



Department  
of Health &  
Social Care

# **Health and Care Act 2022**

## **Impact Assessments for Adult Social Care Provisions**

Published 4 November 2022

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# Introduction

The Health and Care Act 2022 builds on the proposals brought forward by the NHS in the Long-Term Plan, and the collaborative working seen throughout the pandemic and shape a system which is best placed to serve the needs of the population.

Firstly, the Act removes barriers which stop the system from being truly integrated, with different parts of the NHS working better together, alongside local government, to tackle the nation's health inequalities. Secondly, the Act reduces bureaucracy across the system, as the Department of Health and Social Care (DHSC) wants to remove barriers which make sensible decision-making harder and distracts staff from delivering what matters – the best possible care. Lastly, DHSC wants to ensure appropriate accountability arrangements are in place so that the health and care system can be more responsive to both staff and the people who use it.

Alongside the core measures the Health and Care Act 2022 brings forward additional provisions to make targeted changes to allow the government to support the social care system.

This document contains the Impact Assessments (IAs) for three provisions to support social care, namely Discharge to Assess, Provider Payments and Assurance Provisions.

# Policies

The Health and Care Act 2022 brings forward various additional measures to support social care. This document covers three of these provisions, namely Discharge to Assess, Provider Payments and a new Assurance Provisions. Each of these provisions is briefly summarised below. The associated full Regulatory Impact Assessments can be found in the Annex.

## **Discharge to assess**

At the moment, if an individual requires additional adult social care (ASC), NHS Continuing Healthcare (CHC) or NHS-funded Nursing Care (FNC) support following hospital discharge, the Care Act 2014 (Schedule 3) requires health and social care professionals (as appropriate) to assess the individual pre-discharge and develop a package of care. This process has led to delayed discharges for some patients, which are associated with poorer patient outcomes (e.g. loss of independence or muscle deterioration), additional expense to the NHS, and more complex or higher levels of need on discharge.

We are therefore proposing to remove this legislative requirement to enable health and social care partners to work together more effectively and create flexibility for assessments to take place when most appropriate for the individual. This would support safe and timely discharge and enable assessments to take place at a point of optimum recovery, where it is more likely to be possible to make an accurate assessment of their longer-term needs.

The estimated Net Present Value (NPV) associated with this change over a ten-year appraisal period is -£0.3m. This is the cost for NHSE and local authorities to familiarise themselves with the proposed legislation change. We have not identified any other direct costs and benefits associated with the preferred option as it would be voluntary for local areas to follow D2A principles. If local areas chose to follow D2A principles, the impacts would depend critically on the approach they would take (which would vary case-by-case). For illustrative purposes, the Impact Assessment contains an indicative assessment of the societal impact under the assumption that between 50% and 100% of local areas would follow D2A guidance and that patients were entitled to six weeks of state-funded recovery services post discharge.

## **Provider payments**

Existing legislative powers allow the Secretary of State for Health and Social Care to make payments to, or for the establishment of, not-for-profit providers of social care in England. The Secretary of State currently does not have the authority to provide such payments directly to profit-making care providers. Publicly funded adult social care in England is commissioned by local authorities who maintain contracts directly with private for-profit providers, who will in turn provide services to both users who are publicly funded, and those who fund their own care. Local authorities fund the care they arrange through a mixture of central government grant funding, locally raised council tax and business rates, means-tested user contributions and income from the NHS.

Legislative changes in the Health and Care Act will widen this power, allowing the Secretary of State to make direct payments to all social care providers, regardless of whether they are profit-

making or not-for-profit bodies, so that this legal mechanism more accurately reflects the market and can be used to deliver direct support to the sector as required, placing social care on the same footing as publicly provided healthcare and other sectors. This will streamline future financial support and will ensure HMG is better prepared to respond to emergency or unique situations facing the sector in future.

As the change is an enabling power, we do not foresee any direct impacts as a result of the change. However, we have assessed the potential impacts of future uses of the power. We estimate that this could be associated with a net cost of between £0.2m and £1.5m over a ten-year appraisal period associated with the facilitation of payments. These costs would entirely be borne by DHSC. Unquantified benefits include faster delivery of social care services and associated public health and wellbeing benefits and a reduction in administrative burden on local authorities and there would not be any impact on businesses.

### **Enhanced assurance**

Adult Social Care (ASC) provides vital support and care to people who depend on it for their health and wellbeing. Currently, while local authorities have a legal duty to provide ASC, there is not a regular means for evaluating what they are doing well and what needs to improve. There is a lack of data available with which local populations can hold local authorities to account and we therefore cannot be sure that every person who relies on ASC is getting the high-quality care they deserve. The National Audit Office (NAO)'s 2021 report on the adult social care market in England recognised that current accountability and oversight arrangements are ineffective. In particular, the report highlights the Department of Health and Social Care (DHSC)'s lack of visibility of the effectiveness of local authority commissioning and states that the Department is unable to evaluate spending, or the extent of additional funding needed.

Through the Health and Care Act 2022, DHSC is amending the Health and Social Care Act 2008 and the Care Act 2014 to: create a duty for the CQC to review and make an assessment of local authorities' delivery of their Care Act 2014 adult social care functions; enable the Secretary of State to take action, when a local authority is failing to discharge its social care functions.

The costs and benefits of the scheme, both direct and indirect, will be highly dependent on the detail of the approach (scope, frequency, intensity etc) which is yet to be determined. As such, we have chosen to only include a subset of the direct costs in the full economic assessment costs - these costs are considered the direct costs to DHSC through the administrative costs to CQC and local authorities of assessment and the associated familiarisation costs and have a present value cost of £40m. For purposes of providing the potential impacts of the assurance system and their associated magnitudes, we have included an indicative costs and benefits section to show additional quantified costs (although these contain more uncertainty and are highly dependent on the detail of the approach) and a break-even analysis which suggests that the benefits to care users alone are likely to outweigh the costs. Given that the enhanced assurance system is expected to also bring benefits other than improved care outcomes (such as an improved offer to the workforce and NHS savings), we feel that this intervention provides value for money. There would not be any direct impact on businesses.

# Specific Impact Tests

## **Equality**

The policy measures in the accompanying IAs have undergone a full equalities assessment as appropriate.

## **Human Rights**

There are no foreseen impacts on human rights.

## **Privacy**

There are no foreseen direct impacts of the provisions on privacy.

## **Justice System**

There are no foreseen Justice impacts.

## **New burdens**

The measures relating to social care assurance and discharge to assess may have impacts on local authorities and have therefore completed a new burdens assessment.

## **Competition and innovation**

There are no foreseen impacts on competition and innovation.

# Post Implementation Review (PIR)

The government is committed to evaluating the policies it implements. In line with this, a PIR should be undertaken usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. A PIR should examine the extent to which the implemented regulations: have achieved their objectives; are having any unintended consequences; have objectives that remain appropriate; are still required and remains the best option for achieving those objectives; and, whether the objectives could be achieved in another way which involves less onerous regulatory provision to reduce the burden on business and/or increase overall societal welfare<sup>1</sup>.

While in most cases, specific plans for the PIR cannot be finalised until the final form of the policy, and the specific outcomes it is likely to affect, are known, initial planning for the PIR is currently underway, as detailed in the individual IAs.

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<sup>1</sup> Department for Business, Energy and Industrial Strategy, "Producing Post Implementation Reviews", July 2018. [Online]. Available: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/726992/producing-post-implementation-reviews-pir.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/726992/producing-post-implementation-reviews-pir.pdf)

# Annex A – Regulatory Impact Assessment – Hospital Discharge

<p><b>Title:</b> Hospital discharge legislation  <b>IA No:</b> 9576  <b>RPC Reference No:</b> RPC-DHSC-5082(1)  <b>Lead department or agency:</b> DHSC  <b>Other departments or agencies:</b> Department for Levelling Up, Housing and Communities (DLUHC)</p>	<p><b>Impact Assessment (IA)</b>  <b>Date:</b> 27/10/2022  <b>Stage:</b> Final  <b>Source of intervention:</b> Domestic  <b>Type of measure:</b> Primary legislation  <b>Contact for enquiries:</b>  <a href="mailto:Louise.Jordan@dhsc.gov.uk">Louise.Jordan@dhsc.gov.uk</a></p>		
<p><b>Summary: Intervention and Options</b></p>	<p><b>RPC Opinion:</b> GREEN</p>		
<p align="center"><b>Cost of Preferred (or more likely) Option (in 2019/20 prices)</b></p>			
<p><b>Total Net Present Social Value</b> £6,500m</p>	<p><b>Business Net Present Value</b> -£0.06m</p>	<p><b>Net cost to business per year</b> -£0.01m</p>	<p><b>Business Impact Target Status</b> Qualifying provision</p>
<p><b>What is the problem under consideration? Why is government action or intervention necessary?</b>          If an individual requires additional health or adult social care support following hospital discharge, health and social care professionals must work together to assess the individual and develop a package of care. The Care Act requires assessments to take place pre-discharge. This process can delay discharge, resulting in poorer patient outcomes (e.g. loss of independence or muscle deterioration), additional expense to the NHS, pressure on hospital beds so it is harder to give prospective in-patients the healthcare they may need, and more complex or higher levels of care on discharge. Removing this legislative requirement would enable health and social care partners to work together more effectively and create flexibility for assessments to take place when most appropriate for the individual.</p>			
<p><b>What are the policy objectives of the action or intervention and the intended effects?</b></p> <ul style="list-style-type: none"> <li>- To support safe and timely discharge of individuals to maximise their health and wellbeing outcomes (e.g. reduce hospital readmissions, support people back into their own homes more often) by enabling local areas to adopt discharge processes that best meet local needs, which should also improve collaborative working across sectors.</li> <li>- To enable assessments to take place at a point of optimum recovery, so future care decisions are made when they are most likely to be accurate and supportive.</li> <li>- To reduce pressure on NHS staff and facilities by ensuring that individuals do not remain in hospital beyond a time when they no longer need hospital care.</li> <li>- To support the NHS to operate on best value for money principles, enabling them to target resources where they are most needed.</li> </ul>			
<p><b>What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)</b></p> <ul style="list-style-type: none"> <li>- Option 1: Do nothing – <b>rejected</b> because growing evidence suggests a focus on safe and timely discharge once patients no longer require hospital care is better for patient outcomes. Discharge with assessment following a period of recovery is inconsistent with current legislation, which requires assessments for longer-term needs to be completed before discharge.</li> <li>- Option 2: Introduce a new legislative model requiring assessment post-discharge and ensuring that carers and patients are involved in discharge planning. – <b>rejected</b> because strong feedback from health and social care partners suggested the possible legal options risked undermining rather than promoting collaborative working, which would be counterproductive to our policy aims.</li> <li>- Option 3: Remove current legislative barriers to assessing post-discharge – (<b>preferred option</b>): enabling local areas to work in partnership to adapt approaches that best meet local needs and ensuring that carers and patients are involved in discharge planning. Growing evidence suggests that discharging patients to recover at home and then be assessed for their long term needs is the most effective and feasible way to improve patient outcomes, with a strong expectation that overall societal benefits will outweigh costs, due to better patient outcomes, less requirement for long-term care provision and more efficient allocation of acute NHS capacity.</li> </ul>			
<p><b>Will the policy be reviewed?</b> It will be reviewed. The review date has not been agreed yet.</p>			




***I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a***

Is this measure likely to impact on international trade and investment?	No			
Are any of these organisations in scope?	<b>Micro Yes</b>	<b>Small Yes</b>	<b>Medium Yes</b>	<b>Large Yes</b>
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? <b>N/A</b> (Million tonnes CO <sub>2</sub> equivalent)	<b>Traded: N/A</b>		<b>Non-traded: N/A</b>	

***reasonable view of the likely costs, benefits and impact of the leading options.***

Signed by the responsible Minister:



Date:

27/10/2022

## Summary: Analysis & Evidence

## Policy Option 1 (Do nothing)

**Description:** Do nothing. If we did not revoke legislation, local areas would be required by law to assess patients before hospital discharge.

