume that it could be provided in-house by a social worker. Although it has not been possible to make accurate calculations for the costs of this training, we estimate that it will cost between £1 million and £2.5 million. We have used a mid-point best estimate of £1.75 million. Our assumptions and calculations are set out in Table 31 below.

**Table 31: opportunity costs of training other local authority staff (in England)[10/11 prices]**

	Low	Best	High
Hourly cost of social worker (trainer)		£38	
Hourly cost of those being trained		£20 <sup>144</sup>	
Number of staff per session		25	
Number of hours per session		3	
Number of sessions per local authority	4	7	10
Cost per local authority	£6,456	£11,298	£16,140
Total training costs	£981,312	£1,717,296	£2,453,280

7.39 It is not expected that there will be any ongoing costs from law reform. The following table totals the costs and savings described above, uprated to 2015/16 prices.

**Table 32**

<i>£ millions, 15/16 prices</i>	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Transition cost total	£4.7	£2.3	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
Opportunity Cost	£27.6	£13.8	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0

<sup>143</sup> PSSRU, *Unit Costs of Health and Social Care*, 2011.

<sup>144</sup> Assumes that the average salary of those being trained is £15,000.

## **Key assumptions/sensitivities/risks**

### *Key assumptions*

7.40 For the purposes of this cost benefit analysis we have made several assumptions, which are based on the expert opinion of the Law Commission:

- In 2009/10, there were 21,240 social workers working in adult care and support in England who would be affected by our proposals. We have assumed that these numbers will remain constant over the next five years.
- In 2010/11, the total average cost to a local authority of one social worker is £52,363 and that includes the mean basic salary and on-costs.
- There are 182 full-time equivalent legal advisors working for Local Authorities in England. In 2009, there were 3,072 full-time equivalent lawyers working for Local Authorities in England and Wales. We have estimated that approximately 5 per cent of the workload of lawyers in Local Authorities relates to adult care and support. The proportion of the population of England and Wales residing in England is 94.6 per cent and it has been assumed that the proportion of lawyers is the same. We have assumed that these numbers will remain constant over the next five years.
- One day of external legal training costs £45 per social worker. This is based on there being 20 social workers per training session. In-house training creates no additional costs.
- The level of provision of adult care and support services will remain the same.
- The price base year is 2010/11. We have assumed that, subject to the agreement of Parliament, the Care Act would receive Royal Assent in 2014, and 2015 is the earliest that the provisions could come into force.

### *Sensitivities*

7.41 We have built a range of sensitivities into our analysis. These include the following:

- There will be between 5 and 15 per cent (best estimate 10 per cent) fewer complaints to Local Authorities.
- We will save between 10 and 20 per cent (best estimate 15 per cent) of the costs of local authority legal advisors and costs of litigation.
- There will be a time saving in social worker's work of between 0.68 and 1.54 per cent (best estimate 1.11 percent).

### *Risks*

7.42 The main risk to be considered is an inevitable degree of uncertainty around our assumptions, in particular:

- The number of social workers who require training. There is also some uncertainty about the extent of training that social workers will require on the reformed law.
- The transitional costs as in-house training may attract additional costs.



- The extent of the reduction in time spent by social workers on legislative matters.
- The number of complaints and the amount of litigation that will be avoided, as well as the savings to Local Authorities from a reduction in complaints about adult care and support.

## **Specific Impacts**

### *One-In Two-Out*

- 7.43 The proposals for reform of the law set out in this Impact Assessment do not fall within the scope of the Government's "One-In Two-Out" (OITO) rule which states that "any regulatory measure that is expected to result in a direct net cost to business must be offset by deregulatory measures providing savings to business of at least double that amount."
- 7.44 These proposals do not involve any additional regulatory measures which impose costs on business or civil society and therefore are considered out of scope of this rule. The proposed reforms to the law which will undergo pre-legislative scrutiny relate to the responsibilities of Local Authorities and other public sector partners for planning and commissioning of adult care and support services and for meeting the needs of their local population.

### *Equality*

- 7.45 Our overarching aim in reforming the law on adult care and support is to establish a clear, coherent and effective system for adult care and support in England. This will help to clarify the rights of care users and carers.
- 7.46 In reforming the adult care and support statute, we will also look to remove discriminatory and outdated language, such as the definition of a disabled person under Section 29 of the National Assistance Act 1948.
- 7.47 As part of its review of the adult care and support statute, the Law Commission consulted with a wide range of care user and carers, including older people, people with learning disabilities, deafblind adults, people with physical disabilities, alcohol misusers, and people with mental health problems. The Law Commission also participated in several events with representative organisations and user-led organisations.
- 7.48 Further information regarding impacts on equalities is provided in the corresponding equality and rights analysis.

### *Health and well-being*

- 7.49 Our plans for law reform are expected to have a significant positive impact on health and well-being. A key objective of the reforms is to build a clear, coherent legal framework for adult care and support, so that service users and carers can easily understand what they might be entitled to.

### *Human rights*

- 7.50 We do not consider that our proposals for law reform would be incompatible with human rights law. Our proposed reforms would comply with the objectives of promoting and protecting human rights under the Human Rights Act 1998.

7.51 These proposals comply with the objectives of promoting and protecting human rights under the Human Rights Act 1998. Any implications for human rights are likely to be positive. For example, the EHRC have flagged the lack of portability in the system could be construed as compromising the human rights of service users. Our proposal seeks to end this and will therefore be beneficial from the human rights perspective.

*Justice system*

7.52 We do not expect that our proposals for law reform will lead to an increase in cases before the courts or tribunals. Rather, as we detail above, we expect there to be some moderate savings in the resources devoted to litigation on adult care and support.

## 2G. UNIVERSAL DEFERRED PAYMENT SCHEME

### Background – case for change

- 8 Each year, approximately 55,000 people in England enter residential care as a self-funder. This means that they have more than £23,250 in assets and therefore, under the current charging rules for residential care, are liable to pay for all of their residential care fees.
- 8.1 However, for many people, the value of their home is a large proportion of their overall assets. For this reason, as many as 25,000<sup>145</sup> people each year may have to rely on their housing wealth to pay for residential care. It is often difficult for them to draw on their housing wealth in a timely and flexible manner and their only option may be to sell their home in order to pay for care. This creates anxiety and stress in an already difficult period in people's lives.
- 8.2 Since 2001, the Department has promoted a deferred payment scheme, in which local authorities have discretionary powers to defer self-funders' care fees. In other words, the authority pays the self-funder's care fees, but in exchange puts a charge on their property and recovers the amount due to it once the property has been sold.
- 8.3 However, the current scheme is discretionary and there is wide variation in both the number of deferred payment agreements offered in local authorities and in the eligibility conditions attached to local schemes. As a result, only about 4,000 people each year enter into a deferred payment agreement.
- 8.4 The Care Act 2014 contains provisions for a Universal Deferred Payment Scheme. All authorities will have a duty to offer deferred payments, with consistent rules for who is eligible and what fees they can defer. Local authorities will also have permissive powers to offer deferred payments in a wider set of circumstances, for example where an individual narrowly misses the eligibility criteria.
- 8.5 The intention is to give people peace of mind, choice and control over their care options and how to pay for them when they enter residential care and to ensure that people should not be forced to sell their home in their lifetime to pay for care. This impact assessment (IA) assesses the costs and benefits of the scheme, further building on previous IAs and the regulations and guidance to enrich detail previously established.
- 8.6 The costs of the scheme will be kept under review throughout implementation to take into account emerging evidence, for example on demand under the new universal scheme.
- 8.7 The remainder of this impact assessment will:
- Set out the problems faced by people who are at risk of having to sell their home to pay for care;

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<sup>145</sup> We note that there have been updates to the modelling since the publication of the previous version of this IA. This has led to revisions in the number of people at risk of selling their home, and we have revised the assumptions on likely demand for deferred payments.

- Present proposals to address these problems through a Universal Deferred Payment Scheme;
- Assess the impacts of the proposals on the availability and number of deferred payment agreements and the resulting costs and benefits, as well as risks.

## Why action is needed

- 8.8 The objective of the proposed Universal Deferred Payment Scheme is that people should not be forced to sell their home within their lifetime to pay for care. This section sets out how many people are at risk of doing so and what negative outcomes they face:
- Each year, about 25,000 people are *at risk* of having to sell their home to pay for residential care;
  - For practical reasons, they may find it difficult to sell their home quickly;
  - Selling one's home to pay for care causes stress and anxiety for people who are already at a difficult and vulnerable stage in their life.

### ***Some people have to sell their home to pay for residential care***

- 8.9 To estimate the number of people who need to sell their home to pay for residential care we consider the number of people who:
- enter residential care each year as self-funders<sup>146</sup>;
  - would meet the local authority needs test; and
  - have non-housing assets below £23,250.
- 8.10 The Department's social care funding model estimates that, in 2015/16, approximately 55,000 people will enter residential care as a self-funder (see annex B for an explanation of the model). Under the charging rules for residential accommodation (CRAG), they are liable to pay their full residential care fees<sup>147</sup>.
- 8.11 Under the proposed scheme (as well as under many current local authority deferred payment schemes), self-funders would not be eligible for a deferred payment if they had more than £23,500 in savings. Anyone above this threshold could typically afford to pay for a year of residential care out of their savings, without having to draw on their housing wealth.
- 8.12 Excluding people with non-housing assets above £23,250, the *social care funding model* estimates that about **25,000 people each year will be eligible for DPAs. These are people who may be at risk of having to sell their home to pay for care**, either immediately when entering residential care or over the course of their time in residential care as their assets deplete.
- 8.13 Because the need for care is usually unpredictable while people are in reasonable health, all homeowners who *might* turn out to need residential care in their later life are theoretically at risk of having to sell their home if this happens.

### **Difficulties in drawing on housing wealth**

- 8.14 Self-funders may find it difficult to draw on their housing wealth to pay for care. This is because a house is a **lumpy asset**, which cannot be easily subdivided. As a result, people have to give up ownership of the whole house,

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<sup>146</sup> Self-funders are people who have assets above the asset threshold and are therefore considered to be able to pay for their own care; while from 2016 some of these people will be able to receive support through the extended means test, they will continue to be responsible to contribute to their care fees if they are able to.

<sup>147</sup> This excludes people whose home is occupied by a spouse (or dependent relative), as they are not required to draw on their housing wealth to pay for residential care.

even if they only use part of its value to pay for care.

- 8.15 In addition, housing wealth is relatively **illiquid**, so that selling one's home is not always possible at short notice. The charging rules for residential care acknowledge this by exempting housing wealth for a person's first twelve weeks in residential care, providing they meet certain criteria<sup>148</sup>. This means that people's homes would not be taken into account when assessing their ability to pay for care in these twelve weeks and they would therefore not have to sell their home during this disregard period.
- 8.16 However, in many cases, people might want to use this disregard period to sell their home with the intention of paying for their care in the future but find that the twelve week period may be too short to do so. When going into care, people may not be able to put their home up for sale immediately because:
- Going into care often happens in a crisis with little time to plan the sale;<sup>149</sup>
  - People may not always know whether they will stay in care indefinitely;
  - Putting the house on the market may require preparation (e.g. emptying or preparing the home);
  - The homeowner may lack capacity to manage the property and/or legal arrangements may be necessary (e.g. giving power of attorney to their children).
- 8.17 Once the home is on the market, it takes an average of ten weeks to find a buyer and sell the house. In some regions, the time it takes to sell a house can be substantially longer: 13.6 weeks in the East Midlands and 11.6 weeks in the North West.<sup>150</sup> Finally, after the sale is agreed, it will take some time until the sale is finalised and money is received. As a result, people will often find it difficult to draw on the value of their home within twelve weeks, even if they want to sell it.

### **Increased anxiety and potential financial loss**

- 8.18 Given these difficulties in drawing on housing wealth in a flexible and timely manner, self-funders may face a range of negative outcomes:
- Having to sell one's home, in particular in a rushed way, may add to the anxiety and feeling of loss often associated with this period in life;
  - It may also result in financial disadvantages to the homeowner (e.g. rent foregone).

### **Additional anxiety / stress due to having to sell one's home when going into a care home**

- 8.19 Transition into residential care can be a demanding process for clients and families. Glendinning et al (2008) suggest "*older people often approach services at a time of crisis when they feel vulnerable or unwell and find decision making difficult*".<sup>151</sup> Indeed, a recurrent theme in studies about moving into care is one of "*stressful reaction, likened to the experience of loss*

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<sup>148</sup> The authority must have assessed residential care needs and must have less than £30,000 in assets excluding their home.

<sup>149</sup> Glendinning et al (2008): Evaluation of the Individual Budgets Pilot Programme: Final Report

<sup>150</sup> Hometrack 2012: Monthly National Housing Survey, [http://www.hometrack.co.uk/hpsurvey/documents/RDHTSurveyDec2012CMS\\_21122012153607.pdf](http://www.hometrack.co.uk/hpsurvey/documents/RDHTSurveyDec2012CMS_21122012153607.pdf)

<sup>151</sup> Glendinning et al (2008): Evaluation of the Individual Budgets Pilot Programme: Final Report

and grief, (...) potentially as traumatic as divorce or death in the family”<sup>152</sup>. Moving into a care home has been associated with what is sometimes called “relocation stress syndrome” – which involves symptoms such as anxiety, depression, apprehension, loneliness and increased confusion, as well sleep disturbances, weight loss and gastrointestinal upset.<sup>153</sup>

- 8.20 In these situations, to sell one’s home requires additional decisions and organisational effort and may further contribute to feelings of anxiety and stress. Having to sell one’s home is also likely to be a significant source of emotional distress in itself as a home is not only of financial, but also of significant emotional value. In addition, being forced to sell one’s home may reinforce feelings of powerlessness and loss of decisional autonomy, which contribute to depression among people in care homes.<sup>154</sup>

### **Foregone financial benefits**

- 8.21 Having to sell one’s home in a rush may also result in financial losses as people sell their home for a lower price than otherwise possible. For instance, quick sale property agents offer to buy any property as quickly as within a week, but usually pay prices up to 25% below market value.<sup>155</sup> In addition, some people may prefer to keep their property because they expect it to appreciate over time and to generate revenue, e.g. by renting it out or allowing a relative to live there rent-free (with a benefit equivalent to the rent occurring to the relative).
- 8.22 It should be noted that these financial benefits fall on the individual making the agreement. At the same time, there will be corresponding losses to someone else (such as the prospective buyer, who could have acquired the property below market value). Thus, from a societal perspective the *net financial* impact is zero.
- 8.23 However, society may have a preference to allow homeowners to fully benefit from their lifetime savings, even if this implies that others will forego the benefits of owning or using their home. Indeed, it can be argued that deferred payments address an underlying distributional problem: while homeowners continue to pay a contribution towards their residential care fees as defined in the charging rules, the deferred payment agreement ensures that they do not face additional dis-benefits such as the loss of their home.

### **Rationale for government intervention: no market provision and variable public provision**

- 8.24 The previous sections have outlined the basic problem: self-funders who go into residential care may have to use their housing wealth, which is often illiquid and cannot be drawn on in a flexible way. As a result, they may find themselves forced to sell their home to pay for care. This may lead to

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<sup>152</sup> Newson, Pauline 2011: At home then away: supporting new residents as they settle in, in: *Nursing & Residential Care* 13(1), p32-35

<sup>153</sup> Jackson et al (2000): Bridge of continuity from hospital to nursing home – Part 1: a proactive approach to reduce relocation stress syndrome in the elderly, in *Continuum* 20(1), p3-8: and: Mallick and Whipple 2000: Validity of the nursing diagnosis of relocation stress syndrome, in *Nursing Research* 49(2), p97-100

<sup>154</sup> Boyle, Geraldine 2005: The role of autonomy in explaining mental ill-health and depression among older people in long-term care settings, *Ageing & Society* 25, p731-748

<sup>155</sup> Tornsey, Chris 2012: Quick-sale property firms could cost you thousands, <http://www.confused.com/mortgages/articles/quick-sale-property-firms-could-cost-homeowners-thousands-of-pounds>

additional anxiety and stress in what is already a stressful situation.

*Lack of equity release products for people going into residential care*

- 8.25 One solution to this problem could be equity release. Equity release is a financial product that allows people to draw on their fixed assets, for instance to pay for (domiciliary) care. However, the equity release market does not offer products aimed at people in residential care to protect them against selling their home.
- 8.26 Market research shows that equity release products, as they are currently offered, are “*unlikely to be suitable for meeting residential care costs*”<sup>156</sup> for a number of reasons:
- Many people going into residential care would not qualify for equity release products, because their property would not be occupied;<sup>157</sup>
  - Equity release products cap lending at a modest proportion of an asset’s value, and therefore many users would not be able to borrow the cost of an average stay in care.<sup>158</sup> This means that clients would still be subject to the risk of having to sell their home for care;
  - Equity release usually does not offer small and incremental loans (which might be most suitable because length of stay in residential care is uncertain). Instead, typical loans consist of large withdrawals of at least £10,000, which would increase the cost of the equity release scheme to borrowers.<sup>159</sup>
- 8.27 In addition, there are other well-documented demand barriers to equity release. There remains public mistrust of commercial equity release due to perceptions that it is expensive and due to mis-selling problems in the past. Rightly or wrongly, these may make equity release a difficult option for people moving into residential care. The Government is interested in seeing improvements in the market including more flexible and affordable products to help with care costs. However, its assessment, at this stage, is that equity release is not a general solution for residential care users who are at risk of having to sell their homes.

*Current public provision of deferred payment agreements is patchy*

- 8.28 In response to these problems, since 2001, the Department has promoted a deferred payment scheme, in which local authorities have discretionary powers to offer deferred payments (deferrals). In simple terms this scheme could help in the following way:
- The authority is in a situation where it would charge for residential care but the person cannot or does not want to sell their home to pay for this;
  - The authority defers the payment so the person can instead pay later on;

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<sup>156</sup> Hosty, Ged 2012: Meeting social care needs, in: Making the most of equity release: perspectives from key players, The Smith Institute, p51-57

<sup>157</sup> Hosty, Ged 2012: Meeting social care needs, in: Making the most of equity release: perspectives from key players, The Smith Institute, p51ff

<sup>158</sup> Products lend a maximum loan to house value (LTV) ratio. For disabled and older clients the terms can be quite favourable, lending up to 50% of housing equity. However, many clients are unable to borrow the cost of an average stay in residential care, particularly those with less valuable homes.

<sup>159</sup> Terry, Rachel 2012: Asset-rich, income-poor, in: Making the most of equity release: perspectives from key players, The Smith Institute



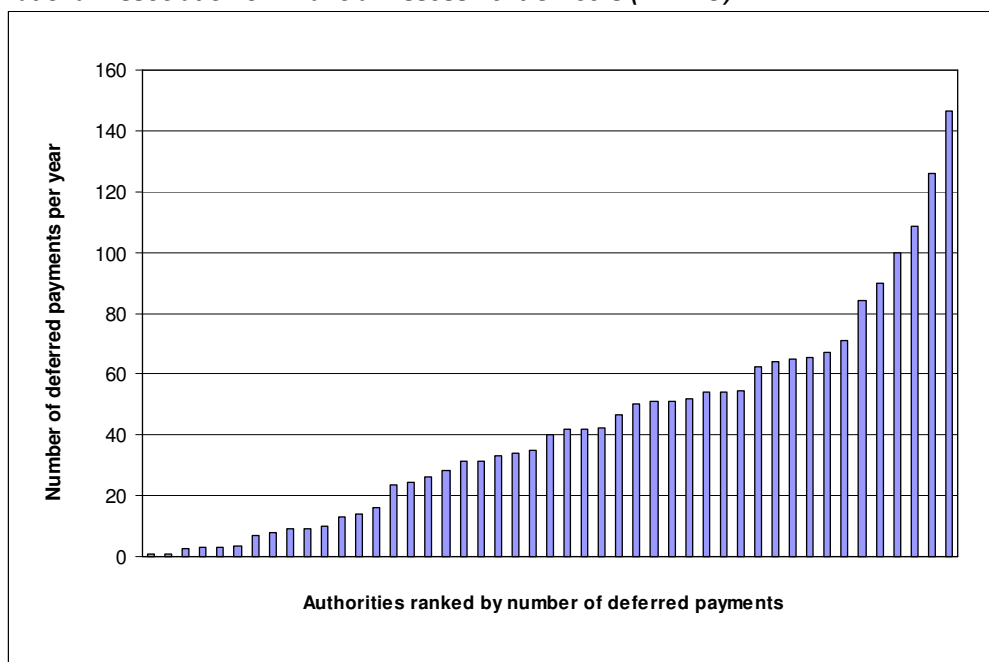
- In return, the person agrees to a charge on their property to secure the debt;
- The person then repays the debt once they have sold their property.

8.29 From 2001 to 2004, the Government also provided a total of £85m of funding to local authorities to facilitate them to offer deferred payments.<sup>160</sup>

8.30 Provision of deferred payments is largely discretionary, in that authorities have powers rather than duties in this area. Department of Health guidance asserts that authorities may be acting unlawfully if they offer no deferred payments at all, but that the decision to offer a deferred payment in any particular case is ultimately a matter for the authority.<sup>161</sup> The Department has issued this guidance partly in response to long-running concerns that authorities were not offering deferrals on the scale the Department had envisaged.<sup>162</sup>

8.31 However, provision of deferred payments among local authorities is still patchy, with some local authorities providing hundreds of deferred payment agreements and others none at all. In addition, local deferred payment schemes can have very different rules, for instance on loan to value ratios and occupation of the home.

**Figure 33 – Number of deferred payment agreements by authority, from a 2012 survey by the Department (DH), the Association of Directors of Adult Social Services (ADASS) and the National Association of Financial Assessment Officers (NAFAO)<sup>163</sup>**



8.32 Figure 33 shows that there is large variation in the provision of deferred payment agreements. One cause of this variation is that, under the current system, there are disincentives for local authorities to provide them. In

<sup>160</sup> Grant allocations of £15m in 2001/2; £30m in 2002/3; £40m in 2003/4.

<sup>161</sup> Local authority circular - LAC DH (2009) 3

<sup>162</sup> Local authority circular - LAC DH (2009) 3

<sup>163</sup> The survey asked authorities about the number of deferred payments ending and beginning in 2011/12. To minimise the impact of random variation in-between years, we have calculated the number of deferred payments per year as the average between those two figures.

particular, they cannot charge interest on deferrals and, therefore, authorities effectively make a loss every time they provide a deferred payment.

8.33 **Variation in local policies:** In 2012, the Department, in collaboration with the Association of Directors of Adult Social Services (ADASS) and the National Association of Financial Assessment Officers (NAFAO), surveyed local authorities about their deferred payment schemes. Responses to the survey revealed considerable variation in the way authorities implement the current discretionary scheme. In particular, a substantial minority of authorities offers deferred payment agreements under conditions which are likely to reduce take-up:

- In nine out of 59 respondent authorities, deferred payments were offered only to people whose home was occupied, either by a relative or by a tenant;
- In two local authorities, deferrals were offered only in compelling individual circumstances;
- Some authorities only offered deferred payments to people with liquid assets below a threshold of less than £23,500 (three local authorities, in one case as low a threshold as £4,000).

8.34 **Variation in local take-up:** To assess the degree to which the offer of deferred payments in each area meets the demand for deferred payments, we calculate the take-up rate in each authority, i.e. the share of new self-funders in residential care who take out a deferred payment agreement in any given year:

**Take-up rate** = deferred payment agreements / new self-funders in residential care

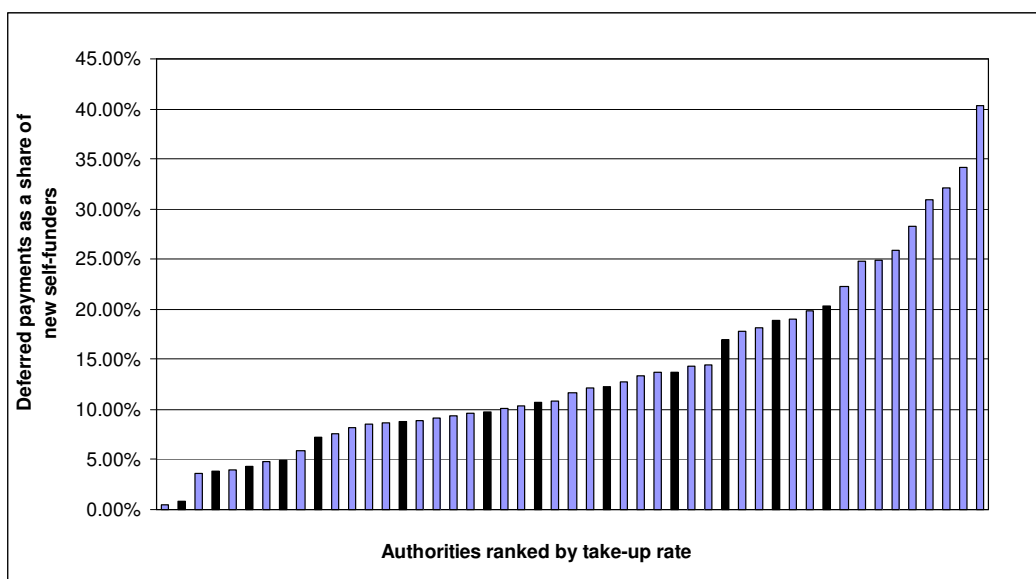
8.35 The number of new self-funders in each authority is estimated based on:

- Local authority level data from the Care Quality Commission (CQC) on the total number of care home beds in homes which contain older people;
- An estimate of the occupancy rate in care homes in each English region;<sup>164</sup>
- Data on the number of people in residential care who are supported by their local authority, including those placed by other local authorities from a CQC survey in 2009;<sup>165</sup>
- Data on the number of people supported by continuing health care in residential care, using data from the Department and Laing and Buisson;
- Finally, the estimates are scaled to fit Personal Social Services Research Unit (PSSRU) data on the total number of self-funders at the national level.