### FULL ECONOMIC ASSESSMENT

Price Base	PV Base	Time Period	Net Benefit (Present Value (PV)) (£m) N/A		
2019/20	2020	10 years	Low: N/A	High: N/A	Best Estimate: N/A

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value)
Low	N/A	N/A	N/A
High	N/A	N/A	N/A
Best Estimate	N/A	N/A	N/A

**Description and scale of key monetised costs by 'main affected groups'**  
 There are no costs or benefits associated with this option. **This is the baseline against which all other options are appraised.**

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

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

**Description and scale of key monetised benefits by 'main affected groups'**  
 There are no costs or benefits associated with this option. **This is the baseline against which all other options are appraised.**

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

Key assumptions/sensitivities/risks	Discount rate
N/A	N/A

### BUSINESS ASSESSMENT (Option 1)

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

**Description:** Legislation making it mandatory to conduct long-term needs assessment post-discharge

## FULL ECONOMIC ASSESSMENT

Price Base	PV Base	Time Period	Net Benefit (Present Value (PV)) (£m)		
2019/20	2020	10 years	Low: N/A	High: N/A	Best Estimate: £7,600

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value)
Low	N/A	N/A	N/A
High	N/A	N/A	N/A
Best Estimate	£0.4m	£1,100m	£9,300m

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

- **Health and ASC sector:** A total ongoing cost of approximately £7.2bn to provide additional recovery services and an additional coordination cost of approx. £1.8bn over 10 years. Additionally, there is an ongoing cost for identifying and consulting with unpaid carers of approx. £0.3bn over 10 years.
- **NHSE:** A one-off familiarisation cost of £0.3m.
- **Local authorities:** A one-off familiarisation cost of approx. £0.02m.
- **Care Providers:** A one-off familiarisation cost of approx. £0.06m

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

- Unpaid Carers: carers should always be actively involved in discussions about discharge, to discuss whether they are willing and able to provide the care that an individual needs, and this should be taken into account during discharge planning. We anticipate that in some situations, carers may choose to allocate more time to care for patients who are discharged from hospital earlier. For some, this may result in a short-

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Benefit (Present Value)
Low	N/A	N/A	N/A
High	N/A	N/A	N/A
Best Estimate	£0.0m	£2,000m	£16,900m

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

- **NHSE:** Discharging patients earlier would free-up NHS capacity worth at least £9.5bn for acute hospital beds and community beds saved. The overall societal benefits of this would likely be higher as beds could be allocated to patients with more urgent health care needs.
- **Receivers of care:** The provision of recovery services would generate savings of around £7.4bn for self-funders over a 10-year appraisal period.

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

- **Local authorities:** Assessing needs at a point where patients had further recovered would reduce their long-term social care requirements, which would primarily reduce costs on local authorities.
- **Receivers of care:** Earlier discharge and increased levels of independence at the time of assessment, are expected to reduce requirements for long-term care services and the associated costs (for self-funders). In addition to financial benefits, earlier discharge is expected to improve wellbeing outcomes for patients (e.g. less hospital readmissions and higher levels of independence).
- **Unpaid carers:** A duty requiring the involvement of carers in discharge planning would help ensure that carers are involved in choices about discharge. This would have a positive impact on the wellbeing of unpaid carers as their needs would be reflected where appropriate in discharge plans.

Key assumptions/sensitivities/risks	3.5%
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- The impact of D2A would depend heavily on how local areas choose to implement discharge guidance in practice and how additional services are funded. We have made various assumptions to quantify the associated impact. In particular, all quantified costs are based on the assumption that patients will be entitled to 6 weeks of state-funded recovery services post discharge. As other D2A options could be implemented, the final impact could differ from the expected impact quantified in this assessment.
- We assume that 100% of local areas would follow D2A guidance under this option.
- Estimated costs and benefits are based on a preliminary review of D2A undertaken by NHSE and case studies from local areas who have adopted D2A during the pandemic. These figures have not been published yet and could be subject to change as new evidence becomes available.
- We assume that the number of patients entitled to recovery services will increase by 3% annually (due to demographic changes).
- We assume that social care costs rise in line with average earnings due to the labour-intensive nature of social care work.

#### **BUSINESS ASSESSMENT (Option 2)**

<b>Direct impact on business (Equivalent Annual) £m: -£0.06mn</b>			<b>Score for Business Impact Target (qualifying provisions only) £m: N/A</b>
<b>Costs: £0.06mn</b>	<b>Benefits: N/A</b>	<b>Net: -£0.06mn</b>	

## Summary: Analysis & Evidence

## Policy Option 3 (preferred option)

**Description:** Revoke legislative requirements to assess pre-discharge. This is the preferred option.

### FULL ECONOMIC ASSESSMENT

Price Base	PV Base	Time Period	Net Benefit (Present Value (PV)) (£m)		
2019/20	2020	10 years	Low: £4,600m	High: £7,300m	Best Estimate: £6,200m

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£0.39m		£400m	£3,900m
High	£0.39m		£1,000m	£9,600m
Best Estimate	£0.39m		£800m	£6,500m

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

- **Health and ASC sector:** A total ongoing cost of approximately £5.4bn to provide additional recovery services and an additional coordination cost of approx. £0.8bn over 10 years. Additionally, there is an ongoing cost for identifying and consulting with unpaid carers of approx. £0.3bn over 10 years.
- **NHSE:** A one-off familiarisation cost of £0.3m.
- **Local authorities:** A one-off familiarisation cost of £0.02m.
- **Private Care Providers:** A one-off familiarisation cost of £0.06m.

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

- **Unpaid Carers:** Trusts responsible for adult hospital patients to take any steps that it considers appropriate to involve the patient and any carer of the patient in discharge plans. This should be done as soon as is feasible after it begins making any plans relating to discharge. We anticipate that in some situations, carers may choose to allocate more time to care for patients who are discharged from hospital earlier. For some, this may result in a short-term reduction in work hours and associated financial costs (only if they are willing and able).

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	£0m		£1,000m	£8,400m
High	£0m		£2,000m	£16,900m
Best Estimate	£0m		£1,400m	£12,600m

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

- **NHSE:** Discharging patients earlier would free-up NHS capacity worth at least £7.1bn for acute hospital beds and community beds saved. The overall societal benefits of this would likely be higher as beds could be allocated to patients with more urgent health care needs.
- **Receivers of care:** The provision of recovery services would generate savings of around £5.5bn for self-funders over a 10-year appraisal period.

**Other key non-monetised benefits by ‘main affected groups’**

If local areas choose to follow D2A principles, this would be associated with the following benefits (though other D2A models/options may be adopted alongside this legislative change with differing impacts).

- **Local authorities:** Assessing needs at a point where patients had further recovered would reduce their long-term social care requirements, which would primarily reduce costs on local authorities.
- **Receivers of care:** Earlier discharge and increased levels of independence at the time of assessment, are expected to reduce requirements for long-term care services and the associated costs (for self-funders). In addition to financial benefits, earlier discharge is expected to improve wellbeing outcomes for patients (e.g. fewer hospital readmissions and higher levels of independence).
- **Unpaid carers:** A duty requiring the involvement of carers in discharge planning would help ensure that carers are involved in choices about discharge. This would have a positive impact on the wellbeing of unpaid carers as their needs would be reflected where appropriate in discharge plans.

Key assumptions/sensitivities/risks

3.5%

- The impact of D2A would depend heavily on how local areas choose to implement discharge guidance in practice and how additional services are funded. We have made various assumptions to quantify the associated impact. In particular, all quantified costs are based on the assumption that patients will be entitled to 6 weeks of state-funded recovery services post discharge. As other D2A options could be implemented, the final impact could differ from the expected impact quantified in this assessment.
- We assume that between 50% and 100% of local areas would follow D2A guidance under this option (central scenario 75%).
- Estimated costs and benefits are based on a preliminary review of D2A undertaken by NHSE and case studies from local areas who have adopted D2A during the pandemic. These figures have not been published yet and could be subject to change as new evidence becomes available.
- We assume that the number of patients entitled to recovery services will increase by 3% annually (due to demographic changes).
- We assume that social care costs rise in line with average earnings due to the labour-intensive nature of social care work.

**BUSINESS ASSESSMENT (Option 3)**

Direct impact on business (Equivalent Annual) £m: -£0.06mn			Score for Business Impact Target (qualifying provisions only) £m: N/A
Costs: £0.06mn	Benefits: N/A	Net: -£0.06mn	

# Evidence Base

## Problem under consideration and rationale for intervention

### The issue being addressed

Schedule 3 to the Care Act 2014 sets out the processes for planning the discharge of patients from NHS hospital care to local authority care and support where the NHS body considers it likely that it would not be safe to discharge the patient unless arrangements for meeting their care and support needs were in place. This includes the requirement to assess the individual before discharge and develop a package of care<sup>2</sup>.

These requirements have led to delayed discharge in some areas for some patients, resulting in poorer patient outcomes (e.g. loss of independence or functional decline), additional expense to the NHS, and more complex or higher levels of social care on discharge.

At the start of the pandemic, the top priority for the NHS was treating Covid-19 patients and freeing up NHS capacity and hospital beds (this also prevented existing patients from contracting Covid-19). An approach known in England as 'discharge to assess' (D2A) was nationally implemented with accompanying [guidance](#), whereby people who were clinically ready, and no longer needed to be in hospital, were supported to return to their place of residence where possible. An assessment of longer-term needs took place when the individual reached a point of recovery, providing a more accurate evaluation of long-term support needs. This approach was enabled through the Coronavirus Act 2020, although some local areas have chosen to follow the discharge to assess model for several years.

Following expiry of the temporary Coronavirus provisions, the schedule 3 requirements come into effect again. Government must therefore intervene to enable local areas to continue implementing discharge to assess models that were put in practice during the pandemic, to realise the associated societal benefits.

Discharging patients as soon as they no longer meet the criteria to reside in hospital (in other words, they no longer need acute hospital care) is increasingly recognised as the most effective way to support patient outcomes. The 2018 National Audit of Intermediate Care indicates that intermediate care recovery services over a 6-week period increases levels of independence of patients and can reduce the number of preventable readmissions to hospital<sup>3</sup>. The audit found that 71% of individuals reported an improved dependency score after 6-week period of home-based care. 85% reported an improvement after 6 weeks of bed-based care, and 66% for reablement care. As a result of rising levels of independence, we would expect fewer emergency readmissions and long-term social care needs and thus reduced cost pressures. Hospital readmissions are estimated to lead to additional costs of £1.6bn annually<sup>4</sup>. While this

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<sup>2</sup> The provisions that set out the requirement for assessments to take place in hospital are set out in the National Health Services Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 for Continuing Health Care and Funded Nursing Care assessments, and in Schedule 3 to the Care Act 2014 for social care assessments.

<sup>3</sup> [NAIC \(2018\) Key findings England](#)

<sup>4</sup> [CHKS Report Hospital readmissions.pdf](#)

figure indicates the total cost of hospital readmissions for all reasons, D2A can help lower some of these costs if the necessary recovery services are in place after hospital discharge.

### What sectors / markets / stakeholders will be affected, and how, if the government does intervene?

Under the previous system, some individuals experienced delayed hospital discharge, for example due to awaiting completion of a long-term needs assessment. This was previously referred to as a 'Delayed Transfer of Care' (DToC) which occurred when a patient was ready to leave a hospital or similar care provider but was still occupying a bed. NHS England (NHSE) defined a patient as being ready for transfer when: (1) a clinical decision has been made that a patient is ready for transfer; and (2) a multidisciplinary team has decided that the patient is ready for transfer; and (3) the patient is safe to discharge/transfer.

In 2019/20, there were 1,750,260 days of Delayed Transfers of Care (DToCs). This translates to an average of 4,795 people experiencing a DToC per day. Of these, 59% of DToCs were due to patients awaiting one or more decisions regarding their onwards care arrangements. In contrast, only 16% were caused by patients awaiting further acute hospital care<sup>5</sup>.

These individuals have previously been cared for in acute hospital settings, funded by the NHS.

Where local areas follow D2A principles, patients that would have experienced delayed discharge due to awaiting a long-term care needs assessment are discharged from hospital when they no longer need acute medical care and receive their assessment for ongoing care needs out of hospital. These patients may require post-discharge recovery services up until the point where their long-term needs assessment has taken place (see box 2 for more details on recovery services).

The D2A pathways model is based on four pathways for discharging people, as shown below<sup>6</sup>:

Pathway 0: 50% of people – simple discharge, no formal input from health or social care needed once home.

Pathway 1: 45% of people – support to recover at home; able to return home with support from health and/or social care.

Pathway 2: 4% of people – rehabilitation or short-term care in a 24-hour bed-based setting.

Pathway 3: 1% of people – require ongoing 24-hour care, often in a bedded setting. Long-term care is likely to be required for these individuals.

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<sup>5</sup> <https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2019-20/> - Delayed Transfers of Care Time Series (XLS, 155KB)

<sup>6</sup> These pathways are based on patients aged 65+.



Box 1 provides an overview of the discharge and ongoing support process under the ‘do nothing’ option and under D2A.

Box 1 – The discharge process<sup>7</sup>

<p><b>‘Do-nothing’ (pre-COVID-19 process)</b></p>	<p>A multi-disciplinary team (consisting of doctors, nurses and therapists) will review all patients in acute beds to agree which patients no longer meet the clinical criteria to require inpatient care and will therefore be discharged.</p> <p>Patients needing support to be discharged should be assessed for their immediate health and social care needs. Following a period of recovery, their longer-term health and social care needs should be assessed.</p> <p>For those with the highest levels of complex, intense or unpredictable needs, screening and assessment of eligibility for NHS Continuing Healthcare should be at the right time and location for the individual and when the individual’s ongoing needs are clearer. The full assessment of eligibility should normally take place when the individual is in a community setting. There may be rare circumstances where assessments for NHS Continuing Healthcare may take place in an acute hospital environment. The core underlying principle is that individuals should be supported to access and follow the process that is most suitable for their current and ongoing needs.</p> <p>The hospital and discharge teams will then co-ordinate the persons discharged to their homes, community bedded capacity or directly to care homes depending on their needs.</p> <p>NHSE estimates that at the end of April 2020, approximately 69% of patients were discharged to their homes and about 4% were discharged to care homes.</p>
<p><b>Local areas who adopt D2A</b></p>	<p>A multi-disciplinary team (consisting of doctors, nurses and therapists) will review all patients in acute beds to agree who no longer meets the clinical criteria to require inpatient care and will therefore be discharged.</p> <p>This team will also carry out <b>limited</b> functional assessments once people no longer have a medical need for inpatient care to determine whether someone needs ongoing health and care support. People requiring ongoing support (pathways 2,3 or 4) will be discharged to assess. People not requiring ongoing support (pathway 0) will be discharged to their homes, sometimes with voluntary or community sector or other informal support.</p> <p>Once this decision has been made, the patient’s details will be given to the Transfer of Care hub and they will be assigned to a case manager</p>

<sup>7</sup> [Hospital discharge service: policy and operating model \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/86422/hospital-discharge-service-policy-and-operating-model.pdf); [Hospital discharge service requirements action cards \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/86422/hospital-discharge-service-requirements-action-cards.pdf)

	<p>who coordinates the discharge activities, including transport and onwards medication.</p> <p>Post discharge, the case managers in conjunction with the Transfer of Care hub, will need to work with partners to ensure the staff and infrastructure are available to meet immediate care needs. This includes:</p> <ul style="list-style-type: none"> <li>• a lead professional or multidisciplinary team, as is suitable for the level of care and support needs, will visit people at home on the day of discharge or the day after to co-ordinate what support is needed in the home environment; and</li> <li>• a Trusted Assessor will visit the patient to carry out the patient's social care needs assessments and / NHS CHC assessments of eligibility as soon as possible. Support will be provided as needed by health and/or social care for a specific period of time (to be agreed).</li> </ul>
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The change would therefore have the following key impacts, where local areas adopted D2A:

- D2A can help reduce the average length of hospital stay. Data from NHSE indicates that there was a 26% reduction in patients staying more than 21 days in hospital between December 2019 and December 2020<sup>8</sup>. This reduction is in part due to D2A guidance being adopted by local areas during Covid-19. There was also a 22% reduction in patients staying over 14 days and a 19% reduction in patients staying over 7 days. Please note that not these reductions are not entirely due to D2A; other factors due to Covid-19 may have contributed to this reduction.
- It is estimated that the reduced length of stay in NHS hospital and community rehabilitation beds due to D2A being adopted in England, generates a saving of 6,078 acute hospital beds and 624 community beds per year. This is in comparison to D2A not being adopted in England. This has been estimated by NHSE using data from local areas that adopted D2A during Covid-19.
- The responsibility to care for patients while they were rehabilitating/recovering and were awaiting their long-term needs assessment would be transferred from staff working at the hospital to other staff, including community health, local authorities, the housing sector, private care providers and informal care networks;
- All stakeholders involved in discharging patients from hospital would see a change in their roles and responsibilities. There would likely be a higher need for coordination and engagement between all stakeholders involved in the discharge and assessment process, which would primarily fall on the case worker and Transfer of Care Hub; and
- Patients would benefit from earlier discharge as they could recover in an environment that was familiar to them and because their long-term needs assessments would take place at a point of optimum recovery, allowing a more accurate evaluation of their needs.

Establishing the exact effect on the various sectors under the preferred option is difficult because in the absence of mandatory legislation to follow a specific model of discharge, each local area can develop their own approach to hospital discharge that best meets individuals' needs. However, a recent review of the impact of D2A published by NHS Providers sets out a

<sup>8</sup> [Statistics » Urgent and Emergency Care Daily Situation Reports 2020-21 \(england.nhs.uk\)](https://www.nhs.uk/statistics/urgent-and-emergency-care-daily-situation-reports-2020-21)

strong evidence for the assumption that D2A is cost effective and leads to improved patient outcomes<sup>9</sup>.

*Box 2 – Overview of post-discharge recovery services*

**What are post-discharge recovery services<sup>10</sup>?**

- ‘Step-down’ services provide post-discharge to either support an individual to recover from their episode of acute care and return to maximum independence and wellbeing as possible, or to meet their end-of-life choices and needs.
- The care package encompasses all the needs of the individual – health, psychological and social and includes health and social care service provision, by undertaking a holistic assessment of the person. They are usually delivered by a mix of health and social care professionals with a range of different skills, including nurses, social workers, doctors, and a range of therapists.
- Care packages are decided based on an individual care plan and services that wrap around the person based on person-directed outcomes. Several types of services can be included in a post-discharge package which collectively support the recovery of an individual. These services are delivered by health and social care staff flexibly. These include:
  - Reablement: to help individuals to recover skills and confidence and maximise their independence; these are usually provided by local authorities.
  - Rehabilitation: to help individual achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living; and
- These services can be delivered to a person's place of residence or to a bedded facility with flexibility to move between these during the funded period.

**How are these services currently funded?**

Recovery services are usually provided by local authority and Clinical Commissioning Group (CCG) budgets until the long-term needs assessments had been completed. According to data from the Better Care Fund, in 2019/20 approximately £460m had been spent on reablement and rehabilitation services, of which 60% were funded by LAs, 38% were funded by CCGs and approx. 3% were funded jointly by the two<sup>11</sup>.

The NHS Long-Term Plan also commits to increase the capacity and responsiveness of community and intermediate care services, to help reduce admissions and also provide a timely transfer from hospital back home.

<sup>9</sup> [210614-discharge-to-assess-funding-briefing.pdf \(nhsproviders.org\)](#)

<sup>10</sup> [Understanding intermediate care, including reablement | Quick guides to social care topics | Social care | NICE Communities | About | NICE](#)

<sup>11</sup> This spend does not include spend on bed-based step-down services and could exclude some other recovery services that would be required as a result of D2A.

Why is government best placed to resolve the issue? Could the issue be resolved without intervention (e.g. through the market, innovation or other stakeholder led change)?