**Figure 34 – Take-up rate of deferred payments by authority, from the 2012 DH/ADASS/NAFAO survey**

<sup>164</sup> From Laing & Buisson, Care of Elderly People UK Market Survey 2010-11, Twenty-third Edition, London, 2010.

<sup>165</sup> The survey data is updated to take account of changes in the number of supported residents using information from Personal Social Services Expenditure Return;



8.36 Figure 34 shows that there is substantial variation in the take-up rate across authorities. This might reflect genuine differences in demand, but it is likely that it also reflects differences in the local offer/supply. The darkly shaded bars in figure 34 represent local authorities with policies that may reduce demand for deferred payments (as defined in para 8.33) and those authorities have, indeed, less take-up of deferred payments (see also table 35).

**Table 35 – Local policy choices and take-up, based on the 2012 DH/ADASS/NAFAO survey**

	Proportion of new self-funders in residential care who take-up deferred payments
<b>Authorities with more restrictive policies (13 authorities)</b>	9%
<b>Authorities with no obvious restrictive policies (36 authorities)</b>	14%
<b>70<sup>th</sup> percentile of Authorities</b>	18%
<b>80<sup>th</sup> percentile of Authorities</b>	20%

*As a result, many people still have to sell their home to pay for care*

8.37 Overall, it seems reasonable to conclude that the current scheme did not achieve its objective to “ensure no old person will be forced to sell their home against their will when they go into (residential) care”<sup>166</sup>. According to the annual budget survey by ADASS, **approximately 4,000 deferred payment agreements were taken out in 2012.**

8.38 With about 55,000 self-funders entering care every year, this suggests that, overall, about **7% of self-funders** take out a deferred payment agreement. In

<sup>166</sup> NHS Plan, July 2000

light of the variations across local authorities, it appears that the voluntary scheme does not fully meet demand.

## **Policy options**

### **Option 1 – Do nothing**

8.39 Under the 'do nothing' option, provision of deferred payment agreements is likely to remain patchy. Neither local authorities nor the private sector would have any incentives to provide more or different offers of deferred payments than at present.

### **Option 2 – a universal deferred payment scheme**

8.40 This is the preferred option. It clarifies the rules that should apply in implementing deferred payments and aims to ensure that a deferred payment agreement is available to anyone who, otherwise, would be at risk of having to sell their home in their lifetime to pay for care.

8.41 This section sets out the main components of the proposed policy.

#### **Eligibility and security – who can defer and how much?**

8.42 Eligibility: under the policy, there will be a duty to offer a deferred payment to anyone who:

- Is assessed by the local authority as needing residential care;
- Has no spouse / dependent living in their home;
- Has less than £23,250 in savings (i.e. non-housing assets);<sup>167</sup>

8.43 For people with less than £23,250 in savings the deferral is effectively an extension of the twelve-week disregard: allowing homeowners to make use of this initial breathing space and extend it from week 13 in the form of a deferred payment agreement.

8.44 People who do not meet the criteria in para 8.43 at first may nonetheless do so later if their circumstances change, for instance if they deplete their savings. Local authorities also have permissive powers to offer deferred payment agreements in a wider set of circumstances, for example where applicants narrowly fail to meet the core eligibility criteria. A person might for example have slightly more than the savings threshold, and the local authority might decide to offer that person a deferred payment agreement to avoid having to make arrangements for paying for their care twice in short succession.

8.45 Local authorities will need to decide for themselves whether to exercise these permissive powers to offer a more generous scheme in response to local conditions and taking into account funding pressures. Many local authorities already use their current powers to offer deferred payment agreements above and beyond the eligibility criteria set out above. As these powers are *permissive* and not *mandatory* and local authorities will exercise them to

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<sup>167</sup> The threshold will be £23,250 in 2015/16, over time this is likely to change in line with other parameters in the social care means test.

differing degrees, this impact assessment **will not consider the impact of the permissive powers contained in regulations and guidance.**

- 8.46 **Security:** local authorities will be required to seek adequate security for a deferred payment agreement. Usually this will consist of placing a first legal charge against a person's property, but local authorities do have permissive powers to accept other forms of security they deem to be adequate. This is important where a property charge cannot be secured. As each deferred payment agreement will be secured, we would expect a comparatively low default rate, particularly when compared with unsecured loans.
- 8.47 In cases of joint ownership of property being used for security, local authorities will need to seek and obtain the written consent of any third party with an interest in the property to secure their approval of the deferred payment agreement and confirm they are content with the placing of the charge. In some cases the third party may become a co-signatory to the deferred payment agreement.
- 8.48 **Level of care fees:** under the policy, people can defer appropriate care fees. This means that they can also defer fees which are more expensive than the typical local authority funded care home place (i.e. "top ups" above local authority rate). However, local authorities will have discretion to limit what "top ups" they are willing to defer, particularly if the amount is excessive in relation to what the individual can afford.
- 8.49 **Income allowance:** Under the proposed policy, local authorities can require people to pay part of their care fees out of their income. As a result, people will not defer all of their care costs. However, authorities are required to allow people to keep some income to maintain and insure their home and cover any personal expenses. This amount is called the 'disposable income allowance' and helps authorities ensure that people only defer the amount that they need to, while allowing individuals to afford costs associated with owning a home and have some disposable income to spend on their own personal expenses. The level of the allowance will be set at £144 per week, though individuals can choose to surrender some of this £144 if they want to contribute more to their care costs from their income (and thus defer less and pay less interest).
- 8.50 **Limits on the total amount deferred:** local authorities are required to set a limit on the total amount someone can defer (including any interest accrued). This limit will be set at 90% of the full sale value of the home minus £14,250. This allows for the person to retain a 'cushion' of equity in their property, whilst allowing the person to qualify for additional local authority support in paying for their care when they reach the lower capital limit of £14,250 (under the 2015/16 charging regulations).
- 8.51 **Means-testing and the cap on care costs:** In addition to the deferred payment, people will also be eligible for means-tested support and for the capped costs scheme. From 2016, financial help for the costs of residential care will be available on a sliding scale to anyone with less than £118k in total assets. This will reduce what care fees the least well off need to defer. The lifetime cost of care will also be capped at £72k, limiting the total amount someone is likely to defer even if they do need care for a long time. These entitlements also mean that people will be at a very low risk of negative

equity. The funding reform IA contains further details on the 2016 reforms which can be found on the Care Act website<sup>168</sup>.

### **Interest, admin charges and funding**

8.52 **Admin charges:** Local authorities will be able to pass on any administration fees accrued in setting up and maintaining a deferred payment agreement to people agreeing them. Any fees passed on will be added to the total amount deferred.

8.53 **Interest rates:** As opposed to the current scheme, interest will be chargeable throughout the lifetime of the deferred payment agreement. The regulations will specify a maximum rate, which tracks the average gilt rate as set out by the Office for Budget Responsibility at the time of every Budget and Autumn Statement. The most recent Economic and Fiscal Outlook published alongside Budget 2014 projects the average gilt rate will be 3.3% in 2015/16 rising to 4.0% in 2018/19.<sup>169</sup>

8.54 The national maximum rate will change every six months on 1 January and 1 July to track changes in this average rate each preceding Autumn Statement / Budget respectively. In addition, loans will be structured to minimize accumulation of interest. Thus, for instance, clients will not take out a lump sum loan, but instead, the total amount deferred will increase on a draw-down basis in line with their care costs.

8.55 Once an individual has reached the equity limit on their chosen form of security, the individual will not be allowed to defer any further care fees. The equity limit offers protection against users not being able to afford further charges associated with selling their home, and will help to avoid situations in which the user ends up in negative equity and the local authority might not be repaid in full.

8.56 **Risk of non-repayment:** There is a risk that individuals will not repay part (or all) of their deferred payment. There are two categories:

- People avoid repaying the full amount due to the LA under of the DPA; (Type A)
- On the ending of the loan, the selling of the home does not cover the total value of the DPA. (Type B)

#### **Type A**

8.57 The charge placed on the property when setting up the DPA means that this risk is minimal, especially when the property is insured. However, we think it prudent to make some provision for this risk, for example, where the charge not been placed on the home correctly or the LA has not undertaken adequate due diligence. This would also include circumstances where a property is damaged by fire or flood and was not properly insured.<sup>170</sup>

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<sup>168</sup> Care Act Website – funding reform Impact Assessment published at <http://services.parliament.uk/bills/2013-14/care/documents.html>;

<sup>169</sup> For latest publication see OBR – Economic and fiscal outlook supplementary fiscal tables – March 2014 [Table 4.1]

<sup>170</sup> In these circumstances the local authority may be able to recover some of the value of the DPA

8.58 Currently we have minimal evidence of this risk. LAs replying to the previous survey did not raise any problems with recovering DPAs under the current scheme. As a conservative estimate we assume that **0.1% of DPAs are not repaid at all (1 out each 1000 DPAs)**

### Type B

8.59 The main risk is where a deferred amount represents a large share of the asset on which it is secured, and there is a risk that large falls in property prices result in negative equity, which makes it impossible to recover all of the outstanding debt.

8.60 There are two categories of risk that follow from the volatility in house prices:

- Stochastic risk (or uncorrelated), where individual properties see a fall in value.
- Systemic risk (correlated), where a housing crash produces a fall in house prices across the board.

8.61 We model that the risk adjustment required for these two risks will be low , due to low stochastic risk and systematic risks of significant house prices falls. Historical trends in the UK suggest that there is a significant general fall in house prices approximately once every 10 years).

8.62 Individuals who reach high Loan to Value (LTV) ratios (and are therefore at greater risk of default) are those who have had their DPA for a longer length of time (over 90% of those who reach 70% LTV are expected to have had their DPA for more than 3 years, far longer than the expected average length of a DPA).

8.63 The introduction of the cap on care costs in April 2016 provides extra protection against default, as people have to spend less from their housing wealth.

8.64 We estimate the average deferral to be about £20,000 a year and the average duration of a deferred payment is 1 ½ years. Table 36 shows that the vast majority of houses in England are worth more than is required to pay for 1 ½ years of residential care.

**Table 36 – Housing Assets**

House value	Proportion of houses sold in England and Wales (Nov 2012) <sup>171</sup>
Under £50,000	1.60%
£50,001 - £100,000	13.20%

8.65 This risk is further reduced by the proposed equity limit and other mitigating actions, including supporting homeowners to maintain and make use of their properties.

<sup>171</sup> [http://www.landregistry.gov.uk/\\_\\_data/assets/pdf\\_file/0020/34706/HPI-Report-Jan-2013.pdf](http://www.landregistry.gov.uk/__data/assets/pdf_file/0020/34706/HPI-Report-Jan-2013.pdf)

- 8.66 The interest rate includes a component to compensate local authorities for the risk of default they face. This has been set at 0.15% in regulations.

### **Other policy requirements and local decisions**

- 8.67 **Information:** People considering a deferral need good information and advice about their financial options and the implications of a deferred payment agreement. Indeed, access to financial advice may be particularly important for people entering residential care (whether they are considering a deferred payment agreement or not).
- 8.68 Local authorities are required to offer support and advice to people considering taking out deferred payment agreements. We envisage that local authorities and stakeholders will lead on developing local information and advice offerings, setting out the nuances of their own deferred payment agreement schemes. The impact on local authorities of meeting these information and advice requirements is discussed in the information and advice section of the impact assessment.
- 8.69 **Support to homeowners to maintain and make use of their properties:** Local authorities can require people in deferred payment agreements to maintain and insure their homes.
- 8.70 The Department also consulted on the need for support for people in deferred payment agreements to improve, sell or rent out their home. There was recognition that any services would need to reflect local requirements, and could be provided by local government, NGOs or the private sector (with a number of local authorities already offering relevant services). Such measures would also benefit local areas because they would mean that, in general, homes are less likely to fall into disrepair and are more viable for sale and renting. Local authorities can encourage rental of properties further by allowing a person to retain a proportion their rental income, and the guidance encourages local authorities to do so.
- 8.71 **Deferred payments for younger adults:** At present, deferred payment agreements are only available to older adults going into residential care. Under the expanded deferred payments scheme, there will be no age-related limitations on access to deferred payment agreements.
- 8.72 The cost modelling in this IA does not include any potential costs of providing deferred payment agreements to younger adults. The Department consulted with stakeholders on the likely demand for deferred payments from younger adults, and stakeholders agreed there were likely to be negligible numbers of applicants (if any). Stakeholders noted that very few younger adults in residential care would have been able to build up enough assets to be self-funders, and hence be at risk of having to dispose of their assets to pay for their care. Future engagement with stakeholders will continue to seek to confirm this.

### **Assessment of impact of preferred option**



- 8.73 The objective of the proposed Universal Deferred Payment Scheme is that people should not be forced to sell their home in their lifetime to pay for care. By making it mandatory for local authorities to offer deferred payments under certain conditions and setting clear parameters for local implementation, the scheme aims to give homeowners peace of mind, greater flexibility and a wider array of choice in paying for their residential care.
- 8.74 The main impact of the proposed policy is for people who may need to sell their home to pay for care to have the option to take out a deferred payment agreement. This section sets out how this is expected to result in:
- Increased take-up of deferred payment agreements;
  - A resulting increase in expenditure to provide these deferred payments and a corresponding increase in repayments;
  - Administrative costs in running the scheme;
  - Benefits to people taking out deferred payments;
  - Risks, in particular potential impacts on the housing market.

#### ***Increase in the take-up of deferred payments***

- 8.75 We expect take-up for deferred payments to increase under the universal scheme. We estimate the expected increase in the number of deferred payment agreements by comparing current take-up to an estimate of demand under a “low take-up”, a “main take-up” scenario and a “high take-up” scenario in the proposed universal scheme.
- 8.76 Note that previous versions of this Impact Assessment did not account for individuals who are already in residential care prior to when the scheme will come into force (i.e. before April 2015). Some of these people will become eligible for a deferred payment before, in or after April 2015 and a certain portion of these people are expected to take out a DPA once the scheme comes into force.
- 8.77 A more robust method compared to the one used previously has been applied to generate the estimates in this Impact Assessment. The additional take-up assumptions have also been included in the DH Spending Review bid in 2013. Please refer to the Annex C for a more detailed discussion on these groups.

#### ***Do nothing – patchy supply, variable eligibility criteria and lack of awareness limits take-up of deferred payments***

- 8.78 According to the ADASS budget survey, there are approximately 4,000 deferred payments every year (based on new deferrals in 2010/11 and 2011/12). This is equivalent to **7% of all self-funders**.

#### ***Universal Deferred Payment Scheme – universal provision with increased visibility and take-up***

- 8.79 Compared to the do-nothing scenario, we assume that the universal scheme would ensure that everyone who is at risk of selling their home to pay for care has access to a deferred payment. This means that all local authorities would offer deferred payments within the policy parameters.

- 8.80 We know that provision is patchy and that some local authorities do not offer deferred payments at all. At a minimum, under a universal scheme, we expect that the average take-up across England would be similar to the take-up reported in the 2012 DH/ADASS/NAFAO survey, i.e. 14% of all self-funders.<sup>172</sup> We assume that take up increases to 14% of all self-funders in 2015/16.
- 8.81 We expect that a universal scheme will enhance the visibility of deferred payments and therefore lead to higher demand. Therefore, we assume that total demand in the long run for deferred payment agreements, under a universal scheme, will be about 18% of all self-funders. This is based on current take-up of the large authority at the 70<sup>th</sup> percentile of all of authorities in the 2012 DH/ADASS/NAFAO survey.
- 8.82 We assume a gradual increase in take-up - as awareness of the scheme grows over time – from 14% in 2015/16 to reach 18% of all self-funders by the end of 2017/18.

<b>Central Demand Scenario</b>	<b>2015/16</b>	<b>2016/17</b>	<b>2017/18</b>	<b>2018/19 -&gt;</b>
% take up of all self-funders	14%	14% - 16%	16% - 18%	18%
	throughout the year	Increase through the year	Increase through the year	Steady state

- 8.83 Based on this, we estimate that the universal scheme would increase the demand for deferred payments by up to 7,600 in 2015/16 relative to the baseline, and then increasing from around 5,600 in 2016/17 to around 11,000 by 2024/25. There is a higher increase in 2015/16 than subsequent years since we assume that there is increased take up of people in LAs with current restrictive practice above the standard new flow of people into residential care after April 2015.

**Table 37 – Deferred payments 2015/16 – 2024/25, estimate based on the DH social care funding model, rounded to the nearest hundred<sup>173</sup>**

	<b>2015/16</b>	<b>2016/17</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>	<b>2024/25</b>
<b># of DPAs, current scheme w/ 7% take-up</b>	3,900	4,200	4,700	4,800	5,300	5,300	5,100	5,400	5,700	5,900
<b># of DPAs, Universal Scheme w/ 18% steady state take-up</b>	11,500	9,800	11,800	12,400	13,700	13,600	13,200	14,000	14,700	15,200

<sup>172</sup> This estimate excludes authorities with policies that might reduce demands, as set out above

<sup>173</sup> Due to rounding, figures may not always add up.

<b>Universal scheme</b>										
–	7,600	5,600	7,000	7,600	8,400	8,300	8,100	8,500	8,900	9,300
<b>current scheme</b>										

8.84 We estimate that 18% of all self-funders equates to around 40% of those eligible taking out a DPA, this means that we assume a majority of those eligible will not take out a deferred payment agreement. This may be because some people may prefer alternative arrangements. For example, they may prefer and be able to sell their home before they would need to draw on their housing wealth. Others may prefer to use their liquid savings first and do not stay in care long enough to be forced to draw on their housing wealth (e.g. if they die during their first year in care). Finally, in other cases, deferred payments may also not be appropriate, for example where the property is jointly owned and the joint-owner refuses to have a charge put on the property (or is deceased and the ownership is stuck in probate), or where there is an existing claim on the house from an equity release scheme.

**Uncertainties around demand**

8.85 There are uncertainties around the estimates above. We base our central estimate on the 7<sup>th</sup> decile of all authorities that responded to the 2012 DH/ADASS/NAFAO survey.

8.86 However, it is possible that take-up under a universal scheme would increase above this level, even in authorities with currently high take-up. The authority at the 8<sup>th</sup> decile of all authorities that responded to the 2012 DH/ADASS/NAFAO survey has take-up around 20% of all self-funders. This might be the case if there still is scope for improvement in frontline delivery in those authorities.

8.87 We set out a high scenario where take-up reaches 20% of all self-funders in the long run. We estimate that this equates to around 45% of eligible self-funders taking out a DPA.

8.88 In the high scenario we also assume a gradual increase in take up from 14% in 2015/16.

<b>High Demand Scenario</b>	<b>2015/16</b>	<b>2016/17</b>	<b>2017/18</b>	<b>2018/19 -&gt;</b>
% take up of all self-funders	14% throughout the year	14% - 17% Increase through the year	17% - 20% Increase through the year	20% Steady state

8.89 We consider that 45% take-up among eligible individuals is likely to be too high and a less likely scenario than our central scenario. This is in part due to the fact that these are not benefits but only a loan, as well as the fact that

many eligible individuals will not need a DPA to avoid selling their home. This is reflective of the reality that;

- People become eligible for the scheme when they have less than £23250 in assets.
- At this point could still afford around 1 year in a care home (from income and assets) before being forced to sell their home or take out a DPA.
- A high proportion of people spend less than one year in care before passing away.

8.90 On the other hand, it could be that some authorities with lower take-up already meet demand for deferred payments, suggesting that the demand for the universal scheme is closer to the average of LAs with no obvious restrictions, around 14% of all self-funders. We set this out as a low scenario.

8.91 In the low scenario we assume that demand remains at 14% from 2015/16.

<b>Low Demand Scenario</b>	<b>2015/16 -&gt;</b>
% take up of all self-funders	14% Steady state

8.92 In addition, we propose to introduce interest charges on deferred payments, which may reduce demand. We do not have firm evidence on how interest payments will affect demand. However, we expect that the overall impact of interest charges on demand will be limited, because, for most people, interest charges would be minor when compared with the potential well-being and financial benefits. Table 38 gives an approximation of the interest someone would pay on a deferred payment of different duration, for an average of £20,000 per year, assuming an interest rate of 3.5%. Note that the figures below have been approximated by using half the interest rate in any ongoing year, assuming that new loans spread equally across any new year. The calculations show that for the majority of people on short loans, interest payments will amount to about £500.

8.93 Therefore, we expect that the introduction of interest will not reduce overall demand strongly. It might encourage some people to repay earlier, unless they have a strong emotional tie or would benefit financially from keeping the property. Given the overall uncertainty, the Department will monitor take-up closely when the scheme is implemented.

**Table 38 – Approximate interest payments over the duration of a deferred payment with a 3.5% interest rate**

A	B	C	D	E
Duration in years	Share of deferred payments with longer duration	Deferred payment (excl interest)	Deferred payment with interest	Interest (=D-C)
1	53%	£20,000	£20,350	£350
2	25%	£40,000	£41,412	£1,412

3	11%	£60,000	£63,212	£3,212
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8.94 We have highlighted that there is uncertainty in the likely demand for deferred payments, both on the high and low side of our central scenario. The Department will work with Local Authorities to monitor the demand for DPAs on the implementation of the universal scheme.

8.95 Table 39 illustrates the impact on the number of new DPAs from the different assumptions. Increased or reduced demand for DPAs impacts the costs and benefits proportionally and therefore does not affect the economic appraisal that follows in this Impact Assessment.

**Table 39- Impact on new DPAs in low and high demand scenarios**

Number of new DPAs	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
<b>Low Scenario</b>	11,500	9,200	9,700	9,700	10,700	10,600	10,300	10,900	11,400	11,800
<b>Central Scenario</b>	11,500	9,800	11,800	12,400	13,700	13,600	13,200	14,000	14,700	15,200
<b>High Scenario</b>	11,500	10,100	12,800	13,800	15,200	15,100	14,700	15,500	16,300	16,900

### Costs of preferred option

8.96 This section sets out the costs of the proposed universal scheme compared to a do-nothing scenario, in which the take-up of deferred payment agreements will be unchanged and no interest charged. Costs include both the inherent cost of providing loans (i.e. deferred payments) as well as the costs of administering the scheme.

8.97 The modelling takes account of the wider reforms to care funding expected to come into effect in April 2016 – and which are described in detail in the impact assessment on social care funding reform notably:

- A £72k cap on reasonable care costs; and
- Means-tested support for residential care for people with assets of less than £118k.

8.98 It should be noted that all estimates in the below section are national averages. The costs of deferred payments will vary across regions and the Department will take this into consideration when determining funding for the scheme.

### Total monetised costs of additional deferrals

8.99 The main financial impact (to the public sector) of providing deferred payment agreements lies in the temporary costs of paying self-funders' care fees for the duration of the agreement. The fees (plus interest and any admin charges accrued) are repaid when the agreement ends. The interest payment reflects the costs associated with the deferred payment scheme to the local authority.

8.100 This section sets out our estimates for the total volume of deferred payments (and repayments) under the do-nothing and under the proposed universal scheme, as well as under a range of scenarios.

*Basic modelling assumptions*

8.101 The Department models the total volume (in monetary terms) of deferred payments based on projections from its social care funding model (explained in Annex B). For each self-funder, the model calculates their deferred payment, using the charging rules for residential care and the proposed eligibility rules for deferred payments. The model then calculates the amount of care fees the individual will defer, taking into account how much they are able to contribute from income. The duration of the deferred payment agreement is determined by the individual's length of stay in residential care and whether they end their agreement before death. Note that further information on the model's underlying assumptions in relation to future demographic changes, length of care journey, prevalence of disability and several others are can be found in Annex B. Core assumptions used in the model are:

- The take-up of deferred payments;
- The level of deferred payments, i.e. care fees net of any contribution people make towards their care costs from their income;
- The duration of deferred payments, i.e. the time until loans are repaid;
- The interest rates
- The default rate

8.102 **Administration costs:** Any administrative charges will be passed on to the individuals taking out DPAs and the model assumes that these charges are repaid once the deferral ends. Therefore the same repayment profile for DPAs and admin cost has been applied. In general, the estimated payments and repayments of administrative charges are now added into DPA payments and repayments positions and reflected in 'net funding requirement' columns of tables 47-50. It is noted that administrative charges will also attract interest.

8.103 The 2012 DH/ADASS/NAFAO survey asked local authorities to estimate the administrative costs of setting up, monitoring and collecting repayment in a deferred payment scheme. Responses indicated a wide range of costs from £170 to over £1000 (see table 40 for the range of estimates). Responses to the recent consultation 'Caring for our Future' also provided a similar spread of results.

**Table 40 – Range of administration costs as reported in the 2012 survey**

Estimated administration cost per deferred payment	Less than £250	£250 to £500	£500 or more
<b>Number of local authorities</b>	9	8	3

8.104 Because of uncertainty around the responses to both the consultations and the survey (in particular, whether respondents considered all types of cost when responding), we talked, in depth, to a local authority with a large

number of new deferrals each year, whose scheme we expect to be in steady state. That authority had reported legal costs of around £375 per deferred payment. In addition, it reported its activity in administering financial assessments and monitoring the scheme (including monitoring the debt, producing annual statements for those with a deferral and collecting repayment). Table 41 summarises the overall costs of administering a deferred payment, assuming on-costs of 30%, adjusting for the higher unit costs in the local authority in question, and inflating from 2012/13 prices to 2015/16 prices.

**Table 41 – Summary of estimated administration costs per deferred payment, in 2015/16 prices**

A	Legal costs	£384
B	Ongoing monitoring	£77
C	Financial assessments	£77
<b>D</b>	<b>Total LA staff costs (=A+B+C)</b>	<b>£537</b>
E	Including on-costs (=D*1.3)	£698
F	Land registry fees	£51
<b>G</b>	<b>TOTAL costs (=E + F)</b>	<b>£750</b>

- 8.105 **Level of deferrals:** The costs of the deferred payment scheme will depend on the level of care fees people chose to defer. This, in turn, will depend both on the level of care fees they have to pay and the amount they are able to contribute out of their own income.
- 8.106 As set out above, under the proposed universal scheme, people will be able to defer any reasonable fee (even if this is above the local authority rate in their area). Therefore, we assume that care fees for people taking-up a deferred payment are equivalent to the national average self-funder fee. DH modelling suggests that the average annual value of a deferral would be about £20,000 in 2015/16 prices.
- 8.107 **Duration of deferred payments:** The monetised value of deferred payments will depend on their duration, i.e. the time until people repay. We estimate this based on responses to the 2012 DH/ADASS/NAFAO survey.

**Table 42 – Duration of deferred payment agreements ending in 2011/12, from the 2012 DH/ADASS/NAFAO survey<sup>174</sup>**

	Share out of all deferred payments
<b>Less than 1 year</b>	47%
<b>1 to under 2 years</b>	28%
<b>2 to under 3 years</b>	14%
<b>3 years or more</b>	11%

- 8.108 It should be noted that the introduction of the proposed Universal Scheme may affect the duration of deferred payment agreements. For instance, being able to charge interest reduces incentives for local authorities to ensure deferred payments are of short duration. At the same time, interest payments give stronger incentives for individuals to use deferred payment agreements as breathing space only. We also expect that the duration of deferred

<sup>174</sup> In the survey, 41 out of 59 respondent authorities provided information on the duration of deferred payments.

payment agreements - and in particular the duration of longer-term deferred payment agreements not taken out for breathing space – will be most strongly influenced by mortality rather than policy parameters.

- 8.109 **Interest rate:** We assume that, under the do-nothing option, no interest is charged, while, under the proposed scheme, local authorities will charge the national maximum interest rate as set out in regulations. For this impact assessment we assume an interest rate of 3.5%, which is in line with the latest projections published by the OBR.
- 8.110 Income used to pay for care: The maximum weekly income that an individual can opt to retain is £144. However, we consider it unrealistic to assume that all individuals will make the same choice and opt to keep the maximum amount, given that there will be competing incentives and individual circumstances will vary. For example, the benefit of retaining the maximum income allowance would come at a cost of deferring larger amounts and therefore paying more interest
- 8.111 There is evidence from the equity release market that suggests people will defer less than the maximum they are allowed to. A DH-sponsored , industry report on the equity release market, published in January 2014, states that while some equity release products offer loan to value ratios exceeding 50%, the typical borrower has opted to release less than a quarter of their housing wealth over the last three years.
- 8.112 The National Association of Financial Assessment Officers (NAFAO), and some individual LAs, have argued that individuals will not need to retain more income than the statutory Personal Expenses Allowance (currently £24.40 per week). We should therefore expect financial assessment officers to advise people of this fact in individual cases, and for this to have some ‘anchoring’ effect on decisions.
- 8.113 In addition, we should expect some people will rent their property and be able to retain up to 50% of the rental income without increasing the amount deferred (in fact, we would expect use of rental income to reduce the amounts deferred and associated cost to LAs).
- 8.114 It would be more reasonable to assume that some people will choose to defer smaller amounts, and so pay less interest, by retaining less than the £144 maximum weekly income allowance. We assume that people choose on average to retain £125 of their weekly income.
- 8.115 **Care cost price inflation:** The modelling assumes that social care prices will rise at around 2% over headline inflation from 2015/16 onwards.
- 8.116 **Late repayments:** Previous versions of this Impact Assessment were based on the assumption that all loans are repaid fully as soon as the deferred payment agreement ends (either at death or because the person in question has sold their house). It was previously also acknowledged that repayments may not always be made in a timely manner and that late repayments will occur where someone dies while their deferred payment is still ongoing and no arrangements have been made to sell the home. Table 43 provides a sense of the delay between the end of a DPA and repayment.



**Table 43 – Time between the end of a deferred payment agreement and its repayment, based on responses from the 2012 DH/ADASS/NAFAO survey**

<b>Authorities with typical repayment</b>	<b>... within three months</b>	<b>... between three and six months</b>	<b>... between six and twelve months</b>	<b>... after more than a year</b>
<b>Percentage of total deferred payments</b>	30%	20%	40%	10%

8.117 Table 43 shows that the time between the end of the deferred payment agreement and the repayment varies considerably, with only half of all repayments occurring within six months. This has two impacts on the total value of the scheme:

- Repayments occur later than predicted by the average duration of deferred payment agreements;
- Repayments are higher than predicted, as more interest accrues.

8.118 In the light of this evidence, the assumptions regarding delay of repayments have been updated in the DH cost model to incorporate an average delay of a quarter of a year (ca. 13 weeks). For more information on this adjustment, please refer to Annex C

### **Modelling the difference between the do-nothing and the preferred option**

8.119 Table 44a summarises the volume of deferred payments and repayments under the current voluntary scheme (do nothing) and the universal scheme under the central demand assumption with a 3.5% interest rate.

8.120 The analysis in this section focuses entirely on new deferrals commencing from after the start of financial year 2015/16. Deferrals that have been taken-up before this point will not be affected by the proposals and the new interest charges will not be applied to them.

8.121 The usual assessment frame for government policies is ten years (2015/16 – 2024/25). However, some of the deferred payment agreements that have been taken out in the years preceding 2024/25 will still be ongoing by the end of that year. To fully assess the costs and benefits of the proposed scheme, we need to take into account that these deferred payment agreements will be repaid eventually. Otherwise, analysis would wrongly imply that all deferred payments which are still outstanding by March 2025 would not be repaid, which will clearly not be the case.

8.122 Therefore, the below calculations take into account all payments and repayments related to deferrals taken out in 2014/15 – 2024/25, including where these occur after 2024/25. It does not take into account any new deferrals occurring after 2024/25, as these deferrals fall outside of the ten year assessment period.

**Table 44a – Deferred payments and repayments under the central demand scenario where demand reaches 18% in the long run (£m, 2015/16 prices)<sup>175</sup>**

			15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	After 24/25	TOTAL
Do nothing	A	Deferred Payments (in £m)	45.0	109.2	148.9	177.8	180.9	191.5	202.4	218.0	233.5	246.6	0.0	1,753.7
	B	Repayments (in £m)	3.6	30.5	76.1	121.7	142.9	159.0	174.5	189.1	204.1	220.0	313.1	1,634.7
	C	Net spent (A-B)	41.3	78.7	72.8	56.1	38.0	32.5	27.9	28.9	29.4	26.6	-313.1	119.0
Proposed scheme	D	Deferred Payments (in £m)	137.6	282.8	411.7	521.1	548.1	592.7	645.7	714.2	790.3	886.4	0.0	5,530.6
	E	Repayments (in £m)	12.9	83.0	206.8	346.6	422.8	492.5	566.1	639.7	721.7	833.5	1,001.7	5,327.3
	F	Net spent (D-E)	124.8	199.8	204.9	174.5	125.2	100.2	79.7	74.4	68.6	52.8	-1,001.7	203.3
<b>ADDITIONAL FUNDING NEEDS (F-C)</b>			<b>83.5</b>	<b>121.1</b>	<b>132.1</b>	<b>118.5</b>	<b>87.3</b>	<b>67.7</b>	<b>51.8</b>	<b>45.6</b>	<b>39.2</b>	<b>26.2</b>	<b>-688.6</b>	<b>84.3</b>

\*Note that for the purpose of appraising the scheme over the standard 10 year period, it is assumed that the scheme will be wound down after 10 years. This assumes that no more DPAs are issued after 2024/25 (i.e. zero payments “after 2024/25”); however, because some DPAs which were made in years prior to 2024/25 will be ongoing and repaid after 2024/25 (i.e. repayments of £313m in the current scheme and £1,001 m in the proposed scheme).

8.123 In tables 44b and 44c, we summarise the impact on payments and repayments under the low and high scenarios introduced above.

**Table 44b – Deferred payments and repayments under the low demand scenario where demand reaches 14% in the long run (£m, 2015/16 prices)**

			15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	After 24/25	TOTAL
Do nothing	A	Deferred Payments (in £m)	45.0	109.2	148.9	177.8	180.9	191.5	202.4	218.0	233.5	246.6	0.0	1,753.7
	B	Repayments (in £m)	3.6	30.5	76.1	121.7	142.9	159.0	174.5	189.1	204.1	220.0	313.1	1,634.7
	C	Net spent (A-B)	41.3	78.7	72.8	56.1	38.0	32.5	27.9	28.9	29.4	26.6	-313.1	119.0
Proposed scheme	D	Deferred Payments (in £m)	137.6	271.6	363.5	429.7	436.0	466.0	504.7	556.6	615.1	689.5	0.0	4,470.3
	E	Repayments (in £m)	12.9	83.0	200.9	317.8	361.1	402.8	454.7	506.5	567.1	651.0	779.2	4,336.9
	F	Net spent (D-E)	124.8	188.5	162.6	111.9	74.9	63.2	50.0	50.0	48.0	38.5	-779.2	133.4
<b>ADDITIONAL FUNDING NEEDS (F-C)</b>			<b>83.5</b>	<b>109.8</b>	<b>89.8</b>	<b>55.9</b>	<b>37.0</b>	<b>30.7</b>	<b>22.1</b>	<b>21.1</b>	<b>18.6</b>	<b>11.9</b>	<b>-466.1</b>	<b>14.4</b>

**Table 44c – Deferred payments and repayments under the high demand scenario where demand reaches 20% in the long run (£m, 2015/16 prices)**

			15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	After 24/25	TOTAL
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<sup>175</sup> Due to rounding, figures may not always add up.

Do nothing	A	Deferred Payments (in £m)	45.0	109.2	148.9	177.8	180.9	191.5	202.4	218.0	233.5	246.6	0.0	1,753.7
	B	Repayments (in £m)	3.6	30.5	76.1	121.7	142.9	159.0	174.5	189.1	204.1	220.0	313.1	1,634.7
	C	Net spent (A-B)	41.3	78.7	72.8	56.1	38.0	32.5	27.9	28.9	29.4	26.6	-313.1	119.0
Proposed scheme	D	Deferred Payments (in £m)	137.6	288.5	435.8	566.9	604.1	656.0	716.2	792.9	877.9	984.8	0.0	6,060.8
	E	Repayments (in £m)	12.9	83.0	209.7	361.1	453.7	537.4	621.8	706.3	799.0	924.8	1,112.9	5,822.6
	F	Net spent (D-E)	124.8	205.4	226.1	205.8	150.4	118.6	94.5	86.7	79.0	60.0	-1,112.9	238.2
<b>ADDITIONAL FUNDING NEEDS (F-C)</b>			<b>83.5</b>	<b>126.7</b>	<b>153.3</b>	<b>149.7</b>	<b>112.4</b>	<b>86.2</b>	<b>66.6</b>	<b>57.8</b>	<b>49.5</b>	<b>33.4</b>	<b>-799.9</b>	<b>119.2</b>

### Costs of operating the system

8.124 In addition to the expenditure of allowing people to defer their care fees, there will be additional costs resulting from setting up a deferred payment scheme.

#### Set-up costs

8.125 From the 2012 DH/ADASS and NAFAO survey and a previous survey in 2011, we know that at least 70 local authorities already offer deferred payments. While they will face some costs in expanding their activity or adapting their policy to universal scheme, we expect set up costs to be limited in these authorities, as they build on their existing schemes.

8.126 However, up to 80 local authorities currently offer little or only a very limited number of deferrals. These authorities will face a range of costs which may include:

- establish policies relating to their deferred payments offer, including a policy on what if anything they intend to accept as security beyond a charge on a property;
- write guidance for and provide training to care managers on the new scheme;
- produce information for people who may need a DPA;
- establish and cost an administrative and legal process.

8.127 The Department has been working with local authorities on implementing the deferred payment scheme and will continue to provide implementation support centrally.

#### Risks and uncertainties

8.128 The above analysis is subject to a number of uncertainties. This section describes the potential scope and impact of these uncertainties.

#### *Year-on-year variation in demand at local level*

8.129 At the local level, demand for deferred payments varies considerably over time. In the 2012 DH/ADASS/NAFAO survey, the average difference between

the number of deferrals that ended in 2011/12 and those that began in 2011/12 was +/- **28%**. This fluctuation may reflect a variety of factors such as

- Local housing market conditions (e.g. higher prices may encourage people to sell their home rather than taking out or keeping a deferred payment agreement);
- Local policy choices regarding the wider social care system, which will affect whether or not people go into residential care (and as a self-funder).
- Random year-on-year variation, e.g. in the characteristics of each new cohort of self-funders, which may mean that more or less self-funders are eligible for a deferred payment agreement.

8.130 However, given the overall volume, this variation is modest when compared to local authorities' financial resources. Indeed, for most authorities in the 2012 DH/ADASS/NAFAO survey, year on year variation was less than 5% of their reserves.

### ***Risks resulting from empty homes***

8.131 If people take out a deferred payment agreement rather than selling their home, this may result in a situation where their home is temporarily unoccupied. This, in turn, may affect the housing market and result in adverse wider social impacts (through a loss of consumer surplus, where people are priced out of the market and pressure on housing prices). The analysis below estimates these impacts on the housing market. It shows that, at the national level, the impact on the housing market is likely to be relatively small, resulting in about 3,500 unoccupied homes and limited pressure on housing prices, but there could be more significant localised effects, which may affect the balance of costs and benefits.

8.132 This analysis is supported by the evidence available from stakeholders. In summer 2013, the Department consulted on the likely impact of deferred payment schemes to the housing market. Whilst local authorities recognised the logical potential for an impact on the housing market, local authorities with existing schemes that had taken a view on the impact on the housing market observed minimal impact, and those projecting the impact predicted minimal impact.

### *Quantification of the reduction in housing supply*

8.133 As set out in table 37, we estimate that, by around 2020/21, the Universal Deferred Payment Scheme will increase the annual flow of new deferred payment agreements by about 8,000. The analysis that follows is explained in more depth in Annex C and it is noted that the estimated impact on the housing market is very small.

8.134 Firstly, about half of all deferrals end within a year. These **short-term deferrals** might end because the person taking out the deferral dies (possibly before they could have sold their home), or because the deferred payment agreement was taken out to provide temporary 'breathing space' by people who then proceed to sell their home. In either case, we expect that the home would have been empty for approximately the same period of time, even if the person had not taken out a deferred payment.

- 8.135 Similarly for people who take out **longer-term deferrals** of more than a year, their homes would also have been empty for some time at least had they not taken out a deferred payment agreement. For example, if they had been forced to sell their home, they might not immediately be in a position find a buyer. Sometimes people will also enter care not knowing how long they will stay and therefore, initially, will not arrange to sell their home.
- 8.136 Finally, it is important to consider that not all properties with a deferred payment agreement will be empty. Instead, people in the scheme may wish to ensure that their **property is occupied**, for instance, by renting it out. We estimate that this will be the case for about one third of all properties with a longer-term deferred payment agreement. This estimate is based on responses from nine authorities in the 2012 DH/ADASS/NAFAO survey, who offered deferrals only to people who ensure their home is occupied. Take-up in these authorities was about 7% of all self-funders, i.e. approximately a third of our best estimate for take-up in the universal scheme. However, there is considerable uncertainty around this estimate:
- In the nine authorities in question, people were obliged to ensure their home was occupied if they wanted to take out a deferred payment. This is a strong incentive for people to do so, e.g. by asking a relative to move in. Fewer homes will be occupied under a universal scheme, under which this specific eligibility condition is not required.
  - We expect that local authorities will work to encourage people to rent out their homes, thereby increasing occupation rates.
  - People with long-term deferrals are more likely to want to ensure that their property is occupied (for instance when compared to people who take out an agreement primarily as a 'breathing space' loan with a view to selling their home).
- 8.137 The guidance encourages local authorities to further incentivise rental by allowing people to retain a proportion of any rental income they might generate. In recognition of the diversity of local housing markets, the amount of income authorities allow people to retain is at their discretion. This is intended to increase rates of rental, but in the absence of data on the effectiveness of such an intervention, this impact assessment does not attempt to model this element of the policy.
- 8.138 Taking the assumptions outlined above together, we estimate that about 3,000 deferrals each year will result in additional unoccupied properties (in 2015/16).

**Table 45 – Number of new deferred payments resulting in empty homes**

		2015/16
<b>A</b>	Number of deferrals (annual flow)	8,000
<b>B</b>	... of which short-term deferrals (=A*47%)	3,800
<b>C</b>	Long-term deferrals (=A-B)	4,200
<b>D</b>	.. of which rented out (=C*33%)	1,400
<b>E</b>	<b>Long-term deferred payments, no occupation (=C-D)</b>	<b>2,900</b>

- 8.139 As set out above, we expect that increases in the number of unoccupied homes will mainly result from longer-term deferred payments. Given the

average duration of these deferrals, we estimate that these will be unoccupied for about two years. Based on this assumption, we expect that the universal deferred payment scheme will reduce the supply of available homes by 5,800 homes in 2015/16 (=2,900 deferrals \* 2 years).

### *Resulting externality*

- 8.140 Unoccupied homes are more likely to be poorly maintained. The resulting deterioration of the property may, in turn, have negative spill over effects on neighbouring properties and negatively affect their value.
- 8.141 Under the proposed scheme, people will retain enough income to maintain and insure their property, and are likely to be required to do so by the deferred payment agreement they enter into. We expect this to reduce the number of long-term empty homes at risk of deterioration. This impact assessment assumes that these policies prevent and offset any externalities linked to empty houses.

### *Wider welfare implications*

- 8.142 Assuming that the supply of housing is fixed, the number of occupied homes across the country will fall by 5,800 under the best take-up estimate. Fewer homes will be affected under the alternative, lower uptake scenario. This higher take-up estimate scenario would be equivalent to about 0.03% of about 22 million homes in England becoming unoccupied.
- 8.143 In addition, it is worth recognising that in reality, the supply of housing is not fully inelastic. Any reduction in supply will be partially mitigated through an increase in prices: where fewer houses are available in an area, some people will be willing to pay higher prices for access to the remaining housing stock, which, in turn, increases incentives for sellers or property owners to provide housing. There are about 710,000 empty homes in England<sup>176</sup> - even if only 0.8% of these were brought into the market in response to the new unmet demand, this would be sufficient to balance the reduction in housing supply projected to be due to deferred payments.
- 8.144 This reduction can result in three separate impacts, which are explained, in more detail, in Annex C:
- A loss of consumer surplus as some people are unable to find accommodation at the price they are willing or able to pay;
  - Price pressures in the housing market, which might increase prices/rents resulting in a transfer of wealth from buyers/renters to sellers/landlords;
  - Rent (or equivalent income) foregone to people taking out a deferred payment agreement.
- 8.145 **Loss of consumer surplus:** as a result of the reduction in available housing stock, some people will be unable to find accommodation at the price they are willing to pay. Therefore, they lose out on the benefit of that accommodation (net of the rent they would have paid).

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<sup>176</sup> <http://www.emptyhomes.com/statistics-2/empty-homes-statistic-201112/> ; Often they are rented homes that have fallen into disrepair; sometimes the owner has inherited the property. In many cases the owner lacks the funds or the skills to repair and manage the property.

- 8.146 However, this effect is likely to be small: a reduction in the housing stock by 6,000 homes is equivalent to a shift in the total supply of housing by 0.027%. Given the responsiveness of demand and supply to prices, we expect this to generate only a similarly small shift to prices. People who are priced out of the market by this small shift in prices will have had little net benefit from their accommodation (once rent is taken into account). Annex B calculates the corresponding loss of consumer surplus to be, in total, as little as **£20,000 per year**.
- 8.147 In practice, supply will respond to fill the gap created by 6,000 homes taken off the market. Thus, some of the resulting excess demand will translate into higher prices, some of it will be addressed by an increase in houses supplied by other home owners/landlords. We estimate that, overall, **the number of occupied homes will fall by 3,500** (see Annex C).
- 8.148 **Impact on market rents:** The reduction in housing supply might increase prices/rents in the housing market. In Annex C, based on estimates for the demand and supply elasticities for housing, we estimate that prices could increase by up to £3.85 per year per household. Across 22 million households in England, this effect could add up to about £85m, which are transferred from home sellers/renters to home owners/landlords. *A priori*, this transfer of wealth is neutral from a social perspective. However, taking into account the differences in income between landlords and renters, in particular, we estimate that these transfers result in a reduction of social welfare by **£13m per year**.
- 8.149 However, it should be noted that this impact is contingent on price pressures being passed on to consumers. Given the size of the effect, which amounts to about £0.3 per household per month, rents may not be adjusted to pass on this potential increase.
- 8.150 **Foregone rental income:** As 3,500 less homes will be occupied, their owners forego any rental income they could have earned on them. This adds up to **£42m per year**. The social welfare effect of this reduction in rental income is uncertain. In particular, as people *decide not to rent* out their house, they must value doing so more than the rent they forego. Therefore, arguably, the benefit of not having to rent out their home outweighs any loss in rental income. However, there is a risk as people may misjudge their own utility or not take into account the utility of rental income to others (such as their family). In practice, local authorities will offer support in renting out the property and people's families are likely to be involved in the decision-making and, indeed, the management of the rental process, and the guidance encourages authorities to consider how best to incentivise rental income, including by allowing people to retain a proportion of any income they generate (which might otherwise be taken to reduce net deferrals).
- 8.151 **Local variation:** It should be noted that the above discussion treats the housing market as one coherent market for the whole of England. In reality, there are many local housing markets and both the incidence of deferred payment agreement and the underlying structure of the local housing market will differ.
- 8.152 Local variation could mean that in many areas the impacts on the housing market could be very small, but also means it is possible that in some local areas there could be more significant impacts on housing shortages and

prices. In such areas, the negative impacts on the housing market could substantially affect the balance of the costs and benefits generated by deferred payments.

- 8.153 Local areas that support people to rent out or sell their properties are likely to see fewer empty homes and this support could mitigate local impacts on the housing market. The Department will work with the sector to develop such a support programme.

## **Benefits**

- 8.154 As set out in table 37, we expect that the introduction of a Universal Deferred Payment Scheme will lead to an increase in the number of deferred payment agreements by about 7,600 in 2014/15 and around 9,300 in 2024/25. This section discusses the expected benefits generated by deferred payments:
- Reduction in stress and anxiety for those who go into residential care as self-funders and will not have to sell their home as a result of the universal deferred payment scheme;
  - Peace of mind for anyone who may be at risk of having to sell their home in the future;
  - Financial protection for homeowners.

### ***Improved well-being through a reduction in anxiety and stress***

- 8.155 The main benefit of deferred payments lies in the reduction of anxiety for those who otherwise would have to sell their home. As set out above, the stress of moving into a care home has been associated with a range of symptoms such as:
- Anxiety
  - Depression
  - Loneliness and increased confusion
  - Sleep disturbances
  - Weight loss
  - Gastrointestinal upset
- 8.156 Having to sell one's home in a rush when going into residential care can be a source of further stress and anxiety, which may reinforce these symptoms and thereby reduce people's quality of life. The proposed deferred payment scheme will prevent people from suffering this additional stress and anxiety, and thereby will improve their quality of life.
- 8.157 There is no quantified information on the prevalence of given levels of anxiety in people who go into care homes or on the specific impact of having to sell one's home in that situation. Therefore, we cannot easily monetise these benefits. However, we illustrate the potential value of the reduction in anxiety and stress, by creating a **central scenario** describing the approximate well-being impact of a deferred payment and making a number of assumptions:
- Firstly, we assume that anyone who makes a deferred payment agreement will benefit, to some extent, from a reduction in anxiety.
  - Secondly, we assume that the positive impact on their quality of life can be represented by a move on the EQ-5D quality of life scale from "no anxiety" to "moderate anxiety". This translates to a quality of life improvement of 0.071. It should be noted that this is an estimate for the average self-funder and will vary for individuals depending on a) their



attachment to their home and b) their overall health state and level of anxiety.

- Finally, we expect this improvement occurs once for each agreement and has an average duration of 1 year.

8.158 Taken together, the above assumptions suggest that each deferred payment agreement improves the well-being of the person taking-up the deferral by about 0.071 quality-adjusted life years (QALYs) per agreement. As the QALY is valued at £60,000, this suggests an expected monetised benefit of **£4,260 (=0.071 \* £60,000) per recipient**.

### ***Sensitivity analysis – duration of benefits***

8.159 The above estimate is sensitive to the assumptions used. In particular, for our central estimate, we assume that a reduction in anxiety occurs, on average, for approximately one year after someone has made a deferred payment agreement.

8.160 However, in practice, for some people, the impact of a deferred payment agreement may be limited to the transition period only, as people settle into their new environment and become more able to deal with the prospect of selling their home. For others, selling one's home may be a dreadful prospect even as they settle into residential care. In particular, their ability to cope and actively manage any sale may decline with their health state. As a result, their benefit from the agreement is not limited to the first year.

8.161 As sensitivity analysis, we vary the duration of the quality of life improvement caused by deferred payments. As a lower bound, we estimate that the quality of life improvement set out above will persist for about half a year. This takes into account that it may take that long for many people to sell their home (including the twelve-week disregard) and to settle their anxiety afterwards. The resulting **lower bound** quality of life improvement would be **£2,130 (=£4,260/2)** per deferred payment agreement.

8.162 As an upper bound, we assume that the reduction in anxiety is felt throughout the whole duration of the agreement, as, arguably, not having to sell one's home will generate peace of mind throughout the whole stay in care. Given an average duration of a deferral of about 1 ½ years, this suggests an upper bound value benefits of **£6,390 (=£4,260 \*1.5)** per deferred payment agreement.

8.163 **Alternative example:** It should be noted that this range does not take into consideration other sources of uncertainty, such as the intensity of the anxiety felt. Those who feel the least benefit from a deferred payment agreement may not take them out in the first place. However, one might consider that there are different degrees of impact among those who make a deferred payment agreement:

- Some people will only feel the indicated reduction in anxiety (a quality of life impact of 0.071) for a limited time – assumed to be three months after the twelve-week disregard ends (which would be the time it takes to settle the sale, during which their savings would be at risk). The total quality of life loss is 0.018 (=0.071 for 3 months);
- For others, however, the anxiety may be more severe initially, especially where they are already in a fragile state. Therefore, we assume that it can

be represented by a move from “moderate” to “severe” on EQ-5D which translates into a quality of life loss of at up to 0.434 if they do not already score “severe” on another dimension. We assume that this state would last for about six months, resulting in a quality of life loss of 0.217.