Following expiry of the temporary Coronavirus provisions, the schedule 3 requirements come into effect again. Government must therefore intervene to enable local areas to continue implementing discharge to assess models that were put in practice during the pandemic, to realise the associated societal benefits. Removing the procedural requirements set out in legislation to carry out relevant needs assessments pre-discharge requires revoking legislation.

Having worked closely with stakeholders, however, we have chosen not to replace the procedural requirements set out in Schedule 3 to the Care Act 2014 with new legislative requirements, precisely because stakeholders have told us that the legal options available were counterproductive to collaborative working. We have instead agreed to introduce flexibility for local areas to adopt discharge processes that best meet local needs; and draw on health and social care duties to cooperate. Using these duties, we will describe in guidance the roles and responsibilities of partners in hospital discharge, and be clear that local areas will need to develop, and agree how to fund, discharge models that best meet local needs.

## **Rationale and evidence to justify the level of analysis used in the IA (proportionality approach)**

We want to introduce flexibility for local areas to adopt D2A, which has been recommended as good practice since 2017. Based on evidence from the most recent National Audit of Intermediate Care (NAIC) 2018, D2A has the potential to generate major and sustained improvements in hospital length of stay in both acute and community beds, as well as beneficial reforms to the care model, with an increased switch to home-based care packages.<sup>12</sup>

We have used data and evidence provided by NHSE, alongside case studies from local areas who have adopted D2A during the pandemic, as the main evidence base for this assessment. This data/evidence is from February 2021 and is based on local areas that implemented D2A principles during the Covid-19 pandemic. Most of this data is not yet publicly available. Other reliable quantitative data, particularly data that covers the impacts of D2A on post-discharge care and associated health and social care outcomes, is limited. The introduction of the policy during a pandemic year coincided with the suspension of relevant NHS data collection (DTOCs) and makes it difficult to draw causal inference between D2A and lengths of hospital stay. In addition, social care outcome data is reported only annually with latest data available for 2019-20. The assessment is therefore highly reliant on preliminary evaluation undertaken by NHSE and anecdotal evidence from local areas.

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<sup>12</sup> [NAIC 2018 Key findings England](#)

Other D2A evaluations are expected to be published during 2021 and 2022. We aim to review all costs and benefits once these are available.

## Description of options considered

There is strong consensus among health and social care partners that D2A supports better patient outcomes, as well as freeing NHS capacity for the benefit of other patients. We worked collaboratively with health and social care partners to develop the policy proposal to remove the existing legislative barrier to D2A, enabling health and social care partners to work together more effectively, and create flexibility for assessments to take place when most appropriate for the individual. The different options that were considered as part of this process are outlined below.

**Option 1 (baseline):** do nothing. If we did not revoke legislation, local areas would be required by law to assess patients before hospital discharge. This is the baseline against which all other options have been assessed. Government has promoted D2A as best practice since 2017. Since March 2020, the government has directly supported implementation of D2A practice via enhanced discharge funding, to free as many NHS acute beds as possible during Covid-19. Failing to revoke legislation while continuing to promote D2A as good practice would result in government policy continuing to be at odds with the procedural requirements set out in legislation.

**Option 2:** introduce a new legislative model requiring assessments to take place post-discharge. We explored this option at length with health and social care partners but received strong feedback that this option risked undermining collaborative working between the health and social care sectors.

**Option 3 (preferred option):** remove current legislative barriers to assessing individuals post-discharge, enabling local areas to work innovatively in partnership and continue building the relationships and processes they have developed during the pandemic. Through repealing Schedule 3, the system of discharge notices and associated financial penalties set out in the Care Act will also be removed. This provision does not change existing legal obligations on NHS bodies to meet health needs, and local authorities are still required to assess and meet people's needs for adult social care. Nor does it alter the thresholds of eligibility for continuing healthcare, funded nursing care or support through the Care Act.

As option 3 is our preferred option, we are not proposing to introduce a legislative requirement to implement D2A nationally (as proposed in option 2 above); nor are we planning to mandate D2A through guidance. It will be for local areas to agree discharge arrangements that best meet the needs of patients locally. We will develop guidance setting out roles, responsibilities and processes of all partners during the discharge process that builds in safeguards for patients, so that individuals receive the care they need in the right place, at the right time.

It should be noted that the proposed change would not determine who would be required to deliver and fund the care provision needed until the point of assessment. As the decision of

when and how to discharge and assess patients would differ according to the approach agreed locally, the responsibilities and funding for care provisions would fall on stakeholders from the ASC sector differently. This assessment does not represent a comprehensive impact assessment of all possible delivery options and the associated impacts should therefore be regarded as illustrative only.

In addition, as a result of a government amendment to the hospital discharge clause, the initial proposals have been amended to include a duty on trusts responsible for adult hospital patients to involve the patient and any carer of the patient, where appropriate, in discharge planning. This should be done as soon as is feasible after it begins making any plans relating to discharge. We have assessed the costs and benefits of this amendment and updated Options 2 & 3 to take account of this.

## Policy objective

Our policy objectives in developing this proposal are:

- To support safe and timely discharge of individuals to maximise their health and wellbeing outcomes (for example to reduce hospital readmissions and support people back into their own homes more often) by enabling local areas to adopt discharge processes that best meet local needs. As a result of removing legislative barriers to D2A, patients can be discharged as soon as they no longer need medical care if local areas adopt D2A principles.
- To provide flexibility for local areas to carry out assessments to take place at a point of optimum recovery, so future care decisions are made when they are most likely to be accurate and supportive. This will likely reduce the need for long-term care.
- To enable people (or their representatives or advocates if they lack capacity) to make informed choices about any ongoing health or social care needs as they plan their future.
- To reduce pressure on NHS staff and beds by ensuring that individuals do not remain in hospital beyond a time when they no longer need hospital care.
- To support the NHS to operate on best value for money principles, to target resources where they are most needed.

NHSE and other stakeholders are collecting a range of data on delayed transfers of care and other relevant metrics that will enable us to monitor the success of the proposed change. The main metrics are listed below:

- the number of patients who do meet the clinical criteria to reside but are not discharged by 5pm on the day (available daily);
- the number of patients, by lengths of hospital stay (available daily);
- the number of people discharged on each pathway (available daily or weekly);
- the re-admission rate 3 and 7 days after discharge (frequency tbc);

- the number of patients needing long-term care after up to 6 weeks of recovery services (frequency tbc); and
- financial outturn data on patients awaiting discharge.

## Summary and preferred option with description of implementation plan

We want to update approaches to hospital discharge to help facilitate safe and timely discharge. This would be achieved by removing existing legislative barriers to assessment post-discharge, allowing local areas to tailor discharge processes to suit local need. The D2A model promotes continuing healthcare (CHC), Funded Nursing Care (FNC) and Care Act (local authority social care) assessments taking place after discharge from acute care and after initial recovery and rehabilitation. This would allow the safe discharge of individuals into a familiar environment, enabling a more appropriate and accurate evaluation of care and support needs at the right time. Assessing at the optimum point of recovery can improve the quality of assessments and planning for ongoing needs and reduce hospital readmissions. It can also reduce ongoing health and social care costs by maximising an individual's independence. Indicators of success include better patient outcomes and financial savings, primarily to the NHS. The D2A model would not change the thresholds of eligibility for CHC, FNC or support through the Care Act.

We have considered the risk of revoking responsibilities of NHS bodies and LAs currently set out in legislation during the discharge process. It should be noted that although our preferred option would enable local areas to adopt discharge processes that best met local needs, it would not change existing legal obligations on NHS bodies to meet health needs, and local authorities would still be required to assess and meet people's needs for adult social care.

In addition to the separate duties to meet health and social care needs, discharge guidance would set out expectations for how the existing legislative duty for NHS bodies and LAs to cooperate<sup>13</sup> applied to discharge practice. The benefit of guidance is that it could be updated as new evidence and best practice emerged (as has happened with discharge guidance during the pandemic), without needing to amend legislation. The guidance would need to accommodate local working arrangements, and would set out the following:

- a. the functions that needed to take place in hospital (such as a Mental Capacity Assessment), regardless of when assessment took place;
- b. that no-one should be discharged without the interim support they needed pending assessment. If care support were needed on the day of discharge, this must be arranged prior to the person leaving the hospital site, with a home visit the same day where appropriate to co-ordinate what support was needed; and
- c. all patients (or their representative or advocate if they lacked capacity) should be given information and advice when discharged, including who they could contact if their condition changed, how their needs would be assessed and the follow up support they would receive.

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<sup>13</sup> Set out in section 82 to the NHS Act 2006: In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.



We would work collaboratively with NHSE, DLUHC, local government and other partners and stakeholders to ensure our policy thinking was informed by service users, providers and other voices such as voluntary organisations. We plan to co-produce the guidance with partners and stakeholders. As the details of how the guidance would be implemented are currently uncertain, we would use the time before implementation of the guidance to further assess the associated costs, impacts and risks involved with the proposal.

We have considered whether assessment after discharge increases the risk of the assessment being delayed, less accurate or more expensive. Evidence suggests that assessing post-discharge will, on the contrary, result in benefits to the individual and to the system more widely. Various local areas report that D2A has led to a significant decrease in the length of hospital stay, bringing forward the assessment date and avoiding functional decline for many patients.<sup>14</sup> Also, anecdotal evidence suggests that assessments undertaken in hospitals tend to lead to an over-prescription of long-term care packages, so we would expect assessments at the optimum point of recovery to lead to a more accurate evaluation of an individual's long-term needs. Care Act assessments can be carried out by a social worker or other trusted assessor who is skilled, knowledgeable and competent to carry out the assessment. Assessors can be based in the community, so carrying out an assessment at the individual's place of residence will not place additional travel burdens on staff based in hospital.

Having carefully weighed up the costs, benefits and risks, we have concluded that this is the most effective option to facilitate the safe and timely discharge of patients, and which empowers the health and social care sectors to work together collaboratively. We will work closely with NHSE, DLUHC and local government organisations to monitor the impact of revoking Schedule 3 of the Care Act.

## **Monetised and non-monetised costs and benefits of each option (including administrative burden)**

### **Affected Groups**

#### **Care Receivers**

Where D2A principles are followed, individuals who receive CHC, FNC or local authority social care assessments while being treated in hospital, would experience a change in their discharge process and long-term care assessment. According to NHSE's Short and Long Term (SALT) Services data, there were 220,000 patients discharged from hospital in 2018/19 who received financial support for their onwards care package. Uprating this by 3% annually to account for an

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<sup>14</sup> [210614-discharge-to-assess-funding-briefing.pdf \(nhsproviders.org\)](https://www.nhsproviders.org/210614-discharge-to-assess-funding-briefing.pdf)



expected increase in user numbers, this translates to approx. 240,000 users in 22/23, i.e. the first year of our appraisal period.<sup>15</sup>

We have used internal estimates from the Care Policy Evaluation Centre's (CPEC) long-term demand model to estimate the equivalent amount of self-funders who were discharged from hospital (estimated to be 160,000).