- 8.164 An average quality of life loss of 0.071 (as in our central scenario) would require at least 25% of all people making deferred payment agreements to fall into the second group. To match our lower bound scenario (equivalent to a quality of life loss for 6 months), only about 9% of agreements would need to be taken out by people with more severe anxiety.

### ***Wider peace of mind benefits***

- 8.165 The above analysis assumes that deferred payment agreements improve the well-being of those who make them. However, in practice, peace of mind benefits may extend beyond this group. Firstly, the availability of deferred payments may reduce worries and anxiety even for those self-funders who do not take out a deferred payment agreement in the end, but who are at risk of having to sell their home. In addition, peace of mind benefits may also extend to those who are not currently at risk of going into residential care at all. Indeed, knowing that the deferred payment scheme is available and that there is no need to sell one’s home within one’s lifetime may provide reassurance to anyone who may be at risk of needing residential care, at any point in the future. This has not been quantified.

### ***Value of financial protection***

- 8.166 As set out above, being able to keep one’s home may result in financial benefits to some people, as they avoid a distressed sale or continue to benefit from rental income. These benefits fall on the individual in question, while, at the same time, there will be corresponding losses to someone else (such as the prospective buyer, who could have acquired the property below market value). Thus, from a societal perspective the *net financial* impact is zero.
- 8.167 However, it could be argued that society, due to considerations of fairness and justice, prefers to allow people to get the full benefit out of their lifetime savings, even if this means that someone else foregoes corresponding benefits. This has not been quantified.

### **Net present value calculations**

- 8.168 This section summarises the costs and benefits (relative to the do-nothing scenario) which have been identified in the preceding sections and calculates the net present value of the proposals (from a societal perspective).
- 8.169 The main monetised impacts of the proposed policy include changes to:
- Net costs of providing deferred payments, i.e. the difference between loans and repayments. This includes both the additional expenditure due to more deferred payments, and the additional income due to the interest rate. It should be noted interest payments are a financial benefit to government, but a loss to people making them;
  - The well-being benefits to recipients due to reduced anxiety and stress.

- 8.170 We set out our central scenario, which we expect to be the most appropriate representation of costs and benefits:
- Central Scenario: Central scenario on take-up with average benefits (£4,260) using an interest rate of 3.5%

#### *Distribution of costs*

- 8.171 Calculations in this impact assessment include the full social value of the proposals, including the opportunity cost of public funding (Exchequer Funding).
- 8.172 It should be noted that the social valuation of costs and benefits may differ depending on whom these costs and benefits fall on. However, for some of the costs and benefits identified in this impact assessment, it is currently not possible to say with certainty who will bear them. For the purpose of this impact assessment, it is assumed that all public sector costs will be covered by Department of Health funding.
- 8.173 Therefore, the net benefit calculation is subject to uncertainty with regard to who bears the identified costs. **For illustration purposes**, we assume that the total costs of deferred payments net of repayments will be financed out of central funding. Who bears any of the identified costs is contingent on assumptions about the source of funding. This could be either central government (given the initial 'seed' funding provided, this seems likely for the first year) or local government (evidence suggests that many LAs reprioritized the funding provided centrally when DPAs were first introduced, and adopted a cashflow / borrowing model instead).

#### *Opportunity cost of Department of Health funding*

- 8.174 In particular, the below calculations of the social value of costs and benefits need to take into account the **opportunity cost of Department of Health funding**, wherever public expenditure is involved. To the degree that funding comes out of the Department of Health's budget, as an approximation, we expect that its opportunity cost lies in foregone expenditure in the National Health Service (NHS) – even though it is not possible to specify where exactly it would have been spent.
- 8.175 This implies that the foregone spending would have observed the same budget constraint that applies for NHS spending, as defined by the National Institute for Health and Care Excellence (NICE). NICE estimate that an increase of expenditure of £20-£30,000 will on average force the NHS to make economies (e.g. on staff or on drugs or on procedures) that will lead to a loss of a quality adjusted life year (QALY). Therefore, we compare the benefits of a policy with the costs, in terms of the health benefit, that could have been generated through funding to the NHS (at a rate of £25,000 per QALY). At the same time, the Department of Health assigns a value of £60,000 to a QALY, consistently with similar valuation of policies that mitigate mortality or morbidity risk by other government departments, based upon studies of what members of the public are on average willing to spend to reduce their own mortality risk, or to improve their own health outcomes.
- 8.176 A policy proposal that costs £25,000 to the NHS is therefore presented with an opportunity cost of £60,000 on the assumption that it would force an

economy that would displace a QALY, and therefore lead to a drop in overall health benefits that would be valued by the public at £60,000. As a result, as an approximation, the true opportunity cost of funding in the health and social care system is assumed to be £2.4 for every £1 lost (=£60,000/£25,000).

### Discounting

- 8.177 Future expenditure and benefits are worth less to society than costs or benefits of equal size which occur today. Therefore, to calculate the net social value of the proposals, we discount future costs and benefits.
- 8.178 As per Green Book convention, monetary costs and benefits are discounted at 3.5% (in real terms) per year, which is approximately 5.5% in nominal terms. It should be noted that we have used an interest rate of 3.5% in the cost estimates presented in tables 46-47. As a result, if a loan of £100 is made, government foregoes alternative expenditure worth £100. If the loan is repaid after a year, the total repayment will be £103.50, which can be spent by government. However, to society, the value of this expenditure will be less than the original cost of £100, as future expenditure is discounted at 5.5%, resulting in a present value of only £98.1 (=£103.50/1.055).
- 8.179 If local authorities were to fund the scheme out of borrowing, the scheme could be considered cost-neutral if the interest rate charged by local authorities would reimburse them for their own costs of borrowing. The net present value of the financial impact of individual loans would be zero. However, as set out above, no decision has been made about the duration of Department of Health funding for the scheme, so it is assumed for the purposes of this impact assessment that all costs fall on the Department.
- 8.180 A different discount rate is used for health and well-being benefits. This is because the value of a quality-adjusted life year (QALY) is expected to increase in line with GDP, i.e. at 2% per year. Thus, by using a constant value of a QALY of £60,000 in 2010/11 prices, we implicitly discount health benefits at a rate of 2% pa. We correct for this by discounting all health and well-being benefits in tables 46 at a rate of 1.5% pa.

**Table 46 – Central Scenario - Central scenario on take-up with average benefits (£4,260) using an interest rate of 3.5% – all costs and benefits in £m and 2015/16 prices,**

		15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	Repayments after 24/25*	TOTAL
<b>COSTS</b>													
<b>A</b>	<b>Set-up costs</b>	<b>UNQUANTIFIED</b>											
<b>B</b>	<b>Net funding requirement for additional deferred payments</b>	83	121	132	118	87	68	52	46	39	26	-689	<b>84</b>

C	Including opportunity cost of public funding (=B*2.4)	200	291	317	284	209	162	124	109	94	63	-1653	202
<b>BENEFITS</b>													
D	Financial transfer to individuals	83	121	132	118	87	68	52	46	39	26	-689	84
E	Reduction in anxiety and stress	36	26	33	35	39	39	38	40	42	43		371
F	TOTAL (=D+E)	119	147	165	154	126	107	89	85	81	70	-689	455
<b>Net value</b>													
G	Net value (=F-C)	-81	-143	-152	-130	-83	-56	-35	-24	-13	7	964	253

<b>Net present value **</b>	<b>£ 175.7 mil</b>
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**\*\*This is the sum of the discounted net value of benefits minus costs; discounted at 3.5%pa, or 1.5% for the well-being benefits in row G.**

### Summary of impact

- 8.181 This impact assessment has discussed the problems and poor outcomes faced by self-funders who are at risk of having to sell their home to pay for residential care. As it is difficult to draw on housing wealth in a flexible and timely manner, self-funders with limited non-housing assets face the risk of having to sell their home to pay for care. This creates anxiety and stress in an already difficult period in people's lives. In addition, society may have a preference to allow homeowners to fully benefit from their lifetime savings, even if this implies that others will forego the benefits of owning or using their home.
- 8.182 Since 2001, the Department has promoted a deferred payment scheme in which local authorities have discretionary powers to defer self-funders' care fees. However, provision is patchy as there is wide variation in who local authorities deem to be eligible for a deferred payment, and local authorities cannot charge interest on deferred payments, thus making a loss on every deferred payment. The Department proposed a universal scheme, in which it is mandatory for local authorities to offer deferred payment agreements under certain conditions. The scheme also gives authorities flexibility to offer deferred payment agreements in a wider set of circumstances. The scheme aims to give homeowners peace of mind and a wider array of choices when going into residential care.
- 8.183 This is expected to substantially increase the take-up of deferred payment agreements, resulting in larger expenditure on deferred payments and more widespread peace of mind benefits for people going into residential care. At the same time, the proposed scheme will allow local authorities to charge

interest on their deferred payments, thereby reducing the costs (to government) of the scheme.

### **Total monetised costs and benefits**

8.184 Table 46 summarises our best estimates of the total costs and benefits of the proposed scheme. These include costs to government as well as benefits to people making deferred payment agreements. Moreover it needs to be highlighted again that there are benefits (wider peace of mind and value of financial protection) that could not be readily quantified.

8.185 **Costs to the public sector:** As more deferred payment agreements are taken out, the cost to the public sector of providing them increases relative to the do-nothing option. At the same time, however, the proposals will allow local authorities to charge interest, thereby reducing the costs of deferred payment agreements (compared to the do-nothing option). The level of the interest rate will impact on repayments and therefore affects the net funding requirement in the later years of the scheme. It is evident that if the interest rate stays lower for a longer period of time, the net costs of the scheme will be greater than if interest rates increase.

8.186 However, most of the additional interest income falls on later years, while most of the additional costs fall on earlier years. We adjust for this by discounting costs and cost savings at 3.5% (in real terms) per year when calculating the present value of costs and benefits.

8.187 In addition, as set out in above, the total social value of these costs includes the opportunity cost of government funding, which means that both expenditure and income is valued at a higher rate than its nominal cash value (see row C).

8.188 **Benefits to individuals:** Individuals' financial costs and benefits are the mirror image of government's costs: outgoing deferred payments are individuals' receipts, while individual's repayments are income to government. However, as deferred payments are received in earlier years, while repayments are made in later years, the **present value of the net cost to individuals** is estimated at a lower value.

8.189 In addition, individuals benefit from reductions in anxiety and stress (see row E). The present value of these **well-being benefits is estimated at £371m over ten years** (at a 1.5% discount rate).

8.190 **Net present value:** Taking together the above calculations, we estimate the net present value of the proposed policy to be about **£175.5m over ten years**.

### **Equality impact**

8.191 The Department conducted an engagement exercise over Autumn 2011 with care users and members of the care and support sector on reform of social care. This encompassed discussion of proposals for universal deferred payment agreements.

8.192 The engagement found support for deferred payments; a workshop on social care funding reform involving representatives from local authorities and

disabilities groups noted that “*Universal deferred payments would give people additional choices and flexibility in meeting their care costs and there was strong support for them.*”<sup>177</sup>

- 8.193 Deferred payment agreements will be subject to eligibility criteria, notably whether someone needs residential care and whether they have limited liquid assets. Beyond this the scheme will not actively discriminate on the basis of equalities characteristics such as age, gender, sexual orientation, belief or socio-economic status. However it is likely there will be a differential level of uptake of deferred payments across different population groups. This is discussed below.
- 8.194 The take up of deferred payment agreements should reflect the **makeup of people in care homes** – as such we expect them to cater mainly to disabled and older people, predominantly women.<sup>178</sup>
- 8.195 A detailed equalities analysis based on available research is below:<sup>179</sup>
- 8.196 **Disability:** People in residential care almost exclusively have a disability or mental impairment. A 2004 study attributes residency to the following conditions in order of priority: Incontinence; dementia; stroke; heart disease; arthritis; diabetes and endocrinal problems; depression; fractures; lung and chest disease; cancer; epilepsy and Parkinson’s disease.<sup>180</sup>
- 8.197 Deferred payment agreements will help this group arrange appropriate care and support without having to sell their home to pay for care at the same time.
- 8.198 **Age:** Residential care users are predominantly older people. A 2006 census of UK homes found that 92% of residents are aged over 75, and 60% are over 86.
- 8.199 **Gender:** 78% of residents are female. This is generally accepted to reflect two factors: i) increased longevity amongst women is associated with a higher prevalence of age-specific disability; ii) women are more likely to survive male spouses and have less access to informal care.
- 8.200 Deferred payment may particularly benefit **lower and middle socio-economic groups**, specifically homeowners with limited income and savings to fund their care. This is the group likely to be at greatest risk of selling their home to pay for residential care.
- 8.201 We note that authorities have, to date, been less willing to offer a deferred payment agreement to credit risks including those with pre-existing debts or charges on their property or whose home is co-owned. These groups will probably tend to belong to lower social economic groups. Local authorities will have flexibility to decide on what, for them, would constitute ‘adequate security’, and so have discretion to accept alternative forms of security

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<sup>177</sup> *Caring for our Future*, Workshop on Funding Reform held 22 November. A summary can be found at: <http://caringforourfuture.dh.gov.uk/2011/11/23/22-november-workshop-summary/>

<sup>178</sup> Statistics for Gender, Age and Disability are drawn from *Care of Elderly UK Market Survey*, 2011-12, Laing and Buisson (2012)

<sup>179</sup> Statistics for Gender, Age and Disability are drawn from *Care of Elderly UK Market Survey*, 2011-12, Laing and Buisson (2012)

<sup>180</sup> Summarised in Laing and Buisson

(including making special provisions for situations where other sources of debt are involved).

- 8.202 Deferred payment agreements may benefit **carers** by allowing them to live in the resident's home (with the resident's consent, subject to this not rendering the property disregarded). This will particularly help carers whose right to live in the home is not already guaranteed under CRAG (i.e. those who are not spouses or civil partners or included in the list of relatives in the guidance).<sup>181</sup>
- 8.203 Deferred payment agreements will not differentiate based on **sexual orientation or transgender status**. It is possible there will be differential levels of take-up between heterosexual/non-trans people and LGB or transgender people but the evidence for this is unclear:
- There is no concrete data for the proportion of LGB or T individuals in residential care
  - All things being equal, one would expect the population of residential care settings to reflect the older population at large.
  - There are grounds to expect a *higher* representation of LGB or T individuals in residential care. Older LGB and T individuals:
    - May be less likely to have children, and
    - Are statistically more likely to live alone or to experience isolation
  - These factors may mean that LGB and T individuals are more likely to need residential care because they have less access to informal care.
  - However, some studies suggest LGB and T individuals tend to delay using residential care because of concerns about discrimination in care.
- 8.204 **Race:** Deferred payment agreements will not differentiate between users based on race, but it may be the case that certain ethnic groups are less likely to make an agreement or may be less likely to qualify.
- 8.205 The Joseph Rowntree Foundation note that the proportion of the minority ethnic population living in care homes is smaller than the white population living in care homes, and that older people from ethnic minorities are more likely to be living in larger households and a household with one or more carer.<sup>182</sup>
- 8.206 Based on this, it may be the case that the white population is more likely to use residential care and therefore to seek deferred payment agreements.
- 8.207 **Belief:** Deferred payment agreements may be compared to a loan. The Department's proposals include allowing authorities to charge a rate of interest that is sufficient to cover their own borrowing costs.
- 8.208 We note that the payment of interest and charges on deferred payments may present a barrier to Muslim care users. This is because of the tenets of Sharia (Islamic) law, which prohibit the payment of interest.

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<sup>181</sup> The CRAG rules recognise that a resident may wish for their carer to live in their home, and gives Councils the option to reduce social care charges so as to prevent the home being sold (in effect treating the carer in the same way as a spouse, civil partner or dependent relative. However, there is limited use of these powers based on a 2007 FOI survey. Guaranteeing the availability of a deferred payment will allow carers to live in the resident's home if this is what both parties would like.

<sup>182</sup> *Changes in communal provision for adult social care: 1991-2001*, Joseph Rowntree Foundation (2006)



- 8.209 During the legislative passage of the Care Act 2014 we added in a new Section 36 to allow deferred payment agreements to be offered in a manner that would make them compliant with Sharia law. There were mixed views in response to the consultation as to whether it was necessary to enact this or not and as such we have decided not to enact it for April 2015. We intend to engage further with the Muslim community to understand whether there would be a demand for a Sharia-compliant scheme, and if so what would be required of it.
- 8.210 **Socio-economic status:** Deferred payment agreements will benefit homeowners with limited income and savings to fund their care, who would otherwise face selling their home when faced with residential care fees.
- 8.211 The consultation notes that authorities have, to date, been less willing to offer a deferred payment to certain groups, including those with pre-existing debts or charges on their property or whose home is co-owned. This is because authorities are concerned they will have difficulty recovering the deferred amount. These issues may be more prevalent in lower socio-economic groups.
- 8.212 Local authorities will have flexibility to decide on what, for them, would constitute 'adequate security', and so have discretion to accept alternative forms of security (including situations involving other sources of debt).
- 8.213 **Summary of analysis:** Deferred payment agreements benefit people in residential care and their families. The population using care is almost exclusively disabled (physically or mentally) and is predominantly female and aged 75+.
- 8.214 Deferred payment agreements will predominantly benefit homeowners with low income and / or savings, who tend to belong to lower and middle socio-economic groups.
- 8.215 Deferred payment agreements will not differentiate on the basis of race, however ethnic minorities are less likely to use residential care and because of this may make fewer agreements.
- 8.216 Deferred payments will not differentiate on the basis of faith, however charging of interest may pose a barrier to faith groups who have objections on religious grounds. We will keep this situation under review and will engage with the Muslim community to understand likely demand better.
- 8.217 There are no grounds for a differential impact on sexual orientation, marriage or civil partnership. Deferred payment agreements will not differentiate on this basis.
- 8.218 Table 51 provides an overview of our overall equalities analysis.

**Table 51 – Overview of equality analysis**

Protected Group	Specific Impact	Mitigation Action
Age	Deferred Payments will predominantly benefit older people and their families	
Disability	Deferred Payments will almost exclusively benefit people with disabilities and their families	
Gender reassignment	Non-trans people may be more likely to enter residential care and consequently take up deferred payments than trans people	
Pregnancy and Maternity	n/a	
Race	The white population is more likely to use residential care / deferred payments than ethnic minorities.	
Religion or belief	Muslims and other faith groups may object to charging of interest	Section 36 in the Care Act 2014 would allow deferred payment agreements to be offered in a manner that would make them compliant with Sharia law. We have decided not to enact it for April 2015 but we will keep under review whether a Sharia compliant scheme may be needed in future.
Sex	Women are more likely than men to use residential care / deferred payments	
Sexual Orientation	People from the LGB community may be more likely to enter residential care and take up deferred payments than people from the heterosexual community.	
Marriage and Civil Partnership*	n/a	
Socio-Economic Status**	Deferred payments benefit homeowners with low income and savings who face selling their home.  This group is potentially more likely to have pre-existing charges or to co-own their property, potentially making it more difficult to access a deferral	Local authorities have discretion to offer deferred payment agreements in a wider variety of cases, including when people have pre-existing charges or debts.

\* Only needs to be considered with regards to the first aim of 'Eliminating discrimination, harassment and victimisation'.

\*\* Not required by the equality duty but voluntarily considered by DH

### Specific impacts

8.219 The Department has further considered the following specific impacts.

8.220 **One in, two out:** The impacts presented in this impact assessment do not fall under the one in, two out rule as deferred payment agreements do not place new burdens on business or civil society.

- 8.221 **Sunset clause:** As above, the obligation to include a sunset clause does not apply as the Universal Deferred Payment Scheme does not involve new regulation on business or civil society.
- 8.222 **Micro enterprise exemption from regulation:** Deferred payments do not involve new regulation on business or civil society.
- 8.223 **Small Firms Impact Test:** Deferred Payments do not affect small firms. We discuss regulatory impacts below relating to equity release providers, which are exclusively larger businesses.
- 8.224 **Competition:** The Government does not consider a deferred payment agreement to be a financial product. The deferred payment has a very specific purpose – it helps people who would otherwise need to sell their home to pay for residential care to delay the need to do so. This need is not catered for by existing financial services. Insurance-based products do not delay the need to sell the home (because they involve a large upfront premium) and equity release is not a suitable option for people who move into residential care, as providers render access to equity release products conditional on the home being occupied (as outlined in this impact assessment).
- 8.225 Moreover, the Department believes that people should receive an overview of their financial options, including full information about all alternatives to a deferred payment agreement so that they can choose the option which fits their needs best.
- 8.226 On this basis, we do not anticipate competition impacts.
- 8.227 **Environmental and sustainability impacts:** The potential risk that some (though not all) deferred payment agreements may lead to situations where homes are not occupied and are poorly maintained (which in the most serious cases could lead to environmental and sustainability impacts) is outlined above. However, as noted the scheme will include proposals to support people to maintain their property to mitigate these issues. This impact assessment assumes these policies prevent and offset these impacts.
- 8.228 **Human rights:** There will no negative impact on human rights.
- 8.229 **Justice system impacts:** The **Universal** Deferred Payment Scheme has no implications for the justice system.
- 8.230 **Rural proofing:** Deferred payment agreements will be available regardless of local authority area and there is no reason to expect an inequitable impact on rural residents.

## 2H. MARKET OVERSIGHT REGIME

### Background: case for change

- 9.1 In the Social Care White Paper, *Caring for our future; reforming care and support*<sup>183</sup> the Government committed to consult on the issue of market oversight. The Government believed there was a need to review whether current mechanisms to oversee the care and support market are sufficient, and whether additional measures are necessary to support service continuity in cases where a provider of care services fails or chooses to exit the market.
- 9.2 The consultation on market oversight in adult care and support was launched on December 1<sup>st</sup> 2012 and closed on March 1<sup>st</sup> 2013.
- 9.3 The consultation document set out the recommended direction of travel. The recommended approach was for a system of targeted regulation. We believed this option offered the best combination of greatest benefits to people receiving care and support with the lowest cost burden on care and support providers.
- 9.4 The consultation responses reinforced the Government's belief that targeted regulation was the best approach in this area.
- 9.5 The Government believes that there is a need for greater reassurance to people receiving services, which are likely to close or transfer to new ownership. The primary motivation for any change is to minimise the risk of a negative effect on the health and wellbeing of adults receiving care and support in the event of a provider failing financially and ceasing to provide services.
- 9.6 The Government has continued to engage with stakeholders during the passage of the Care Act through Parliament. The sections on market oversight and provider failure were uncontentious both with stakeholders and Parliamentarians. Government has worked with a wide range of stakeholders through a formal working group, to develop the related regulations and statutory guidance for the Act. Resulting regulations and guidance that will be subject to formal public consultation from May 2014 and then – for the regulations - Parliamentary approval, These have not changed the costs or benefits detailed in this IA.

### The social care market

- 9.7 Social care has been operating as a market in England for over twenty years. The 1980s saw the start of the growth in private provision, with the Community Care Reforms of the 1990s providing a major stimulus for growth. Throughout this time, local authorities have continued to be responsible for ensuring that the care needs of their local populations are met.
- 9.8 Today, the vast majority of provision is from the private and voluntary sectors. The proportion of services supplied by councils has fallen greatly over the last 15 to 20 years and they now provide less than 10% of residential care places for older people and around only 16% of home care. Furthermore, the vast majority of providers are small businesses; 43% of care home places are

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<sup>183</sup> <http://caringforourfuture.dh.gov.uk>

provided by operators with fewer than three homes whilst 60% of the 7,145 registered domiciliary care agencies are single agency businesses<sup>184</sup>.

- 9.9 There are a range of different financial and business models operating within the sector, with providers of all different sizes and purposes. There is significant for-profit activity in this sector, and the corporate providers are often backed by a larger investment group, such as Saga (backed by Acromas) and Four Seasons (backed by Terra Firma). We also know that there are some providers who are highly leveraged and with highly complex capital structures. The not-for profit sector also provides a significant proportion of care, and there are a variety of different models of provision – including social enterprises, charitable provision, micro-enterprises, and mutuals – operating within the sector. The Government is keen to encourage this diversity<sup>185</sup>. Of course, the majority of care provision is not from formal services but by unpaid carers, mainly spouses, partners, adult children and other close family. Around 5 million people in England provide such unpaid care.

### Policy framework

- 9.10 The Department of Health sets the strategic policy framework for adult social care, working with local government as partners, to provide overall direction and national objectives for adult care and support. Delivery is the responsibility of local authorities, in line with their own locally determined priorities. Local authorities can also be a source of advice to support people purchasing their own care; around 40% of all those in residential care are now self-funders. The Government has recently published an accountability statement for social care, which outlines this approach in more detail<sup>186</sup>.

### Market oversight

- 9.11 Events over recent years, including Southern Cross falling into financial difficulties, have highlighted the need for the Government to review whether or not current mechanisms to oversee the care and support market are sufficient, and whether additional measures are necessary to support service continuity for vulnerable people, in cases where a provider of care services fails or chooses to exit the market:
- Southern Cross demonstrated that there are specific challenges associated with monitoring and managing failure of very large providers, operating across many geographical boundaries and where there may be highly complex financial structures, which present risks to continuity of service (see below).
  - The National Audit Office (NAO) in their report *Oversight of user choice and provider competition in care markets*<sup>187</sup> highlighted that there are no formal arrangements for monitoring, and if necessary intervening in, markets that cross local authority boundaries. The NAO also said that the

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<sup>184</sup> Laing & Buisson, Care of Elderly People UK Market Survey 2011

<sup>185</sup> The Government has set out its aspirations to encourage a range of different models, including mutual models, in the Open Public Services White Paper, July 2011. See: <http://files.openpublicservices.cabinetoffice.gov.uk/OpenPublicServices-WhitePaper.pdf>

<sup>186</sup> *Department of Health Accounting Officer System Statement*, January 2012. This can be found at: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_132351.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132351.pdf)

<sup>187</sup> *Oversight of user choice and provider competition*, National Audit Office, September 2011. The main recommendations on developing and overseeing user choice and provider competition can be found on page 9 of the report.

recent financial problems faced by Southern Cross illustrated the need for Government to develop a system to address serious provider failure.

- In 2011, the Government published its *Open Public Service White Paper*<sup>188</sup>. The White Paper included a commitment for departments to consider continuity regimes in cases where a provider exits the market. The Government is clear that should a provider exit, it is not acceptable simply to allow services to cease abruptly or for services to be of a poor quality, because local people will feel the impact of that failure. The White Paper stated that if providers of public services are unable to meet minimum standards “*it is essential that the state identifies these providers and intervenes quickly in order to ensure continuity of service*”.

9.12 The case of Southern Cross demonstrated specific challenges for the existing local authority based system. The situation was challenging, because;

- there was no early warning system to anticipate failure and put plans in place
- there was no formal mechanism to ensure exit was well-managed and quality maintained in transition
- residents & families felt a great deal of anxiety and there was no clear system in place to reassure them
- no part of the overall system (central government, local government or the Care Quality Commission -CQC) has the remit or responsibility to formally monitor financial health or performance at a provider level
- the size of the provider (supporting around 31,000 people)
- the complexity of the business’ capital structures
- the scale of the operations of the provider meant some central co-ordination was required
- there were no protocols agreed for all the different stakeholders involved, including individuals receiving care from Southern Cross
- the transfer of services to new providers was extremely complex.

9.13 Despite the collaboration which successfully managed the Southern Cross exit arrangements, the circumstances demonstrated the need for:

- earlier awareness of financial risk,
- mechanisms for intervention if required, and
- clear processes to manage exit and achieve continuity of care during transition
- to reassure people about the process and what it will mean for them, in order to reduce negative impacts on health and well-being caused by stress and anxiety.

9.14 The Government is therefore reviewing its approach to oversight of the care and support market.

### *Engagement*

9.15 The Government’s consultation on market oversight in adult care and support was launched on December 1<sup>st</sup> 2012 and closed on March 1<sup>st</sup> 2013. The

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<sup>188</sup> *Open Public Service*, HM Government, July 2011. The section on developing continuity regimes can be found under ‘Intervening in the case of institutional failure’.

consultation set out the Government's proposals for targeted oversight of adult care and support providers.

9.16 The consultation received c.56 written responses. During the consultation, the Department held and attended events with 111 organisations, which included local authorities, providers, user groups, and banks. These events included four 'deep-dive' roundtables with relevant experts to consider and scrutinise the proposals in greater detail. The four expert sessions looked at:

- Clarifying the local authority duty to provide services and where the threshold for entry into the market oversight regime should be set
- Challenge mechanisms for unsustainable models that compromise quality and legal powers
- Determining the metrics for risk assessment and content of recovery plans
- Examining the model in cases of failure; resolution phase mechanisms and supplier of last resort

9.17 The key themes to emerge from the consultation responses and events were:

- a. **Near-unanimous support for greater oversight-** While there were numerous detailed comments, very few respondents argued against the introduction of a stronger and more formal market oversight regime.
- b. **Managing local impact –**
  - Respondents highlighted the tensions between sharing information with local authorities early to support planning and creating a self-fulfilling prophecy.
  - There were also risks of duplication on oversight requirements through local authority contract management. It was suggested that local authorities would welcome specific guidance on proportionate oversight which might mitigate risks.
  - There was universal support to clarify that the local authority duty applies to all people in all forms of regulated care. Again local authorities would welcome some guidance and further support to execute this function.
- c. **Targeting 'difficult to replace' providers -** There was agreement with the principle of targeted oversight and that this should be targeted at services that are difficult to replace, such as big organisations, providers with a strong regional concentration and specialist services. Local market share was considered to be very important, alongside the number of adults receiving care and support and the number of local authorities relying upon a provider's services. Some voluntary organisations argued to be made exempt from the regime as they considered themselves of lesser risk but this was not a view shared by all voluntary providers or the financial sector.
- d. **A light-touch and intelligent system-** respondents generally felt that the process of oversight should not be burdensome and should focus on a set of KPIs (key performance indicators) similar to those required by lenders. There should be regular dialogue with key providers. Respondents put emphasis on the need for skilled individuals to do the oversight work and the need for 'skilling-up' the regulator taking on the function. Some

respondents did make the distinction between 'light-touch' monitoring and 'light-touch' powers, arguing that the regime should have stronger 'teeth' (see below).

- e. **Effective risk management and mitigation:** There is some debate about whether contingency plans can be prepared before a risk develops. There was clear support for the regulator to monitor risks to sustainability and to satisfy themselves that the provider had a strategy in place to mitigate risks. However, the benefit of taking some reasonable steps to prevent avoidable failure through better risk management was welcomed.
- f. **Stronger "teeth":** Most organisations argued for the regime to have greater powers or "teeth" to enforce compliance amongst providers. The vast majority of organisations felt that a risk pool or special administration scheme would be disproportionate. There was however, a call for a 'pause', similar to the Homes and Communities Agency (HCA) power, which can call a 28 day moratorium to work with creditors and insolvency practitioners when companies fail. Further discussions with the Insolvency Service, insolvency practitioners and lawyers, however, showed that this was not practical and has not been taken forward. Respondents generally recognised that commercial mechanisms already exist to support an orderly failure and exit, with a transfer to alternative ownership, in the majority of cases. Many also thought that the CQC enforcement powers were strong (e.g. the power to deregister) and could be used as a threat. It was argued that the new regime should be built around the existing system.
- g. **Communications: Respondents envisaged a role for the regulator** to effectively communicate with adults who are receiving care and support about the process of failure as in many cases this will have no material impact on the care services they receive. The regulator and local authorities should reassure people that their services will continue. The language of the regime risked misinterpretation by the public and commissioners and should be amended to avoid causing unnecessary anxiety or market impacts.
- h. **Rejection of alternative proposals** – The impact assessment for the consultation set out a series of alternative interventions, including a special administration regime and a risk pooling system. There was near unanimous support for our initial view that we should not proceed with these options. These proposals have therefore been rejected.

### *On-going engagement*

9.18 The Department of Health has regular engagement with key stakeholders and will continue to do so. The above consultation therefore, builds on earlier engagement with interested parties. In autumn 2011 the Department published a discussion paper analysing the issue of market oversight and inviting responses.<sup>189</sup> We received 21 formal responses to this paper. Furthermore, as part of a wider engagement exercise on adult care and support reform the Department sought views on market oversight. There were 565 responses to that engagement exercise<sup>190</sup>. Below we provide a summary of the key themes from earlier engagement.

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<sup>189</sup> *Oversight of the Social Care Market*, Department of Health, October 2011

<sup>190</sup> A full independent analysis of the Caring for Our Future Engagement by Ipsos Mori can be found at [www.caringforourfuture.gsi.gov.uk](http://www.caringforourfuture.gsi.gov.uk).



### **Summary of Feedback to ‘Oversight of the Care Market’ and the ‘Caring for our Future’ Engagement Exercise**

All responses voiced concern over the collapse of Southern Cross and the impact that provider failure could have on residents’ health and wellbeing. There was widespread agreement that the protection of adults receiving care and support should be the principal concern in such situations – especially as providers are providing both care and accommodation. Many commented on the need for all those reliant on services from an independent provider to be protected appropriately, whatever the size of the provider. Some commented that those with high-level needs who relied on domiciliary care should be given similar reassurance.

We also heard from many that any new measures in this area should take into account the need to continue to encourage private investment into care and support and promote a greater diversity of services. Some felt that any measures that weakened the investment proposition risked undermining the wider sustainability of the care and support system. A small number of respondents questioned the role of private equity in the market, believing that this had led to a focus on short-term gains and irresponsible lending decisions – incompatible with long-term stability and a focus on the needs of individuals. However, there was widespread acknowledgement that a market operated in care and support and that the Government’s policy was for this market to continue.

Some providers and professional advisors argued that the successful resolution of the Southern Cross situation, illustrated that the market could cope with such failures successfully. It was also noted that care and support had a diverse market with many thousands of providers, which was a powerful way to ensure service continuity. However, others thought that greater regulation and Government intervention was required to protect adults who are receiving care and support .

On further regulation, some believed that appropriate regulation could bring greater stability and improve the sector’s reputation, but said it must be implemented in a proportionate and fair way. Others stated that the sector might be unable to sustain the increased costs and burdens often associated with regulation. A number requested greater clarity over CQC’s remit in this area, most notably over the regulator’s role in assessing whether a provider had the financial resources to meet its obligations. Many also commented on the likely correlation between quality and financial indicators.

From the wider engagement on markets as part of ‘*Caring for Our Future*’, a common view emerged that local authorities needed to better understand their local market, identify risks to provision and commission in a more strategic and sustainable way. Some, however, raised the issue of whether it was realistic for local authorities always to manage the market effectively, given the size and complexity of some providers. Linked to this were comments about the role of local authorities in purchasing care and fee levels. The Devolved Administrations also raised the issue that that the larger providers operated across the UK and that there were benefits in a co-ordinated response.

#### *Engagement during passage of the Care Act*

9.19 The Government has continued to engage with stakeholders during the passage of the Care Act through Parliament. The sections on market oversight

and provider failure were uncontroversial both with stakeholders and Parliamentarians, echoing the broad agreement found in earlier consultation and engagement. Government has worked with a wide range of stakeholders through a formal working group, to develop the related regulations and statutory guidance for the Act. Resulting regulations and guidance that will be subject to formal public consultation from May 2014 and then – for the regulations - Parliamentary approval, These have not changed the costs or benefits detailed in this IA,

### **Analytical narrative**

- 9.20 The need to support continuity of service is a feature of many markets where there are limited alternative providers or where the loss of the service, even temporarily, can cause a significant reduction in consumers' welfare. For example, the utility sector in the UK (water, electricity, gas) has a continuity of service requirement on the network provider wherever it is a natural monopoly. In addition, retail providers of the same service can be required to act as the provider of the last resort, if one retail company were to fail; for example, the gas and electricity regulator requires that one retail service provider acts quickly to address the needs of the consumers of the failing provider. Implicit in these continuity of service provisions, is the argument that the loss of the service, even temporarily, can cause significant reduction to consumer welfare because the services are considered as essential for carrying out normal activities.
- 9.21 Service provision in care and support, by its very nature, addresses the needs of people with high levels of need. Care and support supports people of all ages with certain physical, cognitive or age-related conditions. Those with a high level of needs and their families rely on the provider for ensuring their overall health, safety, dignity and well-being. Should the provider close or fail, these individuals and families may not be in a position to be able to find alternative service provision at short notice. However, it is essential that they continue to receive the services to meet their needs.
- 9.22 Any intervention needs to be targeted at those providers who would be most difficult to replace if they were to exit the market. Responses to the consultation confirmed the Government's view that local authorities are currently able to manage the vast majority of provider exits successfully, and that a central regulator is only necessary for those providers who have a larger regional or national presence, or those who provide very specialist services.

### **Rationale for intervention – what is the market failure?**

- 9.23 In this section, we discuss the rationale for intervention. This falls into three main parts – a) the rationale for intervention to preserve service continuity overall, b) issues relating to continuity of care arising from local level provider exit and c) issues relating to continuity of care arising from larger regional and national, and specialist, providers.

#### *A) The rationale for preserving service continuity*

- 9.24 A market has been developing in care and support for over twenty years; and as part of their role, local authorities have been managing provider entry and exit. Throughout this time, local authorities have been ensuring individuals' needs continue to be met.

- 9.25 Evidence suggests the disorderly closure of a care and support provider can cause a great deal of anxiety to individuals, carers and their families.<sup>191</sup> If poorly managed, there is a significant risk that there may be an adverse effect on the health, well-being and dignity of adults who receive care and support.
- 9.26 The most recent evidence, from interviews with 70 residents in Birmingham before, during and after care home service closures suggests that when exit is managed well by a local authority, there should be no negative effect on individuals' health and wellbeing.<sup>192</sup> Indeed, a move could be beneficial if it leads to higher quality care. However this study notes, that in the case of large-scale emergency closures, well-managed processes may not be possible, given the lack of time for a local authority to plan and also because the scale of impact may be across a number of local authority areas.
- 9.27 The collapse of Southern Cross raised the prospect of such a risk to individuals' health and well-being. Although in the end, this overall risk was limited only to the closure of two care homes in the UK, during the uncertain period when the company fell into financial distress, some residents, families and carers were caused a great deal of anxiety. The potential for similar risks and potentially of higher magnitude from other providers remains a concern.
- 9.28 We are not aware of any evidence relating to the effect of closure of a domiciliary service on the health and well-being of individuals receiving services, and their families and carers. We believe it is reasonable to assume that the effect would be of a similar significance to the effect of a residential care provider failing.
- 9.29 In both the consultation and the engagement exercise that the Department of Health ran in 2011, a number of responses highlighted that people could find themselves in a vulnerable situation, should their provider fail and therefore steps needed to be in place to preserve service continuity.<sup>193</sup>
- 9.30 There is currently little available evidence on how well provider exit is managed across the country. Through both the consultation and the '*Caring for Our Future*' stakeholder engagement, the Government heard that practice might not be consistent or uniform across the country. The evidence suggests that if a move to a new residential care home is managed well, the risks to health and well-being can be effectively mitigated; and indeed, in some cases if a move leads to improved quality, outcomes can improve. SCIE have published best practice guidance on how to manage the closure of a care home.<sup>194</sup>

*B) Issues relating to continuity of care arising from local level provider exit*

- 9.31 Continuity of care is important regardless of the type of service provision. While the smaller care home operators could span more than one local authority

<sup>191</sup> Scourfield P, 2004, '*Questions raised for local authorities when old people are evicted from their care homes*'; Woolham, J (2001). *Good practice in the involuntary relocation of people living in social care*'

<sup>192</sup> Evidence from the Health Services Management Centre at the University of Birmingham has found adopting good practice limits potential negative impacts on individuals' health and well-being and, for some people, may give slight improvement in outcomes. See: *Achieving closure: Good practice in supporting older people during residential care closures*, July 2011. This is a joint publication by Health Services Management Centre at the University of Birmingham and ADASS, in association with SCIE.

<sup>193</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_130439.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130439.pdf)

<sup>194</sup> <http://www.scie.org.uk/news/mediareleases/2011/080911.asp>

boundary, the vast majority are likely to be operating in very limited geographical areas. CQC data shows that there are only 39 providers of residential care in England with more than 1000 beds<sup>195</sup>

- 9.32 Our assessment is that within these local markets, there is generally adequate competition<sup>196</sup> as evidenced by the fact that there has been market entry and exit at the local level for 20 years, without it being necessary for central government to become involved. Evidence shows that the year to April 2011, 114 homes were deregistered (representing a 20 year low in closures) with 182 homes were deregistered the year before. 133 new care homes were registered in the year to April 2011, with 145 new registrations the year before.<sup>197</sup>
- 9.33 Given the number of providers and the level of competition in care homes, we believe it is reasonable to argue that there is no significant market failure at the local level, at the current time. The impact of closure of a small provider can be satisfactorily handled at the local level and the well-being of its adults receiving care and support adequately protected, without any need for new measures.

*Continuity of care at the local level*

- 9.34 The provider should be primarily responsible for transition arrangements and ensuring no one who accesses their services is left without care.
- 9.35 We believe it would be too great a burden on business and would not be proportionate, if we were to assess the financial health of these smaller organisations at a national or local level – especially as we want to reduce barriers to market entry and actively encourage new, innovative providers of care such as micro-enterprises, mutuals and social enterprises.
- 9.36 In order for local authorities to continue to be able to manage local-level provider failure successfully, our view is that;
- commissioners will need to promote diversity and have regard to the importance of market sustainability, particularly through commissioning practices. For example, there could be significant risks, if a single provider develops a dominant position within any local market
  - commissioners and providers will need to have the information to facilitate an effective solution e.g. up to date data on alternative providers and services. If sufficient information is not available, it could become a barrier to ensuring effective service continuity. This points to the need for local market intelligence and relationships that are fit for purpose.
- 9.37 Notwithstanding the argument that plurality within the market should act as a powerful safeguard, we do know that if any provider exit is managed badly at a local level, there is a risk that there may be a negative impact on the health and well-being of those individuals affected. However, this process is within the control of the local authority and provider, who can ensure that effective systems are in place and that best practice in cases of any home closures is followed.

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<sup>195</sup> CQC raw data, 2012 (unpublished)

<sup>196</sup> Forder J, Allan S (2012) *Care Markets in England: Lessons from Research* available at <http://www.pssru.ac.uk/publication-details.php?id=4127>

<sup>197</sup> Laing & Buisson, Care of Elderly People UK Market Survey 2011

9.38 The *Care Act* is looking to strengthen and clarify local authority duties with regard to the market.<sup>198</sup>

9.39 Specialist services may not face the same level of competition as care services for frail older people. Were there to be financial failure of such a provider and disorderly closure, the analysis could be similar to that for a national or regional provider, even if the provider was local.

*C) Issues relating to continuity of care arising from larger regional and national, and specialist, provider exit*

9.40 We classify these providers as those with a significant national or sub-national coverage, of a level that would pose significant information and coordination challenges, should they fail. Such instances present risks to ensuring continuity of care.

9.41 Where a provider operates across a number of local authorities, it is unclear who has complete oversight of that provider's operations – both in terms of the risks to continuity of service and co-ordination should something go wrong. Managing the transfer or closure becomes increasingly difficult when there are many thousands of residents and a high number of stakeholders and authorities involved. Evidence suggests that the sector is likely to see further consolidation over time, meaning provision could become more concentrated in the future and we may see a greater number of larger providers across residential, domiciliary and specialised care and housing services.

9.42 There may also be risks to continuity of care associated with those providers that have high market concentrations at a regional level or offer care that is highly specialist. The nature of the care and support market suggests that local and regional concentrations are just as important as national patterns of provision. Indeed, the recent NAO report highlighted that Southern Cross as a large national care home provider had 9% of the market nationally, but a much greater share in certain regional areas.<sup>199</sup> In parts of the North East, Southern Cross accounted for some 30% of care home places. We know that this may be a particular issue for some specialist services. To note, the Office for Fair Trading consider a range of indicators when assessing market dominance (including market share, the ability to raise prices, barriers to entry) and these all need to be analysed to assess the extent of market power.

9.43 We are also seeing increasingly complex operating and financial business models emerging in the care and support sector, particularly in residential care, which can make it harder to assess financial viability and be difficult to untangle quickly in distressed circumstances. For example, investors in care and support companies can have a wide-ranging portfolio of diverse business interests. We are aware that many providers are carrying substantial debt, which are often structured in complex arrangements and the subject of covenant restrictions. Some of these debts will need to be refinanced over the next few years and, given the current circumstances in the wider economy, this will be challenging. We also know that the care market has close and complex interactions with other markets, such as the property and financial markets; and we understand that there is appetite from providers to offer services spanning both health and

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<sup>198</sup> <http://careandsupportbill.dh.gov.uk/home/>

<sup>199</sup> *Oversight of user choice and competition*, NAO, September 2011, p30.

care, and housing and care. Where there are a number of different branches or subsidiaries to a company, there is a risk that problems in a different part of the business could affect their care and support provision.

- 9.44 Our analysis of the situation for larger players operating nationally or regionally is different to smaller providers. Here, we believe there is a case for a different approach, as the market (which includes commissioners and providers) may not be able to deliver an effective solution on its own. If an organisation providing care to many hundreds or thousands of vulnerable people were to run into financial distress and risk of sudden failure, making arrangements for continuity of care for such large numbers of adults receiving care and support, would require a substantial degree of coordination between many councils and potentially many alternative providers. It would be challenging for this to be conducted effectively by individual councils. This is evidenced by the need for central government coordination and information sharing activities during the difficulties with Southern Cross. Moreover, news of the financial distress and risk of failure of such a large provider would cause anxiety and potential significant welfare loss to large numbers of adults receiving care and support and their families, even if a solution was subsequently found.

#### Residential Care

- 9.45 In residential care, the ten largest providers account for around 20% of the UK care home market by places. The top twenty providers account for around 28% of the market, by places. On this basis, Four Seasons and Bupa both have almost a 5% market share, with both having over 20,000 beds. Barchester and HC-One both have around a 3% market share and around 12,000 beds. Care UK has a 1% share, with around 5,000 beds.<sup>200</sup>

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<sup>200</sup> Laing & Buisson, Care of Elderly People UK Market Survey 2011/12

**Table 54**

<b>Provider</b>	<b>Number of places (January 2012)</b>	<b>Market share (as % of England)</b>
<b>Four Seasons</b>	23,446	5.4
<b>BUPA</b>	21,720	5
<b>Barchester</b>	12,683	2.9
<b>HC-One</b>	11,430	2.6
<b>Care UK</b>	5,007	1.1
<b>Methodist Homes</b>	4,812	1.1
<b>Anchor</b>	4,203	1
<b>Orchard Care Homes</b>	3,879	0.9
<b>Bondcare Group</b>	3,781	0.9
<b>European Care</b>	3,719	0.8

## Home Care

9.46 In home care, there is a multiplicity of small providers, and fewer, larger providers with SAGA the biggest, following its purchase of Allied and Nestor Healthcare. There were 5,400 registered homecare businesses in England at mid-2011 (including 675 in the public sector). The estimated total market size in 2010-11 is £5.7bn (annual turnover) and the top 10 operators account for 16.5% of the market (by annual turnover). The CQC approves around 500 new domiciliary care agencies in England each year.<sup>201</sup>

9.47 The Government recognises that there are risks to the individual should a home care provider fail – and these need to be properly assessed and addressed by both providers and commissioners. However, the majority of home care providers are much smaller operations and local authorities are best placed to manage their local entry and exit (as explained above). In considering the risks to continuity of care for individuals if a larger home care service provider exited the market we made the following observations;

- in the home care sector, adults receiving care and support are in their own homes.
- the core cost component in providing continuity care would be the home care staff themselves. An alternative provider could employ such staff on the same terms or an individual could do so themselves, relatively quickly.

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<sup>201</sup> Laing & Buisson, Domiciliary Care UK Market Report 2011/12, and from Laing's Community Care Market News, May 2012

- there is neither physical infrastructure nor accompanying debt conditions.

#### Specialist housing (housing with care)

- 9.48 There are also a range of models of care and retirement housing, such as extra-care housing. Specialised housing is a growing sector, however accurate data on size is hampered by multiple definitions and differing methodologies. The Elderly Accommodation Counsel (EAC) data<sup>202</sup> suggests there are 821 extra care housing schemes in England although the Care Quality Commission reports there are 564 extra care locations.<sup>203</sup> In most cases the care provision would be classified as domiciliary care provision (see above).
- 9.49 In some cases the organisations will be overseen by the Homes and Communities Agency. In future regulation will need to ensure it does not stifle important innovations in the sector and that risks of duplication are managed. The original policy had been to exempt providers currently regulated by the Homes and Communities Agency (HCA) but ensure cooperation and coordination where necessary to manage continuity of care. Discussions with the HCA since the IA was agreed in March 2013 have shown that the HCA regime is not comparable to the market oversight regime we are to establish, concentrating on maintaining public housing assets with insufficient focus on another part of a provider's business. In view of this, we are proposing not to exempt the small number of providers expected to face regulation by both CQC and HCA, but rather to ensure that the regulators cooperate and share relevant information so as to minimise burdens on businesses. Analysis shows that at most 3 additional providers are likely to require oversight by CQC because of this, this balances an overall slight reduction in provider organisations that will be regulated by CQC for financial oversight as the entry criteria have been refined.

#### Summary

- 9.50 The argument for intervention is that resolving a large scale failure requires a coordinated effort to bring about a solution, and that this needs to be achieved in a way which acts in the interest of all. A further issue is that potential alternative operators, keen on taking over the failing provider's business may be hampered by lack of information and coordination, leading to greater barriers to finding a market-led solution. In summary, there are two key types of potential market failure from the failure of larger providers – information failure and coordination failure, arising from both the lack of information and the misaligning of incentives between different purchasers or between providers and purchasers.

#### **Proposal for intervention: targeted regulation**

- 9.51 The Government is proposing this intervention, which is based on the premise that local authorities continue to oversee the smaller players in the local care market and to put effective plans in place to ensure continuity of care, should any provider exit the market in their local area. This is based on our assessment, outlined earlier in this document, that there is no market failure amongst smaller providers to warrant central Government intervention.

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<sup>202</sup> Statistics on Housing with Care (EAC June 2010]

<sup>203</sup> CQC State of Care Report 2010-2011



- 9.52 The Southern Cross case illustrated among other things that the Government did not have sufficient early knowledge of the financial situation and hence intervention was more protracted. In order to avoid such a situation in the future, we believe some early knowledge of the financial situation of those providers whose potential for financial failure are likely to cause the highest adverse effects is needed. This knowledge would help in a resolution appropriate to the level of risk posed by the financial failure of these providers.
- 9.53 Based on the risk profile of these providers, our assessment is that further regulation is required to ensure that any potential financial collapse of these providers does not result in adverse effects to adults receiving care and support. This could happen if the provider were to close in a disorderly manner. It is important, however, that any regulation is targeted and proportionate to the level of the risk.
- 9.54 We propose new targeted regulatory interventions;
- enhanced intelligence of a group of providers that are above a certain threshold, set according to their difficulty to replace
  - sustainability planning: when it spots threats to the ongoing sustainability of a provider, the regulator will need to assure itself that the provider is taking sufficient steps to mitigate the threat
  - measures to manage provider distress and failure, including the development of continuity of care packs containing information that the regulator requires to ensure there are no gaps in the care individuals receive from the provider, if and when the provider fails.
- 9.55 The regulatory powers would be used to;
- require the submission of financial data from a targeted set of providers to a central body. This will provide an early warning system and aid in the planning of large-scale market exit.
  - have some power to coordinate information and possibly activity, in cases where a provider's business crosses more than one local authority area. As discussed earlier, there is a risk of an information or co-ordination failure in such instances. In the consultation, we argue that addressing these failures would require a national level response and some coordination powers.
  - a power to commission an independent business review, at the provider's expense to examine opportunities to avoid failure and manage risks to sustainability
- 9.56 We also propose to clarify the responsibilities of local authorities when providers fail. We propose that local authorities have a duty to meet the needs for temporary care and support of any person whether self-funded or local authority supported, and whether in receipt of residential or non-residential care, if they have urgent unmet needs as a result of provider failure. The consultation responses indicate that this accurately reflects the role local authorities are already performing when providers fail. We therefore do not believe this clarification will impose costs on local authorities.