In total, we therefore expect that approx. 400,000 care receivers would benefit from the proposed change in 22/23.

It should be noted that more individuals would be expected to benefit from the policy if additional funding were also made available to prevent hospital admissions from individuals currently receiving care in the community. Due to a lack of national-level agreement on such type of funding, we have not included such benefits in this assessment.

### **Patients' families and their wider unpaid care network**

In some instances, patients' families and their wider unpaid care network will choose to support patients after they have been discharged from acute care, until their long-term health and care needs assessments have taken place. NHSE estimates that 95% of all patients (or between 190,000 and 390,000 patients) will be discharged to their homes on pathway 0 or 1 and might therefore need some sort of support from informal networks. Where a trust is responsible for an adult hospital patient and considers that the patient is likely to require care and support following discharge from hospital, the relevant trust must, as soon as is feasible after it begins making any plans relating to the discharge, involve any carer, including young carers, of the patient and the patient themselves, where appropriate. When discussing discharge arrangements, there should be open communication with carers about whether they are willing and able to take on caring responsibilities, and this should be taken into account during discharge planning.

### **Care providers**

Under the baseline (whereby assessments were carried out before discharge), we understand that some local areas involved social care providers in the decision about onwards care packages, though they were not commonly involved in this process. Assessments were carried out jointly by health and social care staff in hospital. Providers played a role in delivering the onwards care packages that were agreed during long-term needs assessments. The existing legislation, that we propose to revoke, does therefore not directly impose requirements or restrictions on providers.

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<sup>15</sup> This uplift captures the expected increase in the number of health and social care receivers over time which is assumed to be 3% annually. Due to uncertainties surrounding Covid-19 a slightly lower cumulative 5% increase has been deployed to the uplift from 18/29 to 21/22 numbers.

However, where local areas adopt D2A principles, we may see a shift in demand for services from care providers from the private and voluntary and community sector and associated impacts on the market structure. Firstly, demand for domiciliary care services are likely to increase as more patients are expected to be discharged home from hospital and will be entitled to reablement services. On the other hand, we could also see a reduction in demand for long-term care services, as additional reablement services lead to faster recovery and reduce the need for some patients to be admitted to care-homes in the long-term. Overall, the impact on the market structure will depend critically on the bespoke model's local areas adopt to implement D2A.

According to the CQC register, there are approximately 14,000 care home and domiciliary care providers. Of these, around 6,400 provide residential/nursing care and 7,200 provide non-residential services to social care patients. Approximately 200 of these providers provide both residential and domiciliary care services. In total, around 850 care providers act as a charity (approximately 7% of all providers).<sup>16</sup>

## **Health and ASC sector**

For the purpose of this assessment, we assume that patients will be entitled to the provision of up to 6 weeks of recovery services post discharge. This would introduce an additional burden on stakeholders from the Health and ASC sector (mainly local authorities and Clinical Commissioning Groups (CCGs)). How funding of those services will be agreed between stakeholders will differ by local area. We are therefore unable to attribute these costs to a specific stakeholder from the ASC sector at this point.

In addition, social care and clinical staff involved in the discharge process of patients may see a change in their roles and responsibilities.

## **NHSE**

Where D2A principles are not followed and patients remain in hospital until assessments are complete, NHSE is responsible for funding the acute hospital beds and associated care. If D2A principles are followed, this support will be provided outside of hospital and might be funded by NHS or LAs, the VCS or informal carers; The amount of funding NHSE has to provide to care for patients awaiting their long-terms needs is therefore expected to reduce significantly overall. In addition, NHSE staff involved in the discharge process of patients will see a change in their roles and responsibilities.

## **Local authorities**

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<sup>16</sup> <https://www.cqc.org.uk/about-us/transparency/using-cqc-data>

There are 152 local authorities operating in England who provide social care services. In addition to some of the ASC sector costs which will be borne by local authorities, local authorities are also expected to benefit from D2A as care receivers will be further recovered when their needs assessments take place, and might therefore require less intensive long-term care packages, which are primarily funded by local authorities.

## Option Appraisal

The cost benefit analysis that follows assesses a range of different costs and benefits that we would expect under one or more of the proposed options. All of these impacts are based on the assumption that patients would receive up to 6 weeks of state-funded recovery services post-discharge. Local areas might choose to implement other ways to embed D2A practices, taking into account the conditions of their local markets, resource capacity and their financial situation. Actual impacts might therefore differ from the estimated impacts illustrated in the assessment below and the analysis should therefore be treated as indicative only. Funding decisions on social care beyond 2021-22 will be decided at the next Spending Review.

The costs and benefits we have identified under these assumptions are:

### **One-off costs**

- **Familiarisation costs:** one-off costs for NHSE, local authorities and care providers to acquaint themselves with the proposed legislative changes.

### **Ongoing costs**

- **Provision of recovery services outside of hospital:** Under the 'Do nothing' option, care for patients awaiting their long-term care assessment is provided by NHSE as patients are still being treated in hospital. Under the proposed change, some patients will require recovery services outside of hospital while awaiting this decision. The change will therefore introduce a new cost for the providers and funders of those services from the ASC sector.
- **Coordination cost:** Where the decision is being made to discharge patients prior to assess, there will be an additional burden on health and care staff to determine who will be responsible for the intermediate care provision and to coordinate this provision accordingly.
- **Wellbeing costs for patients:** Delaying the assessment date for long-term care provisions could result in some negative consequences for patients. For example, for some patients, there is a risk that intermediate care provision delivered at home might not fully meet their intermediate care needs, although discharge processes would be explicit that no one should be discharged without proper support arrangements in place. For some patients, a longer period of uncertainty about future levels of care might also have a negative impact on their wellbeing.

### **Ongoing benefits**

- **Freeing up NHS capacity:** If more local areas followed D2A principles as a result of the new guidance, this would significantly reduce the amount of time that patients needed to stay in acute hospital settings while awaiting their assessments and the associated costs on the NHS. At the end of February 2021, 4.7 million people were waiting to begin

hospital treatment (a 14-year record high)<sup>17</sup>. D2A could help reduce this waiting list where local areas followed D2A principles. For example, the Midlands Partnership NHS Foundation Trust implemented D2A principles during Covid-19 and reduced their average length of hospital stay from 26 days to 19 days<sup>18</sup>.

There is also an expectation that people with care needs are less likely to be readmitted to hospital from long-term social care if they had a longer period to re-gain independence and recover, under provision of recovery services. This would further reduce pressure on the NHS.

- **Reduced self-funder spend on recovery services:** If all patients were entitled to 6 weeks of state-funded recovery services, this would generate a saving for those patients who would have paid for their onwards care packages themselves under the baseline.
- **Reduced long-term care provision:** D2A enables care assessments to be made at a point in time when patients have reached optimum recovery, when their physical and mental health are more reflective of their long-term needs. It is therefore expected that the assessments under D2A will be more accurate and reduce the level of health and social care services required in the long run, leading to additional saving potentials for local authorities and other care providers.
- **Improved health and wellbeing outcomes for patients:** If patients were discharged earlier, this could generate various other improvements to public health and wellbeing outcomes:
  - Long-term needs packages could be expected to be more suited to actual long-term care needs of care receivers. This is because care assessments would be made at a point in time when patients had reached optimum recovery.
  - Reducing the length of stay in hospital beds would reduce risks from hospital acquired infections such as nosocomial infection and the level of confusion for those with cognitive impairments. In addition, reduced lengths of hospital stays are expected to lead to less muscle deterioration and general functional decline of patients and therefore less recovery services needed.
  - Finally, there are likely to be benefits to patients' mental wellbeing as they would spend less time in hospital, reducing uncertainty about their future, and resulting in less isolation from friends, family and familiar surroundings.
- **Discharge notices:** legislation currently provides that an NHS body may seek reimbursement from a relevant LA, where a patient's discharge has been delayed due to a failure of the LA to arrange for a social care needs assessment, after having received an assessment and discharge notice. This system of discharge notices, and the associated financial penalties, will be revoked.

All quantified costs and benefits in this section are estimated in 2019/20 prices and measured over a 10-year appraisal period starting in the year where costs and benefits are expected to begin (2022/23). In line with Business Impact Target (BIT) guidance, the Net Present Value presented in this section has been calculated using 2020 as the Base Year.

To ensure consistency in our calculations we have adopted the Standard Cost Model (SCM) approach published by BEIS where appropriate. Where we have used wage rate data we have

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<sup>17</sup> [NHS waiting list hits 14 year record high of 4.7 million people | The BMJ](#)

<sup>18</sup> [Discharge to assess: the case for permanent funding](#)

taken hourly wage rates from the 2019 Annual Survey of Hours and Earnings (ASHE)<sup>19</sup> and the Adult Social Care Workforce Data Set<sup>20</sup>, using the median rate of pay and uplifting by 20% to account for overheads in line with HMG's The Green Book<sup>21</sup> guidance.

## **Option 1 – Do Nothing**

Under the 'Do nothing' option, the legislative requirement to assess pre-discharge would remain. There are significant risks associated with this option. For the purpose of this assessment, we assume that health and social sectors would choose to revert to assessing pre-discharge post-pandemic if the proposed legislative change were not made. This would increase pressure on the NHS, due in part to beds occupied by patients awaiting their needs assessment – estimated at 6,700 beds annually. Waiting lists for elective and non Covid-19 treatment have increased and this would also have a negative physical and mental impact on individuals awaiting treatment.

Failing to revoke legislation while continuing to promote D2A as good practice would result in government policy continuing to be at odds with the procedural requirements set out in legislation.

There would be no costs or benefits associated with this option. All other options have been assessed against this baseline.

## **Option 2 – Legislation making it mandatory to conduct long-term needs assessment post-discharge.**

Under option 2, we would introduce a new legislative model requiring assessment post-discharge. Under this option we assume that 100% of local areas take up D2A. The following assessment is based on various assumptions around the delivery of these services, mainly assuming that patients will be entitled to 6 weeks of state-funded recovery services post discharge. This has not been agreed. As local areas might choose to implement other ways to embed D2A practices, impacts might differ from the estimated impacts illustrated in the assessment below.

Additionally, a duty will be introduced that requires trusts responsible for adult hospital patients to involve the patient and any carer, including young carers, of the patient, where appropriate, in discharge planning. This should be done as soon as is feasible after it begins making any plans relating to discharge.