#### *Coverage of the regulation*

- 9.57 We believe that the regulation does not need to extend to all providers, but needs to be targeted on those likely to present the greatest risk from disorderly closure. This means that burdens would not fall on small and medium providers.
- 9.58 It could be argued that this may seem unfair to the larger providers and that might impact upon their ability to compete effectively; however we are of the view that choosing those providers whose failure could cause the largest adverse effects on adults who are receiving care and support is a proportionate response to the risk they carry and which a competitive market should recognise.
- 9.59 We believe that the following types of providers will need to be monitored, regardless of their financial stability;
1. providers that are large
  2. providers that have significant geographical concentrations
  3. providers of specialist services, where alternative care provision may be difficult to secure.

*Responsible body*

- 9.60 The Government considered whether the appropriate regulatory body to undertake this function should be either CQC or Monitor, and has selected CQC largely because of their existing relationships with care and support providers and local authority commissioners.

**Costs of preferred option**

**Costs to perform the function of regulation**

- 9.61 The role of the regulator would be to oversee providers that are 'difficult to replace' if they were to fail. This includes providers who are large, have particular regional concentrations or are highly specialist. We assumed in the original IA signed off in March 2013 that this will be 50-60 organisations based on available CQC data. Subsequent work with a wide-ranging stakeholder working group and CQC has led us leave this figure unchanged when the IA was revised in April 2014. The rationale for this is explained below.
- 9.62 The stakeholder working group has considered and agreed that the provisional entry criteria, for consideration in public consultation, should be :-

*For residential care*

1. *Bed capacity in England of 2000 or more beds*  
*OR*
2. *Bed capacity in England of 1000 or more beds*  
*AND EITHER*
  - a. *The provider operates care homes in more than 15 local authorities*  
*OR*
  - b. *The provider has more than 10% of care home beds in more than 2 authorities*

Based on the latest CQC data, this leads to 32 providers being brought into the regime.

*For domiciliary care*

1. *Number of hours of care provided by the provider is 30,000 or more in a week*  
*OR*
2. *Number of people to whom care is delivered in a week is 2000 or more*  
*OR*
3. *Number of people to whom care is delivered in a week is 800 or more*  
*AND*  
*The number of hours of care provided by the provider in a week divided by the number of people to whom care is delivered in a week exceeds 30 hours.*

Based on the latest CQC data, this leads to an additional 12 providers being brought into the regime.

*Specialist providers*

- 9.63 We have agreed that it is not possible to develop objective criteria to cover this, largely because CQC does not record or analyse data by type of provider that could lead to an assessment of whether the provider would be difficult to replace. Given this, we are proposing an expert panel that meets regularly to consider whether given the above criteria for residential and domiciliary care there are any further providers that are not in the regime that would be difficult to replace if they failed. The panel would then recommend that the Secretary of State for Health should use his powers in the Care Act to compel these additional providers into the financial oversight regime.
- 9.64 The stakeholder working group and CQC estimates this will lead to an additional three providers being brought into the regime.

*Providers previously considered for exemption*

- 9.65 The original IA was based on the policy intention to exempt care providers who also provide social housing from the regime where they are already regulated by the Housing & Communities Agency. During the development of the policy it has become clear that the HCA oversight regime is not comparable to the CQC regime that will be established. Given this, we now propose NOT to exempt these providers, but rather, be clear that CQC and HCA should cooperate and share information so as to minimise burdens on provider businesses, which was the policy intent that drove the original exemption policy.
- 9.66 The estimated 3 providers who would have been exempted are now captured by the entry criteria above.

**Total number of providers expected in the regime**

- 9.67 The total number of providers in the regime is therefore expected to be: 32 residential care providers, 12 domiciliary care providers and 3 additional specialist care providers, giving a total of 47. As the size of provider organisations changes over time and so the numbers captured in the regime is subject to change, and as the number of specialist providers is a subjective

estimate, and as the regulations have yet to be publicly consulted on or received Parliamentary approval, we believe it is prudent to leave the IA calculations of costs and benefits based on the previous assumption that the number of providers in the regime would be 50 – 60.

- 9.68 We have considered the costs of regulators who perform similar function including Monitor, the Civil Aviation Authority and the Homes and Communities Agency.
- 9.69 Based on the costs and functions of the above regulators we estimate that to oversee c. 60 organisations the regulator will need to employ approximately 15<sup>204</sup> FTE staff, of which around 2/3 will be senior staff and 1/3 will be junior staff.
- 9.70 In the Health and Social Care Bill Impact Assessment<sup>205</sup> staff performing the function of provider regulation were expected to cost £84K, including on-costs, after applying pay rate assumptions. This would apply to c. 10 staff. We assume the remaining 5 staff would be expected to cost £40,000 including on-costs.

**Table 55**

<b>Category</b>	<b>Unit Cost (£s)</b>	<b>No. of Units</b>	<b>Total Cost (£000s)</b>
Senior Staff	84,000	10	840
Junior Staff	40,000	5	200
Total wage costs, including on costs			<b>1040</b>

- 9.71 In addition, we expect there to be some additional running costs relating to spend on consultancy services and corporate services including legal advice.
- 9.72 We estimate the consultancy costs will be £150,000 initially, and £50,000 a year thereafter. We assume that extra consultant time will be needed in the first year to help define and implement the new regime.
- 9.73 We have no information on the likely costs of corporate services. However, at Monitors inception, DH estimated that the new organisation would require an annual budget for legal services of £4 million. Assuming that the need for legal advice is proportionate to the size of the organisation, we assume that the new regulatory function will require legal advice and other corporate services of around £100,000 per year.
- 9.74 This suggests that the cost to the regulator of carrying out this regulation would be of the order of **£1.3 million** in year 1 and £1.2 million thereafter. The exact cost will depend on the exact regime adopted.

### **Costs of providing data for firms in the threshold**

<sup>204</sup> This staff mix is based on the CAA's staffing structure. We also assume 1 regulator per 4 providers.

<sup>205</sup> [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_129917.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129917.pdf)

- 9.75 The consultation provided no data on the cost of providing financial data to the regulator. Many respondents said that they did not have enough information to estimate a cost, or that the cost would depend on the data requested. Some were concerned that charities would need to put in place new financial systems in order to produce the data required.
- 9.76 However, the CQC and KPMG were of the view that the data the regulator would require from all companies above the threshold is likely to be the same information that firms produce regularly for their own management purposes. BUPA's consultation response said that costs should be minimal providing information requirements remain 'light touch' and do not significantly add to that which is already provided and the threshold set at an appropriate level.

### Estimating costs

- 9.77 We do not have any information on the cost of extracting existing information from management reports and providing it to a third party. However, we assume that this would largely be an administrative role, with some oversight from a corporate manager.
- 9.78 We assume that providers will be required to assemble and send the financial information to the regulator once a quarter. We assume that it would take around 3 hours per organisation per quarter and that on costs are 30%.
- 9.79 The 2010 Annual Survey of Hours and Earnings (ASHE) provides the following median wage rates:

Administrative and secretarial	£9.75
Corporate managers, including senior managers	£19.40

- 9.80 If we apply these, and assume that 80% of the time will be administrative and 20% required for manager oversight, then the annual cost of providing data will be:

$$\begin{aligned} & \text{No of data collections} * \text{no of hours work} * (\text{admin costs} * 80\% + \text{management} \\ & \text{costs} * 20\%) * \text{on costs} \\ & = 4 * 3 * (80\% * 9.75 + 20\% * 19.40) * 1.3 \end{aligned}$$

**=£180 a year per organisation**

### Costs of meeting the regulator

- 9.81 In addition, we assume that the each firm above the threshold will meet the regulator quarterly to discuss their metrics. We assume that each meeting will last half a day, and require in total 2 days of manager time including preparation.
- 9.82 The cost of meeting the regulator is then

$$\begin{aligned} & \text{Number of meetings} * \text{staff time to prepare and meet regulator} * \text{hourly wage} * \\ & \text{on costs} \end{aligned}$$

$$4 * 14 * \text{£}19.40 * 1.3 = \text{£}1,410$$

9.83 Our best estimate is that the annual cost to any care and support provider in the threshold of providing metrics data to the regulator and meeting to discuss it will be **£1,590** per year per organisation.

**Cost of preparing sustainability plans, independent business reviews and continuity of care packs**

9.84 The key cost drivers in terms of the above requirements are likely to be the following:

1. The number of organisations that are required to prepare these
2. Whether these organisations prepare these using internal resources or have to ask external advisors to prepare these on their behalf
3. Frequency- whether these are prepared once at the start then updated regularly or prepared as a one-off.

*Number of organisations*

9.85 We assume that 50-60 organisations will be required to submit the metrics. On that basis, in terms of the number of organisations that are required to prepare the documents, we have made the following assumptions:

**Table 56**

		No	Profile over 10 years
A	No of orgs required to submit metrics	60	
B	Number of orgs (from A above) required to submit Sustainability Plans	30 (50% of A)	Spread evenly over the 10 year appraisal period
C	No of orgs (from B above) required to commission Independent Business Reviews (IBR)	12 (40% of B)	Spread evenly over the 10 year appraisal period
D	Number of orgs (from C above) required to submit Continuity of Care Packs (for Continuity of Care Plans)	6 (50% of C)	Spread evenly over the 10 year appraisal period

9.86 There are no existing benchmarks for the costs of preparing sustainability packs or continuity of care packs, as their scope and content will be determined by the regulator and will depend largely on the size, type, complexity of the organisation as well as the nature of the issue causing distress. Therefore, the costs below are based on assumptions. Discussions with some of the stakeholders suggest these cost estimates for the Sustainability Plans and Independent Business Review represent a low estimate.

*Sustainability plan*

9.87 Providers facing challenges will be required to produce ‘sustainability plans’ when risks develop, to satisfy the regulator that they have a strategy in place to manage the challenge and a contingency plan.

9.88 We assume that when an organisation is required to produce a sustainability plan, that 50% will use a mix of internal resources (Admin, Senior Finance Managers and Senior Management Team members such as CFO/CEO) and

50% will use external advisors. Even when external advisors are used, this will require some input from provider senior managers and directors.

9.89 While the challenge persists or is being addressed, we assume that the sustainability plan will to be updated on a monthly basis over a 3 month period and that the updates will take 2.5% of the time taken to prepare the initial plan.

**Table 57**

<b>Cost of Sustainability Plan</b>		
<b>1. Delivered using Internal Resources</b>		Days
Senior Finance Manager time		55
Chief Finance Officer/Senior Management time		20
Admin secretarial		10
Admin secretarial		£1,014
Senior Finance Manager Benchmark cost <sup>206</sup>		£21,993
Chief Finance Officer/Senior Management Benchmark cost <sup>207</sup>		£10,242
Total Cost for delivering a Sustainability plan using internal resources		£32,235
<b>2. Delivered using Advisors</b>		
External Resources		
	Number of advisor days	50
	benchmark advisor daily rate	£999 <sup>208</sup>
	Cost	£49,950
Internal resources to provide information etc.		
	Admin secretarial	5
	Senior Finance Manager days	20
	CFO/Senior Management days	4
	Cost	£10,553
Total Costs for delivery of Sustainability plan using external Advisors		£60,503
<b>Updating the Sustainability Plan</b>		
Plan prepared once when the challenge first emerges		
Updated every month		
Updating cost per month as proportion of initial cost		2.5%
Updating cost per episode as proportion of initial cost-using internal resources		2,418
Updating cost per episode as proportion of initial cost-using advisors		4,538

9.90 If we assume that 30 sustainability plans are produced during a 10 year period then the cost per year will be the average cost of a sustainability report \* 30/10, where the average costs of a sustainability report is:

<sup>206</sup> Corporate Managers And Senior Officials hourly rate of £38.45 plus 30% on-costs used from 2010 ASHE, based on 8 hours/day

<sup>207</sup> Directors and chief executives of major organisations hourly rate of £49.24 plus 30% on-costs used from 2010 ASHE, based on 8 hours/day

<sup>208</sup> Blended daily rate using DH benchmarks.

[(cost of internally produced report + cost of internal update) + (cost of externally produced report + cost of external update)] all divided by 2

9.91 So the annual cost is:

$$30/10 * [(32,235+3*2418)+(60503+3*4538)]/2 = \mathbf{\pounds 149,500 \text{ per year}}$$

*Independent business review*

9.92 An Independent Business Review (IBR), would be conducted by external advisors. Some input would be required from senior managers and directors to provide information and hold management meetings. Also, the IBR, by its very nature, would be required as a one-off and once completed, is unlikely to require updating.

**Table 58**

<b>Cost of Independent Business Review</b>		
<b><i>Must be delivered using Advisors</i></b>		
External Resources		
	Number of advisor days	75
	benchmark advisor daily rate	£999
	Cost	£74,925
Internal resources to provide information etc.		
	Admin secretarial	5
	Senior Finance Manager days	24
	CFO/Senior Management days	6
	Cost	£13,177
Total Costs for Independent Business Review		£88,102

9.93 We assume that 12 Independent Business Reviews will be required in 10 years. Making the annual cost of IRB's in the new scheme

$$\pounds 88,102 * 12 / 10 = \mathbf{\pounds 105,70085 \text{ per year}}$$

*Continuity of care pack*

9.94 The Continuity of Care Pack would be required by the Regulator and produced by the provider. It would include details on the business model and ownership structure, the services offered, the number of clients in each area, and any other information the regulator deemed necessary. It would be required at a time of crisis and, we assume, will need to be updated every two weeks over a 12 week period when the company is in distress. As a conservative assumption, we have estimated that the cost of updating the continuity of care pack will be the same as the initial cost, in a rapidly evolving and changing failure scenario.



**Table 59**

<b>D. Cost of Continuity of Care Pack</b>		
Internal resources to provide information		
	Senior Finance Manager days	6
	CFO/Senior Management days	2
Cost of continuity of care pack		£3,423
Cost incurred every two weeks over a 3 month period,		
Updating cost per 'episode' requiring a Continuity of Care Pack		£20,541
Total cost of a continuity pack		23,964

9.95 We assume that 6 continuity of care packs will be required in a 10 year period.  
Making the annual total cost  $23,964 \times 6 / 10 = \mathbf{14,378}$  per year.

9.96 The total costs for each of the elements over the 10 year appraisal period are shown in the table below.

Start End Year	01-Apr-15 31-Mar-16	01-Apr-16 31-Mar-17	01-Apr-17 31-Mar-18	01-Apr-18 31-Mar-19	01-Apr-19 31-Mar-20	01-Apr-20 31-Mar-21	01-Apr-21 31-Mar-22	01-Apr-22 31-Mar-23	01-Apr-23 31-Mar-24	01-Apr-24 31-Mar-25
	1	2	3	4	5	6	7	8	9	10
<b>Regulator Costs (£)</b>										
<b>Regulator ongoing costs</b>	1,290,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000	1,190,000
<b>Provider Cost of supplying metrics (£)</b>										
<b>Supplying and meet</b>	95,400	95,400	95,400	95,400	95,400	95,400	95,400	95,400	95,400	95,400
<b>Provider One off Costs (£)</b>										
<b>Sustainability Plan</b>	139,107	139,107	139,107	139,107	139,107	139,107	139,107	139,107	139,107	139,107
<b>Independent Business Review</b>	105,722	105,722	105,722	105,722	105,722	105,722	105,722	105,722	105,722	105,722
<b>Continuity of Care Pack</b>	2,054	2,054	2,054	2,054	2,054	2,054	2,054	2,054	2,054	2,054
<b>Provider Updating Costs (£)</b>										
<b>Sustainability Plan</b>	10,433	10,433	10,433	10,433	10,433	10,433	10,433	10,433	10,433	10,433
<b>Independent Business Review</b>	-	-	-	-	-	-	-	-	-	-
<b>Continuity of Care Pack</b>	12,324	12,324	12,324	12,324	12,324	12,324	12,324	12,324	12,324	12,324
<b>Total Costs (£)</b>	1,655,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041	1,555,041

9.97 Uprating to 2015/16 prices.

Table 61

£ millions, 15/16 prices	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Total recurring costs	£1.8	£1.7	£1.7	£1.7	£1.7	£1.7	£1.7	£1.7	£1.7	£1.7

## **BENEFITS**

9.97 The main benefit of this proposal will be to care users, their family and carers and the people who work for a social care provider that has failed while in this regulatory regime. In the event of business failure, a provider has no incentive to, and may be unable to, transfer the care of their clients in an orderly way, for example, where an insolvency practitioner is appointed over a failed business and, in the best interests of its creditors, chose to wind down the business without making alternative arrangements for those affected. This proposal should provide reassurance for people affected by their provider failing that their care services will not be interrupted. The benefits to users are monetised below. The benefit to carers, families and care workers has not been monetised.

9.98 Secondly, the process of regulation may lessen the likelihood of provider failure, due to financial mismanagement. This is because the CQC will assess financial metrics and, for those at risk, will have the power to request the production of sustainability plans and to commission independent business reviews. This benefit is not monetised. However, it should be acknowledged that the primary aim of this new regime is not to prop up failing providers, but to provide reassurance for people affected by their care provider failing that their care services will not be interrupted.

9.99 Finally, in the event of a regulated provider failing, there will be benefits to the local authorities who may have to carry out temporary duties. Where CQC is satisfied that a provider is likely to become unable to carry on providing the care for which it is registered with the CQC because of business failure, it must inform local authorities who may have to carry out temporary duties to meet people's needs and the CQC may also request information from the failed provider which it believes will assist local authorities in ensuring continuity of care. The CQC must share with those local authorities carrying out the temporary duties any information that it believes will help the relevant local authorities to carry out those duties. This will provide local authorities with early warning to ensure financial failure is managed effectively.

9.100 We know from Winterbourne View that the spot price of care can rise dramatically where local authorities have to purchase that care for a large number of individuals at short notice, and that people can be placed in very expensive temporary care while the situation is resolved. As the local authorities affected should receive early warning that a provider in the CQC's regime is likely to fail, it can ensure plans are in place to effectively manage the failure, including arranging alternative services in advance which should go some way to mitigating the associated risks. These benefits have not been monetised.

### Benefits to Care Users

9.101 Evidence suggests the disorderly closure of a social care provider can cause a great deal of anxiety to individuals, carers and

their families.<sup>1</sup> If poorly managed, there is a significant risk that there may be an adverse effect on the health, well-being and dignity of users.

9.102 However, this does not have to be the case. Where a closure is well managed, clients can receive a benefit from their new and potentially more appropriate care. They need not experience anxiety during a well managed transition.

9.103 This is illustrated by a study in Birmingham in which 70 residents were interviewed, during and after service closures (including care home closures). This suggests that when a provider exit is managed well by a local authority, there should be no negative effect on individuals' health and wellbeing.<sup>2</sup> Indeed, a move could be beneficial if it leads to higher quality care. However this study notes that in the case of large-scale emergency closures, well-managed processes may not be possible, given the lack of time for a local authority to plan and also because the scale of impact may be across a number of local authority areas.

### Best estimate

9.104 As a best estimate, we approximate the well-being impact of preventing the disorderly closure of a residential care provider regulated by this regime.

9.105 We make the following assumptions to calculate the well being affect of market oversight:

- where providers close in a disorderly way, people receiving care services experience a substantial increase in their anxiety.
- where providers close in an orderly way, people receiving care services experience no increase in their anxiety, in line with evidence from the Birmingham study above.
- the positive impact on their quality of life can be represented by a move from “severe anxiety” to “no problems” on the EQ-5D scale. This translates to a quality of life improvement of 0.586.
- we expect this improvement to have an average duration of 3 months. This is an estimate of the time taken to resolve the disorderly closure of a care provider, provided by stakeholders during a roundtable and in written responses. It is a conservative estimate, and assumes that there is no ongoing effect on care users anxiety from a disorderly transition to new care arrangements.

9.106 Taken together, the above assumptions suggest that the well-being effect of an orderly resolution to a care provider failure is 0.1465 quality-adjusted life years (QALYs) per affected care services user. With a QALY

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<sup>1</sup> Scourfield P, 2004, 'Questions raised for local authorities when old people are evicted from their care homes'; Woolham, J (2001). *Good practice in the involuntary relocation of people living in social care*

<sup>2</sup> Evidence from the Health Services Management Centre at the University of Birmingham has found adopting good practice limits potential negative impacts on individuals' health and well-being and, for some people, may give slight improvement in outcomes. See: *Achieving closure: Good practice in supporting older people during residential care closures*, July 2011. This is a joint publication by Health Services Management Centre at the University of Birmingham and ADASS, in association with SCIE.

valuation of £60,000, this would give an expected monetised benefit of **£8,790** ( $=0.1465 * £60,000$ ) per care user.

9.107 As set out above, this calculation is an approximation in that there are limits to our knowledge of prevalence and the impact of the additional stress caused by having one's residential care re-arranged in a disorderly way.

9.108 We do not know what proportion of residents would be fully aware of any financial pressures, and hence would experience anxiety. If providers actually reach the point of failure, we would expect the proportion to be high as there would likely be significant media interest and national coverage. Our analysis assumes that all residents in affected providers see some effect, but this may be an overestimate. On the contrary, the experience of Southern Cross demonstrates that failure of a major provider can have anxiety impacts on residents of other organisations, and on carers and relatives in wider society. We have not monetised this wider societal estimate. It would offset any overestimate of benefits, but indicates directly that there is a degree of uncertainty in our calculations.

9.109 We do not have any comparable information for home care.

#### Sensitivity analysis – levels of stress and anxiety

9.110 As sensitivity analysis, we vary the extent to which an orderly closure of residential care will reduce the stress and anxiety of care users. As a lower bound, we assume that people experience moderate anxiety when a care provider closes in an orderly way and severe anxiety when a care provider closes in a disorderly way. This translates to a quality of life improvement of 0.434. If we assume that the disorderly closure takes 3 months to resolve, and that people feel mild anxiety for three months following an orderly transition to new care arrangements, then the lower bound quality of life improvement is then

$(0.434 * 3/12 * 60,000) = \mathbf{£6510}$  per client affected.

#### Estimating the number of people to benefit from the scheme.

9.111 In order to estimate the number of care users to benefit from the new regulatory regime, we need to estimate how many providers within this CQC's regime are at risk of failure in future years. We do not have this information.

9.112 We know that in the last two years, two providers who may have been covered by the regime have failed or experienced financial distress. These are Southern Cross<sup>3</sup>, which had 31,000 care users and a 9% share of the residential care market in England, and Castlebeck, a very specialist provider who have less than 100 social care beds<sup>4</sup> in total. This confirms that provider failures do happen, and that the scale of the

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<sup>3</sup> *Oversight of user choice and competition*, NAO, September 2011, p30.

<sup>4</sup> 2012 CQC registration data

benefits from an orderly transition to new care arrangements will vary considerably from year to year.

9.113 To estimate the benefit from regulation, we make the following assumptions about the firms regulated and their failure rate:

- That the new regime will include 50 – 60 residential and non-residential social care providers, who because of their size, concentration of market share, geographical distribution or specialism, local authorities would find it difficult to temporarily arrange alternative services were they to financially fail (“difficult to replace”).
- That in any 10 year period, 6 firms will fail. Matching the assumptions made in the costs section above.

9.114 Even with the assumptions above, there is a level of uncertainty about how many people would benefit from this new regulatory regime in a 10 year period. In terms of care users, there are substantial differences in the number of people cared for by the top 30 residential care providers. The largest provider cares for around 20,000 people in England and the 30<sup>th</sup> largest provider for around 1,300. On average, CQC registration data shows that the top 30 residential care providers have 4000 social care beds on average, and that the bottom 2/3rds of these have an average of 3000 social care beds.

9.115 Given this uncertainty, we have estimated a range of benefits. To produce an estimate of the benefits of the scheme, we assume that 6 providers fail within a 10 year period. In our high scenario, we assume that this includes one of the top 10 providers, and that the remainder are all smaller providers. For our low scenario, we assume that all the failures are smaller residential care providers. We do not have any information on the number of people who receive domiciliary care services from the larger home care providers. We have not included them in our estimate of benefits.

9.116 Under both scenarios, the people receiving care from the regulated firm that failed benefit from an orderly transition to new care arrangements under the new scheme.

9.117 This is a conservative estimate of the number of people who would benefit from an orderly transition to new care arrangements. Staff, families and carers would also see a reduction in their anxiety from an orderly transition to new arrangements, compared with a disorderly one. However, we have not monetised this.

9.118 The estimated benefits are as follows:

9.119 High estimate assumptions:

- |   |                     |
|---|---------------------|
| • No of failures in 10 years              | 6                   |
| • No of people affected                   | 1 * 4000 + 5 * 3000 |
| • Benefit from orderly transition         | £8790               |
| • No of years that benefit is spread over | 10                  |

**Annual Benefit** =  $(19,000 \times 8790) / 10 =$  **£16.7 million per year**

9.120 Low estimate assumptions:

- No of distress situations in 10 years 6
- No of people affected 6\*3000
- Benefit from orderly transition £6510
- No. of years that benefit is spread over 10

**Annual Benefit** =  $(6 \times 3000 \times 6510) / 10 =$  **£11.7 million**

### **Net present value calculations**

9.121 This section summarises the costs and benefits identified in the preceding sections, relative to the do nothing scenario, in which residential and non-residential care providers who because of the volume of care provided, concentration of market share, geographical distribution or specialism would be difficult to replace were they to financially fail, are not subject to the proposed light touch regulation.

9.122 It presents the changes between the do-nothing scenario and the best estimate costs for the proposed policy. The main monetised costs and benefits include changes:

- the costs to firms of complying with the regulation;
- the cost to the CQC of administering the regulatory regime;
- the benefits to recipients.

9.123 There is a degree of uncertainty, in particular in estimates of the number of providers who fail and in the scale of anxiety arising amongst service users in those organisations. Whilst the headline figures demonstrate a substantial net benefit, with benefits outweighing costs, our judgment is that the evidence does not demonstrate a substantial gain from the policy. There is sufficient evidence to demonstrate that the policy is cost effective and appropriate, but the degree of uncertainty in the figures means it would be unwise to draw conclusions beyond that.

9.124 To account for this uncertainty in some components of the preceding analysis, we present a range of benefits.

9.125 Finally, it should be noted that table below presents our current best estimates and is subject to uncertainty with regard to the distribution of the identified costs. The CQC will be responsible for the operation of the market oversight regime so will develop their operating model that will specify the metrics to collect from providers and ensure compliance. They will undertake a targeted consultation on these issues in 2015.

## Specific impacts

### One In Two Out

9.126 The equivalent annual net cost to business has been estimated as the cost to firms of complying with the new regulatory regime. This is estimated as follows:

*Table 62*

<b>Action</b>	<b>Cost</b>
<b>Supplying metrics</b>	£95,400
<b>Sustainability Plans:</b>	
One-off production cost	£139,107
Updates	£10,433
<b>Independent Business Review</b>	£105,722
<b>Continuity of Care packs:</b>	
One-off production cost	£2,054
Updates	£12,324
<b>Total</b>	£365,041 or £0.365 million



## Equality analysis

**Title: The Care Act 2014: Consultation on draft regulations and guidance for implementation in 2015/16**

This equality analysis sits alongside the final Impact Assessment for Care and Support Reform (May 2014). Both the Impact Assessment and Equality Analysis cover the majority of provisions set within Part One of the Care Act. This includes the general responsibilities of local authorities (including provision of information), assessment and eligibility provisions, direct payments, and safeguarding.

Social care funding reform, which will be implemented a year later (April 2016) and hence is not part of this consultation, will be subject to separate Impact Assessments and Equality Analyses alongside the corresponding consultation later in 2014.

### What are the intended outcomes of this work?

Creation of a single, modern statute for care and support for the first time; the introduction of a national eligibility threshold in care and support for the first time to eradicate unfair postcode lottery; to enable reform of funding system, in line with recommendations of the Commission on Funding Reform.

### Who will be affected?

People who use care and support, carers and their families.

**Evidence** *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment. For more information, see the current [DH Transparency Plan](#).*

### What evidence have you considered?

The Department has drawn on a wide array of sources to develop the Act, a number of which factored in equalities. Some of these include:

- The Law Commission Report into adult care and support;
- Caring For Our Future: reforming care and support – equality analysis
- Consultation responses to the draft Care and Support Act
- Consultation events to support the development of the draft Act
- Outcomes of Social Care for Adults (interim findings, 2011)
- Care for older people: projected expenditure to 2022 on social care and continuing health care for England's older population (Nuffield Trust)
- Disability policy and practice – applying the social model of disability (Barnes and Mercer, 2004)
- Laing & Buisson, Care of Elderly People Market Survey, 2012/13
- Audit Commission reports, *Improving Value For Money in Adult Social Care*, June 2011 and its earlier report *Management of personal budgets*
- In Control, *Personal Outcomes Evaluation Tool*
- Models of Multi-agency Services for Transition to Adult Services for Disabled Young People and Those with Complex Health Needs: Impact and costs (SPRU, 2010)
- National evaluation of the DH integrated care pilots
- Evaluation of the Individual Budgets Pilot programme
- Putting people first: measuring progress, 2009
- Ipsos Mori, Users of Social Care Budgets, July 2011

- PSSRU, Survey of Fair Access to Care Services (FACS) assessment criteria among local authorities in England, 2012.
- Commission for Social Care Inspection, Cutting the cake fairly, 2008.
- Fairer Care Funding, The Report of the Commission on Funding of Care and Support, 2011.
- Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own, June 2008 and “Recognised, valued and supported: next steps for the Carers Strategy”, November 2010.
- Arksey, H. et al, *Carers’ aspirations and decisions around work and retirement*, Department for Work and Pensions, Research Report 290, 2005.

## Disability

The Act is designed to help overturn traditional approaches to disability, and implement a social model approach. This is underpinned by approaches which seek to place greater power in the hands of all service users, including disabled people. This is exemplified in setting out rights for everyone to have a personal budget, as well as consolidating the law around disabled people being able to access direct payments. This will give people greater control over the services they use.

In addition, the Act places a duty on local authorities to ensure that in the future adults who use social care services (including disabled people) will have control over their day to day life.

Question 13 of the consultation specifically asked whether regulations should require local authorities to provide specialist assessors for those with particular conditions or circumstances. Some third sector organisations proposed new requirements for specialist assessors, particularly for those with sensory impairments and with autism or learning disabilities. However, we believe that as Regulation 5 of *The Care and Support (Assessment) Regulations 2014* already lays down requirements around training, knowledge and expertise that apply to all assessments, a requirement for specific specialist assessors for a longer list of conditions or circumstances is not necessary. Indeed, by listing some such conditions, there would be a strong risk of implying that other conditions were not subject to the same requirements, so such a list could well do more harm than good.

## Sex

The most relevant aspect to gender equality is around the provisions in the Act for carers. As the last UK census outlines, there are approximately 6 million carers in the UK, and the vast majority of these are women. The Act for the first time sets out a number of rights for carers for the first time, placing a series of duties on local authorities to meet a carer’s needs for support. This should have a significant benefit for a large number of women.

## Race

No evidence suggests that there will be inequitable impact on race.

One aspect of the Act which we have aligned with language barriers is that of Information and Advice. The Act places a duty upon Local Authorities to provide Information and Advice that is accessible to those for whom it is provided. Guidance will set out that this may also include needing to ensure this information is provided in different languages.

## Age

The Act includes a number of provisions that benefit various age ranges, and have been demanded by a number of groups including Age UK.

The Act will benefit older age ranges as they are the group who predominantly require both domiciliary

and residential care. As the Act seeks to improve both levels of access, and improve how services are provided, this is the group that will benefit mostly as a result of the policy measures. The Act also includes a specific duty on local authorities to prevent or delay the development of care and support needs, which is likely to especially benefit older people as they are most likely to develop such needs and so will be a natural focus of local authorities.

However, it is not only older people who will benefit as a result of the Act. In addition disabled adults aged 18-65 will benefit from improved services.

Furthermore children who are approaching adulthood will benefit from new transition provisions, which will allow adult social care services to assess these children. This will help smooth the transition for disabled children into adulthood.

### **Gender reassignment (including transgender)**

No inequitable impacts upon people who have undergone gender reassignment, nor transgender people, have been identified.

### **Sexual orientation**

No inequitable impacts relating to sexual orientation have been identified. In its consultation response, the National LGB&T Partnership emphasised the importance of local authority staff, as well as other forms of information and advice, using “non-heteronormative, non-monosexual and non-cisnormative language and imagery that presents a range of same-sex situations and gender variant people”. While the Government absolutely believes that the use of inclusive language is paramount, there is already a requirement on all public bodies via the Equality Act 2010 to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it<sup>5</sup> and this should necessarily include the use of inclusive language at all times. It would not be helpful to create a separate requirement around this under the auspices of the Care Act as this would create unnecessary duplication and call into question the application of the Equalities Act in other circumstances that are not mentioned specifically.

### **Religion or belief**

No inequitable impacts have been identified. The wellbeing principle set out at Section 1 of the Care Act includes the duty to have regard to a person’s beliefs, which includes both religious and non-religious beliefs, when exercising a care and support function. This should ensure that people of all forms of belief are not discriminated against by having those beliefs ignored or marginalised compared to other views, wishes or feelings.

We have also considered the impact of the Deferred Payment scheme on the Muslim community, given that Muslims may object to charging of interest and the consultation on the draft regulations and guidance included a specific question about this. There were mixed views in response to the consultation as to whether it was necessary to provide for a Sharia-law compatible scheme or not and as such we have decided not to enact it for April 2015. We intend to engage further with the Muslim community to understand whether there would be a demand for a Sharia-compliant scheme, and if so what would be required of it.

### **Pregnancy and maternity**

No inequitable impacts upon pregnancy and maternity have been identified.

<sup>5</sup> Specifically the Public Sector Equality Duty, Section 149(1)(b) Equality Act 2010

## Carers

The Care Act for the first time enshrines rights for carers in legislation. This includes a duty upon local authorities to provide support for carers.

## Deafblind people

The Act includes a specific duty on local authorities to maintain registers of of sight-impaired and severely sight-impaired adults in their local area. The registers that local authorities already maintain for the sight impaired are significantly more accurate than the registers maintained currently for disabled people and it is important not to lose this good practice. Moreover, there are benefits linked to being registered that does not apply to people who may be registered with other disabilities. For example, someone may be able to get a half-price TV License, help with NHS costs, help with Council Tax bill and tax allowances, leisure discounts and free public transport. However, the concession entitlement will depend on whether the person is registered as severely sight impaired or sight impaired.

In addition to the sight registers, local authorities may also continue to establish and maintain a register of people living in their area that have a disability. Giving local authorities the power to maintain registers for specific groups and categories of people with disabilities should lead to better and more accurate recording according to local priorities compared to the generic registers that currently apply.

## Other identified groups

No other identified groups.

## Engagement and involvement

Was this work subject to the requirements of the cross-government [Code of Practice on Consultation](#)?

**Yes**

### How have you engaged stakeholders in gathering evidence or testing the evidence available?

When it was introduced, the draft Bill and supporting documents (including impact assessments and equality analyses) were made available on the DH website and a dedicated website.

The introduction to the draft Bill explained the legislative proposals, the consultation process and how to respond, and the clauses are written in plain English. We produced an EasyRead version of the draft Act itself, as well as fact sheets and Q&A. All documents were available to download or purchase from The Stationary Office.

On publication, we wrote to stakeholder organisations encouraging them to respond. To raise awareness and encourage debate, the Department used Twitter to summarise the care and support clauses and provide updates on the engagement process.

Comments were invited by email, post or via the dedicated website which invited responses to individual clauses and to a series of thematic questions. Over 1,000 written comments were received from a total of 433 unique respondents, including 246 organisations and 187 individuals.

The consultation process included extensive engagement activity to facilitate meaningful discussion and dialogue with identified stakeholder groups and to encourage those who use care and support, their carers and families and health and social care professionals to contribute their views. Where possible, we made use of existing events, meetings and networks.

Due to the nature of social care, and its interface with traditionally disempowered groups (older people; disabled people; carers) it was considered that a large degree of engagement with such groups to generate a robust evidence base was essential. Hence qualitative evidence with these groups was

generated through this consultation, which was underpinned by an easy read version of the Act.

Pre-legislative scrutiny, which was conducted by a joint committee, provided further opportunity to engage and understand potential impacts as a wide number of witnesses gave evidence on the Act.

A similar approach informed the consultation on the draft regulations and guidance underpinning Part 1 of the Care Act, which was published on 5 June 2014, and ran for ten weeks to 15 August. In order to reach a comprehensive and varied pool of experience and expertise, the consultation contained a mix of digital and face-to-face meetings and events with the full spectrum of stakeholders, including:

- people receiving care and support and their carers;
- social workers and other frontline practitioners;
- local authority finance managers, commissioners and elected members;
- voluntary and private social care providers;
- national representative groups and other charities and trusts; and
- NHS agencies, housing departments, DWP Job Centre Plus and other key partners involved in the reforms.

The consultation encompassed 57 formal consultation events and a large number of smaller meetings and virtual discussions. These events spanned all regions in England, including nine regional events organised jointly with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), a number of “deep dives” on specific topics arranged jointly with the Care and Support Alliance, as well as other events hosted with specific stakeholders. The Department also set up an accessible online platform as the online hub for all Care Act and consultation information.

In total, the consultation drew over 4,000 responses from many different sources. Of these, the consultation website received 1,175 comments in response to the 84 questions we asked through the consultation document.

We also received 551 direct emails to the consultation mailbox. To add to this, officials from the Department also captured feedback collected at the various stakeholder engagement events noted above to ensure this information was fed into the final response document.

### **How have you engaged stakeholders in testing the policy or programme proposals?**

We have engaged with stakeholders around policy design on all policy aspects. We have done this through a number of events, as well as through formal consultation and ongoing engagement. Through these mechanisms stakeholders have been able to provide feedback and suggestions as to how policy should be designed.

The Department developed the draft Care Act regulations and guidance in collaboration with stakeholders, establishing steering groups or similar to guide the development of specific chapters and associated regulations. This has included active consideration of equality issues, and where a potential impact on a specific group was identified a member of a relevant representative group was often invited to join the group. For example, the reference group to develop the guidance on transition from children’s to adult care and support included specific representation from Autism stakeholders, to ensure that the distinct considerations for this group were fully considered.

The summer 2014 consultation on these draft regulations and guidance, outlined above, was a key means of further testing the policy proposals with the widest range of stakeholders possible. The consultation received extensive comment from organisations representing people from specific equalities groups. The organisations responding to the consultation are set out in Annex A of the government response to the consultation, which can be found at: <https://www.gov.uk/government/organisations/department-of-health>

We will continue to engage with a broad range of stakeholders to further test and gather feedback around how best to implement the policies set out in the Act. Again, we will do this through a number of formal and informal mechanisms.

**For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:**

The Government consultation response sets out the details of engagement during the summer 2014 consultation, including the organisations engaged and the key outputs of this engagement. It can be found at: <https://www.gov.uk/government/organisations/department-of-health>

The engagement on the draft Bill built on the collaborative approach that has characterised the entire development of the Act. The table below sets out the groups that were engaged in specific engagement events in 2012. The specific date is set in the right hand column.

These were in effect sessions to generate rich qualitative evidence and data. A note was taken at each meeting, and these notes fed in directly to the development of the Act.

Action on Elder Abuse	9 August
Action on Elder Abuse conference	10 October
Ambassadors' Forum	11 October
Association of Directors of Adult Social Services (ADASS) and Local Government Association	13 September
ADASS Executive	13 September
Care and Support Alliance	25 July
	10 September
	18 September
	17 October
Care and Support Transformation Group	19 July
Care Quality Commission	17 September
Carers in Hertfordshire	27 September
English Community Care Association	8 August
Health and Social Care Partnership and Carers UK	14 September
Henry Spink Foundation	2 October
Law Commission	1 October
Lincolnshire County Council	5 October
Local Government Association	7 August
London ADASS regional branch meeting	12 October
Luton Older People's Partnership Board	18 October
Mencap	21 September
National Care Forum	8 August
National Conference on Adult Services	22-24 October
National Housing Federation	11 October
No Recourse to Public Funds network	19 October
Regional Action West Midlands/Regional Voices Birmingham	16 October
Regional Safeguarding Adults Leads event (Yorkshire and the Humber)	26 September
Right to Control Advisory Group	14 October
Royal College of Nursing	11 October
Royal National Institute for the Blind	23 October
Safeguarding Advisory Group	25 September
Sense	12 October
Skills for Care Board Meeting	27 September
Skills for Care Employer Forum	4 September
Society of Local Authority Chief Executives	4 October
Standing Commission on Carers	3 October
Standing Commission on Carers Cross-Government Programme Board	16 October
Surrey Care Association annual conference	9 October
Think Local Act Personal	26 September
Think Local Act Personal Co-Production Group	24 September
Voluntary Organisations Disability Group	20 September
Voluntary sector joint learning event (London)	11 September
Voluntary sector joint learning event (Sheffield)	1 October

## Summary of Analysis

The evidence considered in the development of the Act, as well as the extensive consultation and engagement work, has pointed to very substantial positive impacts of this Act, for a range of groups who have traditionally been disempowered.

The greatest benefits will be derived by older people requiring care; disabled adults; and carers.

One possible negative impact we have identified is around the provision of information about care and support by local authorities. This will need to be provided in appropriate formats and in the language required by local people. The duty placed upon local authorities is to provide information that is sufficient for its local population.

The evidence suggests that the Act will eradicate the current differential impact that exists due to the inconsistency of eligibility threshold across the country. This is part of the rationale for the Act.

## Eliminate discrimination, harassment and victimisation

Through the Act adult safeguarding boards are being strengthened. This will contribute to the prevention of discrimination, harassment and victimisation by tightening procedures to detect harm done to adults in need of care and support.

There is a general duty of well-being on local authorities. This strengthens the local authority's role and responsibility to ensure that adults receiving social care are protected from all forms of abuse and neglect.

We have sought to eliminate discrimination wherever possible both in primary legislation and in regulations and guidance. For example, the Care Act places a duty on local authorities to involve people in their care and support, including any assessment and care planning process. To ensure equality for those who lack the capacity to either understand their options or communicate their wishes, the Act also places a duty on local authorities to appoint an independent advocate for such a person where there is no one available to act on their behalf.

From April 2016, we will also be putting in place a new appeals system to ensure that people have an accessible and proportionate means of redress where they feel decisions about them have been unfair. This will build on and complement the existing complaints procedures for local Government.

## Advance equality of opportunity

The Act seeks to treat all groups equally. We believe it does this, and does not feature any discriminatory aspect.

The services that the Act addresses are bound by the existing Equality Duty. Care and Support services must therefore have due regard to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

We believe there is equal opportunity for all those with care needs to receive care and support.

## Promote good relations between groups

Not directly applicable. The Act deals with the rights of individuals. However, a knock-on effect of better services, better outcomes, and better equality of access to services should be to improve community

cohesion.

### What is the overall impact?

The overall impact will be to increase equality of access to services, both in socio-economic and geographical/regional terms. By increasing this equality, and thus driving up levels of service provision, there should be improved outcomes across the board. Furthermore, these outcomes should improve across all groups.

### Addressing the impact on equalities

Most notable areas of addressing current impacts on equalities:

- Rights and provisions for carers, which will have greatest benefits for women;
- Improved access to services, and strengthened offer around social care services, will have greatest benefits for older people and disabled adults.

### Action planning for improvement

We do not believe there are any gaps around equalities that we have not identified or considered. On this basis we do not believe or propose to develop an action plan. We will however monitor on an ongoing basis the impacts on different groups of the policies contained within the Act, and how they are implemented from 2015. This will include a specific data collection to assess implementation of care and support reform, including around equalities issues.

Please give an outline of your next steps based on the challenges and opportunities you have identified:

- The Act aims to mitigate any negative impacts around lack of accessibility due to language barriers by requiring local authorities to provide information that is 'accessible' to the local population.
- The Department of Health will strengthen this by providing guidance to local authorities to ensure that information is provided in appropriate formats and languages, which will enable accessibility to services.

### For the record

**Name of person who carried out this assessment: Phillip Anderson**

**Date assessment completed: 14 October 2014**

**Name of responsible Director/Director General: Clara Swinson**

**Date assessment was signed: 14 October 2014**



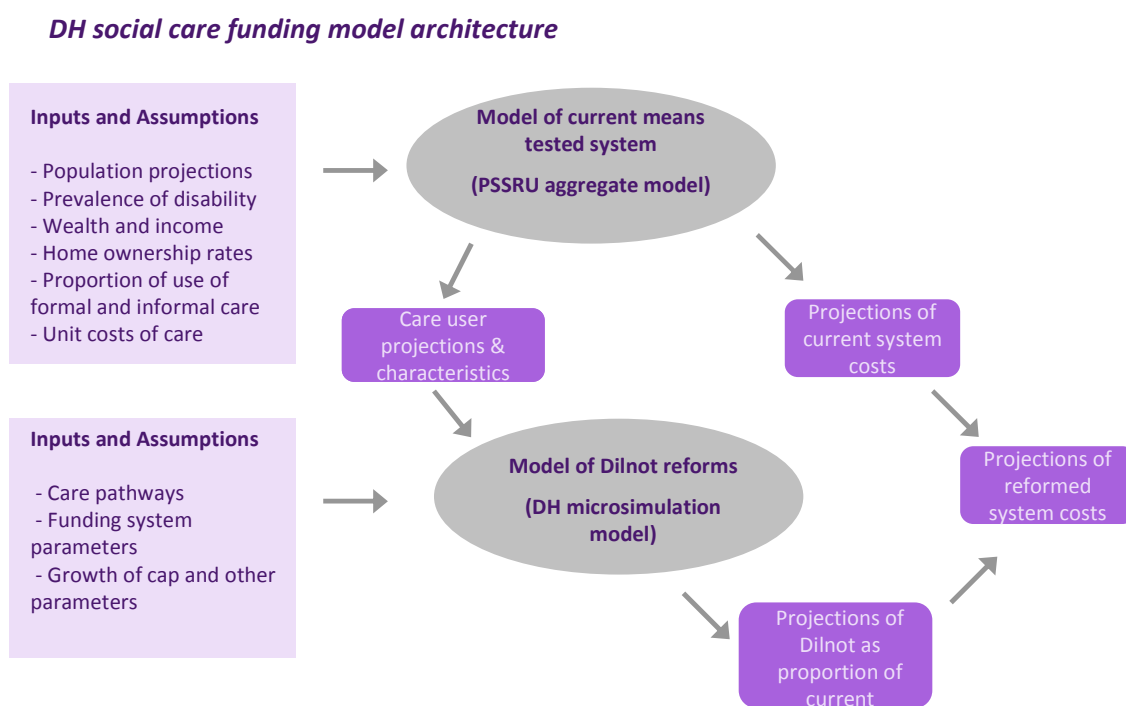
## Modelling of social care funding reforms

1. On this basis, we do not anticipate competition impacts. The costs presented in this Impact Assessment are projections of the likely costs. They are based on a series of assumptions about future trends in relevant factors, including demography, the prevalence of disability and unit costs of care services.
2. It should be noted that the costs have been estimated on the basis of national average data, and so are unlikely to fully reflect the variation in social, economic and demographic conditions in individual local authority areas.
3. This annex provides further information on the modelling and analysis used to estimate the costs of the reforms.

### Older adults

4. The increased public expenditure due to the increased state support for older adults due to the cap and extended residential care means test are modelled using the DH social care funding model. *The model does not make forecasts about the future.* It makes projections on the basis of specific assumptions about future trends.
5. The DH social care funding model is an excel-based micro-simulation model which runs using VBA code. DH analysts designed and developed the model to analyse different funding reform options, including changes to the social care means test and the implementation of a capped cost system. The key outputs of the model are total public spend on older adult social care and the distribution of spend by income and wealth of the different reforms. The model also allows the impact of different reforms to be analysed at an individual level.

**Figure A1: Older adults modelling architecture**

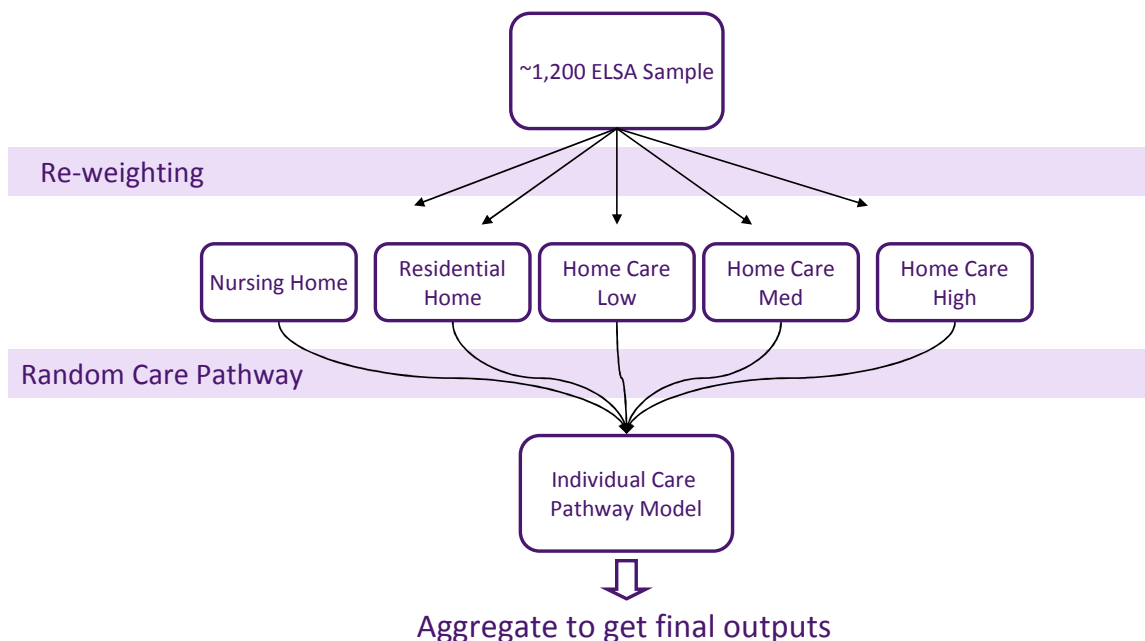


6. The DH model fits into a modelling architecture where the DH model takes inputs from the Personal Social Services Research Unit (PSSRU) aggregate model on

the future projections of the number of care users and their characteristics and the projected costs of the current system. This forms the baseline onto which the % increase in costs for the reformed system estimated by the DH model is applied to produce the final cost estimate.

7. The DH model is a cross-sectional model that retro speculatively simulates uncompleted care journeys of a representative cross section of care users in the cross-sectional month being modelled. It independently models October in the years 2010/11 to 2025/26. These yearly mid-point estimates are multiplied up to produce year estimates.
8. The base sample used in the model is the ADL (activity of daily living) disabled 65+ population from wave 4 of the English Longitudinal Study of Ageing (ELSA)<sup>6</sup>. It models 5 care settings separately; nursing homes, residential homes and 3 levels of home care (low, medium and high intensity).
9. For each care setting the model runs a representative sample through an individual care pathway model. The representative sample is generated by weighting the sample for each year and care setting using weights derived from outputs from the PSSRU aggregate model of the number and characteristics of care users.