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<sup>19</sup> [Earnings and hours worked, occupation by four-digit SOC: ASHE Table 14 - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk)

<sup>20</sup> [Discover the Adult Social Care Workforce Data Set \(skillsforcare.org.uk\)](https://www.skillsforcare.org.uk)

<sup>21</sup> [The Green Book \(2020\) - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

The following impacts have been identified for this option:

### Familiarisation costs - NHSE

There is a one-off cost for NHS staff who would need to familiarise themselves with any changes to discharge legislation. As D2A has been mandatory during the Covid-19 pandemic, we do not expect local areas to require a substantial amount of familiarising themselves with the implications of the legislation change (although there may be some differences in approach post-pandemic). However, we assume that each senior hospital manager would need to familiarise themselves for approx. 30 minutes with guidance and would disseminate the information within their teams, including directing staff to respond to new approaches and best practice.

According to NHSE's monthly workforce statistics, there were 11,459 senior managers employed by Trusts and CCGs<sup>22</sup>. Multiplying this number with the average hourly wage rate for NHSE senior managers of £42 and the estimated familiarisation time of 0.5 hours, this translates to a one-off familiarisation cost for NHSE of £0.3m. We assume that this would be required irrespective of the take up of D2A by local areas.

### Familiarisation costs - LAs

There is a one-off cost for local authority managers who would need to familiarise themselves with any changes to discharge legislation and guidance. We assume each senior local authority manager would need to familiarise themselves for approximately 30 minutes with guidance and would disseminate the information within their teams, including directing staff to respond to new approaches and best practice.

According to the Skills for Care's weighted workforce estimates, in 2019/20, there were 700 senior local authority managers<sup>23</sup>. Multiplying this number with the average hourly wage rate for local authority senior managers of £43 and the estimated familiarisation time of 0.5 hours, this translates to a one-off familiarisation cost for local authorities of £0.02m. We assume that this will be required irrespective of the take-up of D2A by local areas.

## **Impacts on patients**

### **Costs**

#### Wellbeing costs for patients

Delaying the assessment date for long-term care provisions could result in some negative consequences for patients. For example, for some patients, there is a risk that intermediate care provision delivered at home might not fully meet their intermediate care needs, although

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<sup>22</sup> <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/november-2020>

<sup>23</sup> Skills for Care's weighted workforce estimates, 2019/20

discharge processes would be explicit that no one should be discharged without proper support arrangements in place. For some patients, a longer period of uncertainty about future levels of care might also have a negative impact on their wellbeing.

We would mitigate this risk with health and social care partners, and stakeholders, by explicitly stating in guidance that relevant safeguards must be built in where a patient is discharged needing intermediate care and pending a full assessment. This would include considering a patient's wishes and choices – and those of their family, representative or advocate – about where and when a patient is discharged, and the intermediate support they will need.

Giving patients choice and control over where they are discharged, and how their care and recovery needs will be met, is a fundamental part of planning discharge. As set out elsewhere, we will set out clearly in guidance that discussions should take place with the individual and their carer or nominated representative (where appropriate) about the most appropriate discharge pathway, including the longer term funding implications of that decision. Following the 'Home First' principle<sup>24</sup>, everyone should be offered the opportunity to recover and rehabilitate at home or in a bedded setting before their long-term needs and options are assessed and agreed. No one should have to transfer permanently into a care home for the first time directly following an acute hospital admission.

We have considered the risk that some patients may be discharged while they still required hospital care, especially where hospitals were operating at full capacity and felt pressured to free up beds as soon as possible. However, nothing would change about hospitals' legal obligation to treat someone in hospital if they were not medically fit to be discharged. In contrast, D2A, and especially a 'Home First' approach, could lead to treatment in hospital focusing more on supporting patients in regaining their mobility and independence so that they could be discharged home earlier. As mentioned in paragraph 58, there would also be safeguards to assure that the needs assessment carried out by a trusted assessor, as well as the reablement services provided, met patients' needs; and that this did not cause detrimental health impacts which could lead to hospital re-admissions (thereby being disadvantageous for the individual and the NHS).

## **Benefits**

### *Reduced self-funder spend on recovery services*

If all patients were entitled to 6 weeks of state-funded recovery services, this would generate a saving for those patients who would have paid for their onwards care packages themselves under the baseline. Based on SALT data and CPEC projections for self-funders, we estimate that approximately 160,000 people would be entitled to additional funding for recovery services annually, if all local areas followed D2A principles (see table 2).

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<sup>24</sup> The Local Government Association/ADASS have produced two 'top tips' guides: [Top tips guidance on implementing a home first approach to discharge from hospital](#) and [Top Tips guidance on implementing a collaborative commissioning approach to home first](#).



**Table 2: Benefits to self-funders for the provision of recovery services, 100% D2A take-up**

	Number of self-funders <sup>25</sup>	Average monthly self-funder rate, 19/20 prices	Total benefit for self-funders, £m
Short-term - Rehab/significant of level support	98,000	£4,497	£610
Long-term - Nursing, Prison, 100% NHS Funded	5,000	£4,497	£33
Long-term - Residential	5,000	£3,172	£22
Long-term - Community	20,000	£2,973	£83
Long-term - low level support	34,000	£456	£21
<b>Total</b>	<b>160,000</b>		<b>£770</b>

Note that this is under the assumption that the government funds 6 weeks of recovery services for those who are entitled. This has not been agreed and other D2A options may be taken into consideration.

### Reduced long-term care provision

D2A enables assessments to be carried out at a point in time when patients have reached optimum recovery, when their physical and mental health should be more reflective of their medium to long-term needs. It is therefore expected that the assessments under D2A will, overall, reduce the intensity of long-term care packages.

Glendinning et al. (2010) demonstrated in a prospective longitudinal study that total social care costs (without the costs of reablement) were significantly lower in the reablement group (who received up to 6 weeks of reablement) than in the comparison group (home care only) at up to 10 months (£790 vs £2,240).

Similarly, evidence from South Warwickshire suggests that long-term care costs for patients discharged on Pathway 3 (people who require ongoing 24-hour care, often in a bedded setting, and who are likely to require long-term care) was reduced by £0.5m due to patients being less likely to be allocated a package that included nursing care needs<sup>26</sup>. NHSE estimates that overall, 10% of patients with long-term needs assessment will require a package of lower intensity than at the start of recovery<sup>27</sup>. Some of this can be attributed to D2A, where long-term

<sup>25</sup> [SALT 18/19 data](#), Table 9 and own calculations based on CPEC projections

<sup>26</sup> [Quick Guide: Discharge to Assess \(www.nhs.uk\)](#)

<sup>27</sup> [Hospital discharge service: policy and operating model \(publishing.service.gov.uk\)](#)



needs assessments are carried out when patients are further recovered. Some of these benefits would be realised by self-funders.

Robust evaluations of D2A arrangements that were put in place during the pandemic are scarce at the time of writing this IA. DHSC is not aware of any studies or data that look into the impact that D2A has had on long-term care provision. Some of these effects are likely to manifest over time (e.g. the proportion of people being discharged into care homes as opposed to recovering at home). We are therefore currently unable to substantiate or quantify the expected impacts but are exploring ways to evaluate the impact on long-term care provision as part of the proposed post-implementation review.

### Improved health and wellbeing outcomes

If patients were discharged earlier, this could generate various other improvements to public health and wellbeing outcomes.

For example, D2A enables assessments to be carried out at a point when patients have reached optimum recovery, when their physical and mental health should be more reflective of their medium to long-term needs. It is therefore expected that the assessments under D2A will, overall, be more accurate, generating various improvements to patients' health and care outcomes and overall wellbeing.

Earlier discharge would also be expected to reduce the functional decline of individuals and lead to greater independence. In other words, earlier discharge is expected to lead to better outcomes in terms of an individual's ability to conduct essential activities of daily living (ADLs). ADLs include bathing, dressing, walking etc. The 2018 NAIC audit report found that intermediate care recovery services, over a 6-week period, increased levels of independence of patients, compared to a situation where those patients were treated in hospital over the same period, with 93% of service users maintaining or improving their dependency score in home-based services, 94% in bed-based services and 91% in reablement services<sup>28</sup>.

According to internal NHS data, there were 1,379,790 total hospital readmissions over 30 days in 2016/17, of which 184,763 (13%) were classified as 'potentially preventable' emergency readmissions. The likelihood of individuals requiring recovery services post-discharge is highest on their first day after discharge (11%) and decreases significantly thereafter. Providing recovery services for a period of up to 6 weeks for a greater number of individuals is therefore expected to reduce the number of preventable emergency hospital readmissions and associated costs on the NHS. Hospital readmissions are estimated to lead to additional costs of £1.6bn annually<sup>29</sup>. D2A can help lower some of these costs if the necessary recovery services are in place after hospital discharge.

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<sup>28</sup> [NAIC 2018 Key findings England](#)

<sup>29</sup> [CHKS Report Hospital readmissions.pdf](#)

We have also considered the risk that in areas that adopted a D2A approach, readmissions may actually increase because people were sent home earlier in their recovery journey. We have explored this concern with stakeholders, who have told us that decisions about when and where to discharge individuals will always include consideration of risks. Health and care staff in the community manage those risks on an ongoing basis throughout an individual's recovery, including deciding if readmission to hospital were necessary. We currently have no evidence to infer how likely this effect is and whether it will outweigh the expected reduction in re-admissions due to more targeted recovery services. We would expect local areas who adopted D2A models to provide training and support for staff to decide when readmission may be necessary, and for local areas actively to monitor readmissions to evaluate the effectiveness of their discharge model.

We would also expect some other benefits to patients' wellbeing, though we do not have any robust evidence to support these assumptions:

- Earlier discharge would be expected to lead to a reduction in nosocomial infection and other hospital acquired infections. Nosocomial infections are hospital infections that patients may develop during a hospital admission. A reduction of these infections would lower the need for further treatment/care and associated costs.
- There are likely to be wider benefits to patients' mental wellbeing as they would spend less time in hospital, reducing uncertainty about their future, and resulting in less isolation from friends, family, and familiar surroundings. Positive experiences from an earlier discharge have been reported by patients in various local areas who have adopted D2A during the pandemic<sup>30</sup>. For example, more than 95% of patients who were part of the D2A programme in Medway would recommend the service and 84% were confident in the care they received<sup>31</sup>. The positive impact on patients' overall wellbeing is supported by various statements from care and clinical staff who have been closely involved in the D2A roll-out in their areas through the pandemic.<sup>32 33</sup>

The change is therefore expected to improve societal wellbeing overall.