**Figure A2: VBA structure of DH social care funding model**



10. Each individual in the sample is randomly assigned an uncompleted care pathway from a derived distribution of all uncompleted care pathways. The survey data used to derive the distribution is length of stay in (BUPA) care homes (PSSRU)<sup>7</sup>, Admissions to care homes and home care survey 2005 (PSSRU)<sup>8</sup> and 2006 User Experience Survey<sup>9</sup>. Monte-carlo methods are used to average out the variation in outputs resulting in the random selection of care pathways.
11. The individual care pathway model computes the state and private spend for each month of the care pathway; this is dependent on the individual's

<sup>6</sup> <http://www.ifs.org.uk/ELSA>

<sup>7</sup> PSSRU DP 2769 – Jan 2011 – Commissioned by BUPA

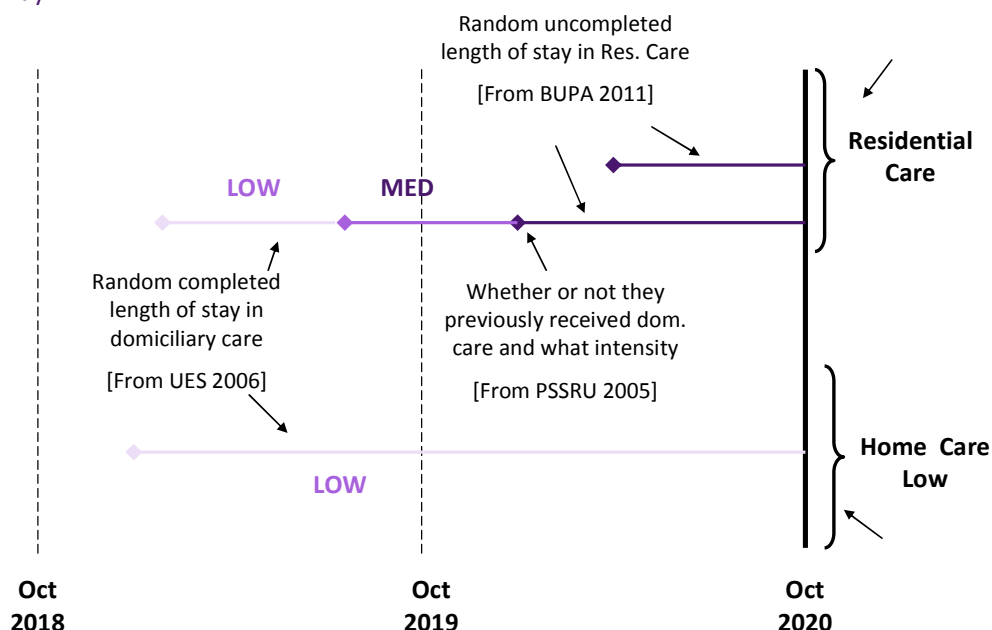
<sup>8</sup> PSSRU DP 2265/3 – July 2006

<sup>9</sup> User Experience Survey 2006

characteristics (income, wealth, household type, housing tenure) and the funding system being modelled. The quantities of the cross-sectional month are aggregated using the weights to produce population level estimates.

### Figure A3: Modelling of uncompleted care journeys

Each person in care at the cross section is assigned a randomly assigned uncompleted care pathway



### Assumptions in the PSSRU aggregate model

12. The majority of the assumptions are relevant to the projections of future costs for the current system, as well as projected the increased spend of the reformed system. From the interaction with the PSSRU aggregate model these assumptions follow through into the projections of cost of the reforms

13. The key assumptions in the PSSRU aggregate model are:

- | KEY ASSUMPTIONS OF THE BASE CASE OF THE PSSRU MODEL  |
|--|
| <ul style="list-style-type: none"> <li>• The number of people by age and gender changes in line with the Office for National Statistics (ONS) 2008-based population projections.</li> <li>• Marital status changes in line with GAD 2008-based marital status and cohabitation projections.</li> <li>• There is a constant ratio of single people living alone to single people living with their children or with others and of married people living with partner only to married people living with partner and others.</li> <li>• Prevalence rates of disability by age group (65-69, 70-74, 75-79, 80-84, 85) and gender remain unchanged, as reported in the 2001/2 General Household Survey (GHS) for Great Britain.</li> <li>• Home-ownership rates, as reported in the 2001/2 Family Resources Survey (FRS), change in line with projections produced by the University of East Anglia.</li> <li>• The proportions of older people receiving informal care, formal community care services, residential care services and disability benefits remain constant for each sub-group by age, disability and other needs-related characteristics.</li> </ul> |

- Health and social care unit costs remain constant in real terms to 2015 and then rise by 2% per year in real terms (but non-labour non-capital costs remain constant in real terms).

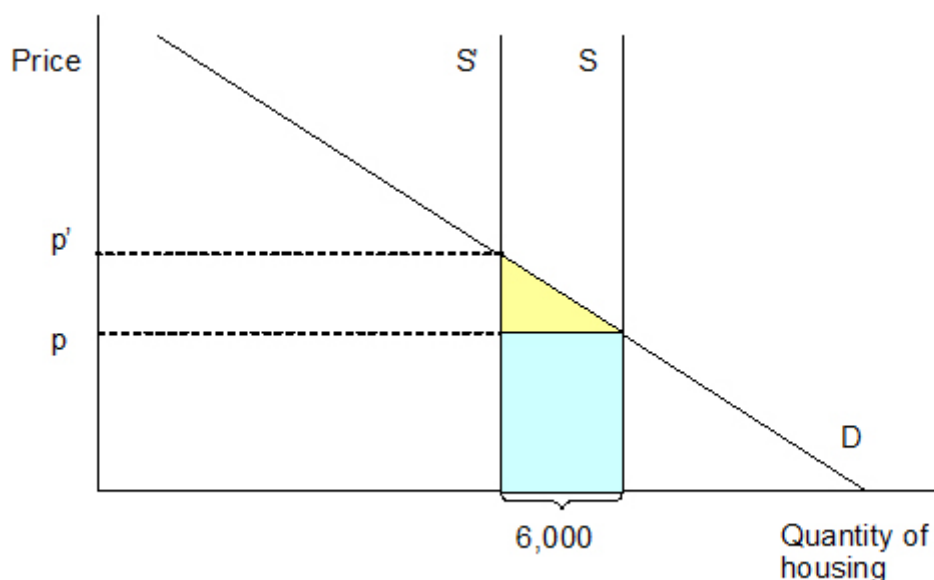
## Social welfare effects of empty homes

1. This analysis assumes that about 6,000 are homes being withdrawn from the housing market (by 2015/16), as their owners take out a deferred payment *and* decide not to rent out their property.
2. This Annex sets out the potential welfare implications of this reduction in housing supply. It should be noted that the calculations in this Annex operate under a number of simplifying assumptions:
  - The housing market in England can be thought of as one unified market. In reality, there are many local housing markets, in which demand and supply elasticities, as well as the incidence of deferred payments will vary;
  - Supply of housing is inelastic (this assumption is relaxed later on in this Annex);
  - The housing market works in a frictionless manner, so that even small price pressures are passed on to consumers (the impact of this assumption is discussed below).

### *Impact of a reduction in supply under inelastic supply*

3. Figure B.1 demonstrates the impact of a reduction in the supply of housing, under the – simplifying - assumption that supply for housing is perfectly inelastic in the short run. In the figure:
  - D is the demand for housing (and the marginal benefit of housing)
  - S and S' are the supply for housing before and after the introduction of universal deferred payments (assumed to be perfectly inelastic otherwise)
  - p and p' is the market price before and after the change.

**Figure B.1 – Empty homes resulting from supply shock (inelastic supply)**



4. If supply is perfectly inelastic, in the short run, the number of occupied homes will decrease by 6,000 because of the additional deferred payments taken out. This reduction will have three major impacts:
  - A reduction in consumer surplus as some people are priced out of the market and lose the use value of accommodation (minus the cost, e.g. the rent) – this is the yellow triangle;

- Prices in the housing market (i.e. house prices and rents) will increase and, as a result, there is a transfer of wealth from buyers/renters to sellers/landlords – this is the rectangle to the left of the yellow triangle.
  - A loss of producer surplus: rent (or equivalent income) foregone to people taking out a deferred payment.
5. In a first step, we quantify these welfare effects under the assumption of inelastic supply, before relaxing that assumption.
  6. **Loss of consumer surplus:** The loss of consumer surplus associated with the reduction in available housing is equal to the area of the yellow triangle. As we can see from the above figure, the size of this area will be determined by the gradient of the demand curve, i.e. the price elasticity of demand. The more elastic the demand for housing, the less housing prices will need to rise to squeeze out the excess demand resulting from the reduction in supply.
  7. We estimate the relevant elasticity of demand to be around -0.5<sup>10</sup>. This suggests that a 1% increase in prices will, all other things being equal, reduce the quantities of housing demanded by 0.5%.
  8. A reduction in the housing supply by 6,000 homes is equivalent to a shift in supply by 0.027% (as there are about 22m households in England)<sup>11</sup>. With an elasticity of demand of -0.5 and based on our assumption of perfectly inelastic supply, this can be expected to push up prices by 0.055% (=0.027%/0.5\*1).
  9. Assuming an average rent of £1000<sup>12</sup> per month, or £12,000 per year, this would result in a small increase in housing prices per household of approximately £6.5 per year. Based on this, we can calculate the loss in consumer surplus as the area of the yellow triangle:

$$\begin{aligned} \text{Consumer surplus loss} &= \frac{1}{2} * \text{change in quantities} * \text{change in prices} \\ &= \frac{1}{2} * 6,000 * £6.5 = \mathbf{£20,000 \text{ per year}} \end{aligned}$$

10. **Effect on market rents and transfer:** In figure B.1, the reduction in housing supply leads to an increase in annual housing prices by £6.5 per year. Across the 22m households in England, this is a transfer of £144m per year from renters/sellers to landlords/ buyers. However, as will be set out below, the actual increase in prices will be mitigated as supply is not perfectly inelastic. Instead, part of the excess demand will be met by an increase in the number of houses supplied, so that the overall increase in prices will be less than indicated.
11. **Foregone rental income:** Finally, as 6,000 homes are taken off the market and may not be rented out, their owners may forego the potential income from renting (or, indeed, selling them). At a rent of £12,000 per year, this is could be a total reduction in rental income of £72m per year. The social welfare effect of this potential reduction in rental income is uncertain:
  - As people decide not to rent out their house, they must value doing so more than the rent foregone, so that, arguably, they do not lose out;

<sup>10</sup> This is at the higher range of what is identified in the literature: Ermisch et al 1996 estimate it to be: -0.35 while King 1980 estimates it to be -0.5.  
Ermish et al: 'The Price Elasticity of Housing Demand in Britain: Issues of Sample Selection', Journal of Housing Economics, Vol. 5, pp.64-86.  
King 1980: 'An Econometric Model of Tenure Choice and Demand for Housing as a Joint Decision', Journal of Public Economics, 14, 137-159.

<sup>11</sup> DCLG English Housing survey 2010/11:  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/6739/2173283.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6739/2173283.pdf)

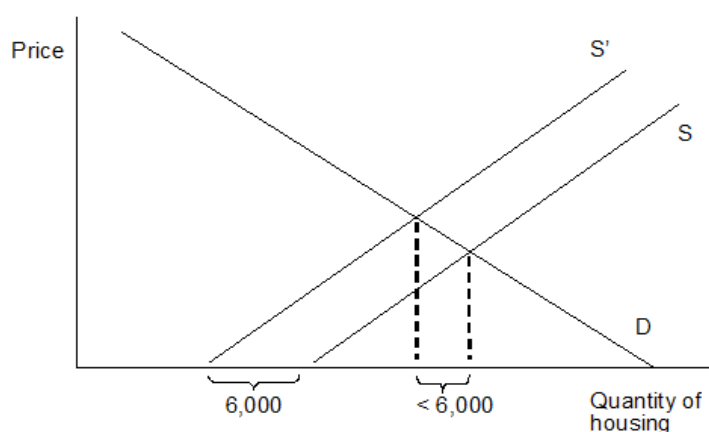
<sup>12</sup> This is above the average rent in England GBP731, as shown here:  
[http://www.lslps.co.uk/documents/buy\\_to\\_rent\\_index\\_feb13.pdf](http://www.lslps.co.uk/documents/buy_to_rent_index_feb13.pdf). However, we take £1,000 per month to be a cautious approximation of the equivalent price of the average household, to take into account that owned property may well be bigger, and therefore on average more expensive than the average rented property.

- However, there is a risk that they misjudge their own utility;
- People in residential care may value the additional income generated from renting less because they have little consumption use out of it. Its value to their family may be higher, so that there could be an externality imposed where homes go unrented. However, in practice, the risk of this externality is often mitigated because people's families are likely to be involved in the decision-making and, indeed, the management of the rental process. Maintaining one's assets for one's heirs is one likely motive of people taking out a deferred payment, so that people may well factor in their families interests when making the decision whether or not to rent.

### **Calculating the shift in prices and quantities under elastic supply**

12. The above presentation is limited by the assumption that supply is perfectly inelastic. In reality, however, the supply for housing is likely to be at least somewhat elastic, as higher prices attract both more building activity (in the medium run), but also set incentives for landlords to ensure their property is let out.

**Figure B.2 – Empty homes resulting from supply shock (elastic supply)**



13. As a result, as figure B.2 shows, the final reduction in the number of available homes resulting from the introduction of universal deferred payments will be less than 6,000 and, consequently, the increase in market prices will be less than indicated above.
14. We estimate that the elasticity of supply ranges between 0.28<sup>13</sup> and 0.45<sup>14</sup> and, as our central estimate, take it to be about 0.35. The overall effect on prices will depend on the interaction of demand and supply elasticities.
15. We can estimate this impact by calculating approximate inverted, linear demand and supply curves:

$$\text{Quantity demanded (in million homes)} = X - a * p \text{ (price in } \text{£ per year)}$$

$$\text{Quantity supplied (in million homes)} = Y + b * p \text{ (price in } \text{£ per year)}$$

Where:

- X and Y are the quantities demanded/supplied (in millions) if the price of housing is zero;
- a and b are the slope coefficients of demand and supply.

<sup>13</sup> Levin and Price 2009: Understanding the Drivers of the Price Elasticity of House Supply and the role of Real Interest Rates and Cyclical Asymmetries  
[http://www.gwilympryce.co.uk/housing/Levin\\_&\\_Pryce%20\\_HousingSupply.pdf](http://www.gwilympryce.co.uk/housing/Levin_&_Pryce%20_HousingSupply.pdf)

<sup>14</sup> OECD 2011: Housing markets and structural policies in OECD countries, Economics Department Working Paper No.836

16. For the demand curve, we know that:
- Given a demand elasticity of -0.5, a 1% change in prices (£12,000\*1%= £120) will lead to a 0.5% change in quantities demanded (£22m \* 0.5% = 0.11m)
  - Therefore the slope of the inverted demand curve is:  
a = change in quantity/ change in price = 0.11/ 120 = 0.000917
  - At a price of £12,000, the quantity demanded is 22 (million). This allows us to solve for  $X = 22 + 12,000 \cdot 0.000917 = 33$
  - This gives the inverted demand curve:  $D = 33 - 0.000917 \cdot p$
17. For the supply curve, we know that:
- Given a supply elasticity of 0.35, a 1% change in prices (£12,000\*1%= £120) will lead to a 0.35 change in quantities supplied (£22m \* 0.35% = 0.077m);
  - Therefore the slope of the inverted demand curve is: a = change in quantity/ change in price = 0.077/ 120 = 0.000642;
  - At a price of £12,000, the quantity supplied is 22 (million). This allows us to solve for  $Y = 22 - 12,000 \cdot 0.000642 = 14.3$
  - This gives the inverted supply curve:  $S = 14.3 + 0.000642 \cdot p$
18. Equilibrium is given where Demand = Supply, i.e.:
- $33 - 0.000917 \cdot p = 14.3 + 0.000642 \cdot p$
  - $18.7 = 0.001558 \cdot p$
  - $p = 18.7 / 0.001558 = 12,000$
19. As 6,000 houses are taken off the market, the supply curve shifts to the left by 6,000 units of housing, which can be described by a reduction in Y by 0.006 (million homes). The new supply curve is thus:

$$S' = 14.294 + 0.000642 \cdot p$$

20. The new equilibrium is where  $S' = D$ :
- $33 - 0.000917 \cdot p = 14.294 + 0.000642 \cdot p$
  - $18.706 = 0.001558 \cdot p$
  - $p = 12,003.85$
21. The new equilibrium price is thus: £12,003.85 per year. In other words, taking into account supply and demand elasticities, we expect an increase in average prices/ rents by £3.85 per year.
22. The resulting quantity of homes can be estimated by inserting this result into the demand curve:
- $D = 33 - 0.000917 \cdot £12,003.85 = 21.996470$  or 21,996,470 homes.
23. In other words, the number of homes falls by 3,530 (=22,000,000 – 21,996,470) rather than 6,000 as estimated under the assumption of inelastic supply.

### ***Welfare effects under elastic demand and supply***

24. **Effect on market rents and transfer:** Prices are estimated to increase by £3.85 per household per year. Using the same line of reasoning as in para B10, this results in a transfer of about £85m per years from buyer/renters to sellers/landlords (=£3.85\* 22m). From a societal perspective, this transfer is a priori neutral. However, to the degree that homeowners and landlords are more wealthy than renters and buyers, there may be a loss of social welfare resulting from a transfer to these groups.



25. This is particularly the case in the private rental market (17% of all households<sup>15</sup>), while it may or may not be the case in the owner-occupier segment of the market (66% of the market), depending on individual circumstances. Indeed, in some cases, the buyer may very well be more wealthy/ have more income than the seller (e.g. where people scale down because they cannot afford to maintain the larger property or because they need to access the wealth stored in the house).
26. We approximate the potential welfare loss by assuming that, in the private rental sector any increase in rents is a transfer from a group in the second income quintile (renters) to a group in the top quintile (landlords). Using Green Book equity weights for these income groups<sup>16</sup>, this suggest a social welfare loss of about **£13m per year** ( $=£85m * 17% * (1.3- 0.4)$ , where the latter term is the difference between the suggested equity weights for these groups).
27. However, it should be noted that this welfare loss will only occur under the condition that markets function in a frictionless enough way to pass on this small, one-off supply shock. As with other goods, suppliers of housing factor in “menu costs” and wider pricing strategies when deciding whether or not to adjust prices. For instance, rents are typically adjusted in steps of £10s per month, while the price pressure resulting from 6,000 empty homes is thought to result in an average increase in prices of about £0.30 per month, suggesting that the price pressure may not be passed on to consumers.
28. **Effect on rents foregone:** Elastic demand also suggests that the overall volume of rents foregone is less than predicted, when considering inelastic supply. While about 6,000 homeowners take their home off the market as a result of deferred payments, other landlords (or sellers) fill some of the supply shortage by putting previously unused properties on the market. As a result the total rent foregone adds up to **£42m** per year ( $=3,500 \text{ homes} * £12,000 \text{ per year}$ ). As above set out above, the social welfare effect of this reduction in rental income is uncertain as people *decide* not to rent out their house, they must value doing so more than the rent foregone.

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<sup>15</sup> English Housing Survey 2010/11:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/6739/2173283.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6739/2173283.pdf)

<sup>16</sup> [http://www.hm-treasury.gov.uk/d/green\\_book\\_complete.pdf](http://www.hm-treasury.gov.uk/d/green_book_complete.pdf), p94

## Updated assumptions on take-up

### Adjustments to deferred payments cost modelling for DH SR bid

1. This section outlines the adjustments to DPA cost estimates ahead of the DH Spending Review which were not accounted for in previous versions of this Impact Assessment. In particular, the original cost estimates for the universal deferred payment scheme did not consider:
  - The time it takes for a deferred payment to be repaid after someone's death ("probate");
  - Deferrals taken out by people who have been in care before January 2015 and may become eligible and take one out after April 2015 ("backlog");
  
2. **Probate:** The "probate" issue refers to repayments of deferred payments agreements (an estimated 70% of all DPAs) that end when the person who took it out dies. In these cases, typically, it will take some time to sell the home and repay the loan. To account for this delay, the DH costing model has been updated to incorporate an average delay in repayments of one quarter which increases costs in 2015/16 by about 10%.
  - i. Deferred payments can end either because the person who took out the deferral has sold their home or because they have died. Where the person has died, there will typically be a probate period, during which the estate is in question is in administration and, thus, cannot be sold.
  - ii. As a result, repayments will happen later than originally modelled (by at least the probate period). This note calculates the average delay on repayment resulting from probate and proposes an adjustment to the current model.
  - iii. **Deferrals ending when the home is sold:** We estimate that 30% of deferrals end when the home is sold. For these deferrals, there will be no delay.
  - iv. This estimate is derived by comparing the average likelihood that a care home resident will die in any given year to the likelihood that their deferred payment agreement will end.
  - v. **Probate when the person dies:** The remaining 70% of deferrals end at the death of the person taking out the deferral.
  - vi. For these deferrals, there will be a probate period of 10 to 15 weeks, depending on whether inheritance tax has to be paid.<sup>17</sup>
  - vii. Based on the distribution of house prices, we estimate that inheritance tax will affect about 50% of all deferrals.<sup>18</sup> This suggests an average probate period of 12.5 weeks for 70% of deferrals, or, an average of 8.6 weeks for all deferrals (=12.5 \* 70%).
  - viii. Assuming it then takes 10 weeks on the market to sell a home<sup>19</sup>, this means that it takes, on average, 16 weeks ( = 8.6 + 10\*70%) from the end

<sup>17</sup> <http://www.netprobate.co.uk/probate-how-long.html>

<sup>18</sup> <http://www.hmrc.gov.uk/rates/ihl-thresholds.htm>

<sup>19</sup> Hometrack 2012: Monthly National Housing Survey, [http://www.hometrack.co.uk/hpsurvey/documents/RDHTSurveyDec2012CMS\\_21122012153607.pdf](http://www.hometrack.co.uk/hpsurvey/documents/RDHTSurveyDec2012CMS_21122012153607.pdf)

of a deferred payment until it is repaid.

3. **Backlog:** The original deferred payment model only includes deferred payments taken out by people who enter residential care after January 2015. However, there will also be no demand for deferred payments by people who have been in residential care before January 2015 (except where deferred payments are already offered as part of the voluntary scheme, which is not part of this costing). These self-funders fall into three main groups:
  - **Group A:** Self-funders who have gone into residential care before January 2015, but who have run out of liquid savings before April 2015.
  - **Group B:** Self-funders who have gone into residential care before January 2015, but who only become eligible after April 2015 as their liquid assets fall below £40,000 (liquid asset threshold).
  - **Group C:** Self-funders who have gone into residential care before January 2015 and who have less than £40,000 before April 2015. In some authorities, they will be able to take out a deferral before April 2015. In others, they may become eligible in April 2015 provided they have not already sold their home.
4. Assumptions on take-up for these groups and duration to estimate the cost of deferrals for self-funders who have been in care before January 2015:
  - **Group A:** we expect that this group will have sold their home and therefore, will not demand a deferred payment.
  - **Group B:** Take-up of deferred payments by 11.4% of all self-funders, life-time loans only;
  - **Group C:** Take-up equating to 5.7% all self-funders, life-time loans only;

***Group B - care before January 2015, falling under the liquid asset threshold after April 2015***

5. Some of the demand for deferred payments is for short-term deferred payments, which people use as “breathing space” while they sell their home. Self-funders who have been in care before January 2013 are less likely to need this type of deferral, because they already had time to sell their home. Even where they take-up a short-term deferral, they are likely to sell their home and repay the deferred payment within the same year. As a simplifying assumption, we assume there are no short-term deferrals by self-funders in care before January 2015, resulting in lower take-up by this group.
1. **Estimating number of short-term deferrals:** We know that about 47% of deferred payments end within the first year. This includes deferrals which
    - End because people repay early, i.e. breathing space loans, where people sell their house quickly.
    - End because people, who do not plan to terminate their loan, die within the first year.

2. We can summarise this relationship in the following equation:

$$47\% = STL + m * (1 - STL)$$

Where

- STL = short-term loans people want to terminate within the first year
- m = mortality rate in the first year

3. We use BUPA data on mortality in care homes as an estimate of the mortality in the first year of a deferral (35%) and solve the above equation to find that approximately 18.5% of all deferrals are short-term loans.

$$47\% = \text{STL} + 35\% * (1 - \text{STL})$$

$$\rightarrow 47\% = \text{STL} + 35\% - 35\% * \text{STL}$$

$$\rightarrow 12\% = 65\% * \text{STL}$$

$$\rightarrow \text{STL} = 12/65 = 18.5\%$$

4. **Take-up estimate:** We estimate that the take-up of deferred payments by self-funders, who have been in care before January 2015, is similar to take-up by those entering care after January 2015 (which for the central scenario is 14% of self-funders in 2015/16), but excludes short-term deferrals.
5. Therefore, we estimate that about 11.4% of eligible self-funders in group A (=14.0% \* (1- 18.5%)) take out a (long-term) deferral.
6. **Duration of deferrals:** As people in this group take-out long-term deferrals only, we assume that the length of their deferrals is determined by their life expectancy. We model this using BUPA mortality data.

***Group C –care before January 2015 and below the liquid asset threshold by April 2015***

7. Self-funders in this group may already receive a deferred payment if they live in an authority which offers them. Otherwise, they will become eligible in April 2015 unless they have sold their home.
8. We estimate the take-up of deferred payments in this group by
- excluding self-funders already receiving deferred payments (estimated at 11% based on the DH survey of local authorities); and
  - excluding all short-term deferrals (as discussed for group B).
9. Based on this, we estimate that approximately 16.5% of eligible self-funders in this group will take out a deferred payment in April 2015:

$$14\% - 7\% = 7\%$$

$$7\% * (1 - 18.5\%) = 5.7\%$$

10. **Duration estimate:** As for group B.

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<sup>i</sup> <https://www.gov.uk/government/publications/adult-social-care-efficiency-tool>