## **Impacts on the Health and ASC sector**

### **Costs**

#### *Provision of recovery services outside of hospital*

If local areas were to adopt D2A, the legislation change would increase out of hospital recovery services compared to the 'do nothing' option as patients would be discharged from hospital earlier and would require recovery services while they were awaiting the assessment for long-term care provisions. This would be associated with an additional cost for two reasons:

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<sup>30</sup> [Quick Guide: Discharge to Assess \(www.nhs.uk\)](http://www.nhs.uk)

<sup>31</sup> [6-medway-D2A-patient-feedback.pdf \(www.nhs.uk\)](http://www.nhs.uk)

<sup>32</sup> [210614-discharge-to-assess-funding-briefing.pdf \(nhsproviders.org\)](http://nhsproviders.org)

<sup>33</sup> [Quick Guide: Discharge to Assess \(www.nhs.uk\)](http://www.nhs.uk)

- 1) Patients who would previously have paid for their onwards care packages themselves, may now be entitled to a period of recovery services. The duration of time of this entitlement is dependent on the funding model in place (which has not been agreed); and
- 2) Patients who would previously have received state support for onwards care packages would now be expected to receive these services on average 8 days earlier than without D2A<sup>34</sup>.

As explained in paragraph 61, we estimate that, if all local areas take up D2A, up to 160,000 patients could be entitled to 6 weeks of recovery services annually who would previously have paid for their onwards care packages themselves. We also estimate that 240,000 state-supported patients would be entitled to an additional 8 days of recovery services under this option.

Applying the following proportional split by care setting and self-funder costs, this would translate to an annual cost to government of approx. £0.8bn annually if all local areas followed D2A principles.

**Table 3: Costs for the provision of recovery services, 100% D2A take-up**

	Number of self-funders <sup>35</sup>	Number of state-supported users <sup>36</sup>	Average monthly LA rate, 19/20 prices	Total cost, in £m
Short-term - Rehab/significant of level support	98,000	160,000	£3,133	£560
Long-term - Nursing, Prison, 100% NHS Funded	5,000	11,000	£3,133	£32
Long-term - Residential	5,000	6,000	£2,412	£21
Long-term - Community	20,000	34,000	£2,973	£110
Long-term - low level support	34,000	29,000	£456	£25
<b>Total</b>	<b>160,000</b>	<b>240,000</b>		<b>£750</b>

Note that this is under the assumption that the government funds 6 weeks of recovery services for those who are entitled. This has not been agreed and other D2A options may be taken into consideration.

<sup>34</sup> 8 days refers to the average amount of days by which the average length of hospital stay can be reduced under D2A. This takes into account the impact of patients who are discharged from hospital earlier as well as the impact on patients who won't be referred to hospitals in the first place. This is informed by internal NHS data.

<sup>35</sup> [SALT 18/19 data](#), Table 9 and own calculations based on CPEC projections

<sup>36</sup> [SALT 18/19 data](#), Table 9

### Coordination cost

Where patients are discharged prior to assessment, there would be an additional burden on health and care staff to determine who would be responsible for intermediate care provision and to coordinate these provisions after discharge.

This burden would likely fall on an interdisciplinary team of local authority and NHSE staff. As every local area would adapt their own approach, it is difficult to estimate the associated cost robustly. If we assumed that hospitals / local authorities deployed case managers (responsible for approximately 10 patients at any time) and whose services would be required for 6 weeks post discharge (high scenario), this would translate to an additional cost of £190m annually. This case manager could either be employed by the NHS or local authorities.

We estimate the total costs on the Health and ASC sector to range between £15m and £190m annually.

## **Impacts on NHSE**

### **Benefits**

#### Freeing up NHS capacity

The proposed option is expected to reduce significantly the time that patients stay in hospital awaiting their CHC, FNC assessment or local authority care assessment. Depending on the take-up of the new flexibilities, this could significantly reduce the workload on hospital staff and the funding needed to provide hospital beds.

NHSE estimates that approximately 6,078 acute hospital beds and 624 community beds could be vacated annually if D2A guidance were followed by all local areas. At a cost per bed of approximately £400/day, this would equate to an annual saving potential of around £900m. Data from NHSE/I supports this expected saving. NHSE/I data indicates that there was a 26% reduction in patients staying more than 21 days in hospital between December 2019 and December 2020<sup>37</sup>. This reduction is in part due to D2A guidance being adopted by local areas during Covid-19. There was also a 22% reduction in patients staying over 14 days and a 19% reduction in patients staying over 7 days. Hospitals could focus their resources on reducing the backlog of people awaiting elective surgery following the pandemic and meeting the needs of a growing population, rather than building new ward space. In addition to the financial benefits of deploying resources more efficiently, there would therefore be additional public health benefits to this change.

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<sup>37</sup> [Statistics » Urgent and Emergency Care Daily Situation Reports 2020-21 \(england.nhs.uk\)](https://www.england.nhs.uk/statistics/urgent-and-emergency-care-daily-situation-reports-2020-21/)

To calculate the cost of £400/day for an acute bed, NHSE drew on Healthcare Resource Group (HRG) data, Treatment Function Code (TRC) data and Resource-Based Costing data. These are taken from 2018/19 patient level information and costing systems data. The daily cost is derived from summing the total cost of providing treatment for all types of hospital admissions and then dividing this cost by the sum of total length of hospital stays. The data used in the analysis was restricted to non-elective patients aged 70 and over and is based on 2.35 million episodes. 142 acute organisations have provided data. HRG & TFC data (which includes all costs including capital costs) gives an average cost figure of £480. NHSE use a lower £400 per day bed cost. This is because the cost of providing care to an inpatient tends to be higher towards the beginning of a patient's admission into hospital. For example, on the first day of an inpatient stay, they may draw on a disproportionate amount of staff time, whereas at the end of their stay when they are near to being discharged, they are likely to draw on less staff time.

These estimates assume that local areas would have the capacity to provide reablement services and that reablement services fully met the care needs of people discharged so that patients would not need to be readmitted to hospital. Social care and health partners would coordinate onward care, making use of community health services where appropriate, to ensure that capacity constraints did not have a negative impact on patients' health and wellbeing outcomes.

In fact, providing recovery services for up to 6 weeks for a greater number of people is expected to reduce the number of preventable emergency hospital readmissions and associated costs on the NHS. This is based on anecdotal evidence from hospital trusts<sup>38</sup> and supported by the National Audit of Intermediate Care, showing that reablement services post discharge increase levels of independence compared to patients being treated in hospital for longer<sup>39</sup>. As most preventable hospital readmissions occur soon after discharge, increased levels of independence are expected to decrease those readmissions overall. We are currently unable to quantify this benefit due to a lack of robust evidence on the impact of D2A on the number of hospital readmissions.

### Discharge notices

As schedule 3 of the Care Act would be revoked, the system of issuing discharge notices and associated financial penalties would no longer be required. While there is no centrally held record of the savings generated by NHSE through penalty notices, we understand that the financial penalties associated with discharge notices are only used on rare occasions. We therefore assume that the financial benefits associated with removing them is negligible overall. The main benefit of revoking the provisions requiring discharge notes to be issued will be to facilitate collaborative working between NHSE and local authorities, thereby supporting the overall policy objective.

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<sup>38</sup> [210614-discharge-to-assess-funding-briefing.pdf \(nhsproviders.org\)](#)

<sup>39</sup> [NAIC \(2018\) Key findings England](#)

### Reduced long-term care provision

As explained above in paragraphs 63-66, we would expect some patients to require less intensive onwards care packages in the 6 weeks post-discharge than they would have done with longer stays in hospital. For example, elderly patients discharged earlier are less likely to experience the muscle deterioration which may have a detrimental impact on their ability to care for themselves. Some of these benefits would be realised by NHSE.

In addition, D2A enables assessments to be carried out when patients have reached optimum recovery. Assessing an individual when their physical and mental health should be more reflective of their medium to long-term needs results in more accurate, often less intensive, care packages. It is therefore expected that the assessments under D2A will, overall, reduce the need for long-term care provision which will primarily benefit local authorities.

## **Impacts on local authorities**

### **Benefits**

#### Reduced long-term care provision

As explained above in paragraph 63ff, we would expect some patients to require less intensive onwards care packages in the 6 weeks post-discharge than they would have done with longer stays in hospital. We are currently unable to quantify this benefit due to uncertainty around how the intensity of care packages would change under D2A. Most of these benefits would be realised by local authorities. We are currently unable to quantify this additional benefit due to a lack of robust data about the impact that D2A will have on long-term care packages.

In addition, D2A enables assessments to be carried out at a point in time when patients have reached optimum recovery, when their physical and mental health should be more reflective of their medium to long-term needs. It is therefore expected that the assessments under D2A will, overall, reduce the need for long-term care provision which will primarily be a benefit borne by local authorities. We are currently unable to quantify this additional benefit due to a lack of robust data about the impact that D2A will have on long-term care packages.

## **Impact on care providers**

According to the CQC register, there are approximately 14,000 care home and domiciliary care providers. Of these, around 6,500 provide residential/nursing care and 7,400 provide non-residential services to social care patients. Approximately 200 of these providers provide both

residential and domiciliary care services. In total, around 850 (7%) of all care providers act as a charity.<sup>40</sup>

We understand that under the baseline, social care providers are not commonly involved in the discharge process. In most cases, assessments were carried out jointly by health and social care staff in hospital. Providers play a role in delivering the onwards care packages that are being agreed during these assessments. Where local areas do not choose to implement D2A, there will be no impact on private providers, as they would continue operating as they did pre-pandemic and demand for their services would likely move towards pre-pandemic patterns (though other factors than D2A could have an impact on changes in demand). Compared to the baseline, there would therefore be no impact on providers, other than a minimal familiarisation cost, assuming that businesses would want to be aware of the legislative change to prepare for potential changes in demand.

Where local areas adopted D2A principles, we would expect to see a change in demand for services provided by care providers from the private and voluntary and community sector and for there to be associated impacts on the market structure.

#### *Familiarisation cost*

We assume there will be a one-off cost for senior managers of care providers who would need to familiarise themselves with any changes to discharge legislation. As D2A has been mandatory during the Covid-19 pandemic, we do not expect providers to require a substantial amount of familiarising themselves with the implications of this change (although there may be some differences in approach post-pandemic). As the legislative change would affect local authorities and hospital staff in the first instance, we assume that providers would spend less time on familiarising themselves with this change. We assume that each senior manager of a care provider would need to familiarise themselves for approx. 15 minutes with guidance and would disseminate the information within their teams, including directing staff to respond to new approaches and best practice. We estimate that legislation familiarisation would translate to a one-off cost of approximately £0.06mn (all care providers).

#### *Changes in demand for social care services*

We would expect to see a change in demand for services from care providers from the private and voluntary and community sector and we expect associated impacts on the market structure. First, demand for domiciliary care services is expected to increase as patients were discharged earlier and most patients are expected to be discharged home from hospital and would be entitled to reablement services.

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<sup>40</sup> <https://www.cqc.org.uk/about-us/transparency/using-cqc-data>



At the same time, we could also see a reduction in demand for long-term care home services, as more patients were discharged to their homes as opposed to care homes and because additional reablement services led to faster recovery and reduced need for some patients requiring long-term care. Overall, the impact on the market structure would depend critically on the model's local areas chose to adopt for the implementation of D2A.

### Domiciliary care providers

Where local areas continued implementing D2A, the impact on domiciliary care agencies is likely to be similar to their experience over the pandemic, where an approach called 'Home First' was widely promoted by the NHS and adult social care partners as a key principle of D2A. Patients were discharged home wherever possible to recover from their illness, rather than to community stepdown beds or care homes. Domiciliary care agencies therefore played an important role in implementing D2A and would likely see the biggest impact on demand for their services for four reasons:

- Various hospital trusts that implemented D2A during Covid-19 have reported significant reductions in average length of hospital stay. For example, the Midlands Partnership NHS Foundation Trust implemented D2A principles during Covid-19 and reduced their average length of hospital stay from 26 days to 19 days<sup>41</sup>. Services required during this time would previously have been provided by the NHS and would now be provided by care providers. This would be a shift in demand from the NHS to the care market, most of which would fall on domiciliary care providers.
- Where patients were discharged to their homes instead of a care home, community step-down bed or other care services, the increased demand would be a shift of services from other care providers towards domiciliary care providers.
- Some individuals would previously have received less than 6 weeks of reablement services after they were discharged from hospital (either home or to other care settings). These individuals would create an additional demand for care providers.
- We understand that in some local areas, representatives from domiciliary care agencies may also *be invited* to contribute to hospital and adult social care discharge team discussions about the level and frequency of care needed by individuals on discharge. While this might also be the case in some areas under the baseline, the demand for these conversations could be expected to increase under this option but would be voluntary on the part of the provider.

While an increase in demand could increase profits for domiciliary care providers, it could also potentially mean greater pressures as providers needed additional staff to meet demand. The social care workforce has undergone significant change over the course of the pandemic. As the hospitality and retail sectors reopen, people who had moved to the care sector (domiciliary agencies and care homes) may return to their original jobs, creating workforce shortages. We will monitor this closely to understand whether it has an impact on local areas' ability to implement D2A, for example through regular conversations with regional and local government contacts.

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<sup>41</sup> [Discharge to assess: the case for permanent funding](#)



The impact on domiciliary care providers would therefore be affected by available capacity and will ultimately be a commercial decision being made by providers. Many local areas report that the implementation of D2A during the pandemic was only possible because local areas have made more use of other social care services, such as day-care or services from the community and voluntary sector. These providers would therefore also be expected to see an increase in demand for their services.

Under the pandemic, some local areas have experienced an increase in domiciliary care users. While we do not have national-level data on this, various local areas reported increases in domiciliary care users as part of their initial D2A evaluations. Evidence from case studies suggest an increase in domiciliary care services in two LAs of between 60% and 105% in 2020/21 compared to the previous year. However, this increase is likely to be affected more by the number of patients being discharged (e.g. as a result of high numbers of people contracting Covid) and a reduced demand for care home placements due to the risk of infection observed during the pandemic rather than the length of time people spent in hospital, and how soon they are discharged. We are therefore unable to draw any inference about the likely impact of D2A on the demand for domiciliary care from these observations.

In order to illustrate the potential, maximum, impact on domiciliary care providers, we could look at the maximum increase in services provided. NHS suggests that approx. 45% of all affected patients (or 180,000 patients per year) would be discharged on pathway 1, i.e. discharged to their homes and entitled to reablement services. If all of these patients demanded the full six weeks of recovery services, this would amount to approx. 1m weeks of recovery services per year. According to the NHS Adult Social Care Finance and Activity Report (ASC-FR), local authorities funded 1.4m weeks of short-term care aimed at maximising independence in 2019/20.<sup>42</sup> An additional 1m weeks would therefore constitute a 75% increase in short-term services currently provided.

This demand would fall on domiciliary as well as other social care providers specialising in the provision of short-term services. Various local areas have highlighted the relevance that VCS organisations have played under Covid-19 to enable earlier discharge and associated onward care. It is estimated that that approximately 50% of home-based recovery services is provided by the voluntary care sector<sup>43</sup>.

### Care home providers

The effect of implementing D2A on private providers of care homes is less clear. On the one hand, they could experience an increase in (short-term) demand because patients, on average, are expected to be discharged from hospital earlier. However, as mentioned in paragraph 10,

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<sup>42</sup> [Adult Social Care Activity and Finance Report - NHS Digital](#), using denominators (activity in hours) for short-term (MAX) services

<sup>43</sup> Predicting and Managing Demand in social care April 2016 Institute of Public Care. To note that this is provision of care and not funding.

under D2A, we would expect that only around 1% of patients discharged early would be directly transferred to a care home setting. This is expected to be a reduction compared to pre Covid-19 rates, so we expect additional short-term demand on care home providers to be very minimal, if any.

On the other hand, we may expect fewer patients to be discharged to care homes overall. Current discharge guidance is clear that no person should be transferred to a care home as a permanent placement for the first time straight from an acute hospital bed. As part of the 'Home First' approach, this would continue to be our policy in future. This could lead to a transfer in demand from care-home providers to domiciliary care providers. In addition, D2A enables assessments to be carried out at a point in time when patients have reached optimum recovery and could therefore reduce the intensity of long-term care packages.

While we are unable to quantify this effect at this stage, it is based on experiences made by various local areas who report that D2A reduced care home placements when D2A was implemented during the pandemic. For example, Somerset county council have stated that they have experienced an 86% reduction in care home placements from hospital during 2020.<sup>44</sup> South Warwickshire has reduced long-term care costs by £0.5m due to patients being less likely to be allocated a package that included nursing care needs<sup>45</sup>. While much of this reduction is likely caused by a general reduction in demand for care home placements due to the risk of infection with covid-19, some of this could be attributed to D2A principles being followed. Stakeholders from the health and social care system confirm that D2A reduces time spent by people in the wrong place.<sup>46</sup>

We therefore expect that the reduction in medium to long-term demand of care homes will outweigh the minimal increase in short-term demand, but are currently unable to quantify the change in demand due to a lack of national-level data.

To illustrate the potential impact, we have looked at NHS SALT data to estimate that in 2019/20 approx. 7% of patients that were discharged from hospital to a care package were transferred to a care home setting. As stated in paragraph 10, we assume that under the D2A pathway model, this would reduce to approx. 1% of all patients, or 2% of patients that receive an onwards care package. This translates to an estimated reduction in the number of patients discharged directly to a care home setting of approx. 19,200 patients annually (due to D2A). Some of these individuals may still be transferred to a care home (after they receive their long-term care assessment). NHSE estimates that overall, 10% of patients with long-term needs assessment will require a package of lower intensity than at the start of recovery<sup>47</sup>. Based on this we could assume that 10% of the 19,000 patients who would no longer be directly transferred to a care home setting would no longer require long-term care in a care home (after assessment). This

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<sup>44</sup> Somerset county council case study, unpublished

<sup>45</sup> [Quick Guide: Discharge to Assess \(www.nhs.uk\)](http://www.nhs.uk)

<sup>46</sup> [Quick Guide: Discharge to Assess \(www.nhs.uk\)](http://www.nhs.uk)

<sup>47</sup> [Hospital discharge service: policy and operating model \(publishing.service.gov.uk\)](http://publishing.service.gov.uk)

would translate to a reduction in long-term care demand from a care home setting of approx. 1,900 individuals. This accounts for approx. 0.6% of the current care home population.

The proportion of organisations from the voluntary and community sector is small. According to the CQC, only 7% of care home providers act as a charity. We therefore expect the impact on care home providers to be mainly borne by private providers.

Overall, it is important to note that the nature of the model that local areas choose to adopt (e.g. 'Home First') will have a greater impact on admissions to care homes than D2A itself. Local areas will need to decide whether and how they want to follow D2A principles, considering their capacity, budget and the local market they are facing. Different operating models will therefore have different impacts on the market.

In absence of a mandated national model, it is therefore difficult to estimate the expected impact. Various evaluations of the policy will seek to look into these impacts further.

*Additional costs and benefits identified in response to the government amendment introduced in the final stages of the Bill process to include carers in discharge planning*

The Act has been amended to introduce a new duty for trusts and foundation trusts to, where appropriate, involve patients and carers, including young carers, at the earliest opportunity in discharge planning for adult patients who are likely to need care and support after their hospital discharge. The clause states that patients and carers should be involved as soon as it is feasible after the trust begins making any plans relating to the patient's discharge. This clause defines a carer as an individual who provides or intends to provide care for an adult, otherwise than by virtue of a contract or as voluntary work. It applies to carers of all ages, including young carers. We have identified the following costs and benefits of this duty and have added them to the total impact of Option 2 as set out below.

## **Impacts on unpaid carers**

### **Costs**

#### *Impact on employment, earnings and well-being*

Using 2019 HSE estimates<sup>48</sup> and ONS 2020 population projections<sup>49</sup> and CPEC ASC projections<sup>50</sup>, we estimate that there are approximately 7.7m unpaid carers over the age of 16 in England in 2021. Depending on take up, it is estimated that between 350,000 and 700,000 patients would be discharged on pathway 0 or 1 under D2A in 2021/22 and might therefore require some level of support from unpaid carers and the voluntary and community sector. Under this scenario, where we assume that all local areas take up D2A, 700,000 patients would be discharged on pathway 0 or 1. Existing or new carers may choose to provide care. The level

<sup>48</sup> [HSE19-Carers-rep.pdf \(digital.nhs.uk\)](#)

<sup>49</sup> [National population projections: 2018-based, 10-year migration variant for Wales - Office for National Statistics](#)

<sup>50</sup> [Projections of Adult Social Care Demand and Expenditure 2018 to 2038 \(lse.ac.uk\)](#)

of support required as well as the associated impact on work hours and salary would vary significantly case-by-case and the impact on unpaid carers is difficult to assess. We are therefore unable to quantify the impact on unpaid carers at this stage. It should be noted that this impact assessment only focuses on the period of time immediately post-discharge and does not consider longer term caring responsibilities. Carers always have the right to revisit their decision about providing care to an individual.

The new duty (paragraph 51) means that carers (including young carers and patients) should be involved from an early stage in discharge planning, where appropriate. This should include establishing whether they are willing and able to provide short term, post-discharge care for patients on pathways 0 or 1, as there is no requirement for individuals to take on this unpaid care. If individuals do choose to provide more unpaid care, they may reduce their work hours and salary during this period, with associated financial costs. In some circumstances, unpaid carers may qualify for carers allowance.

The provision of unpaid care can also have a negative impact on the health, well-being and quality of life of unpaid carers. This is particularly the case for higher intensity caring.<sup>51</sup> Although some studies report positive impacts of providing unpaid care on an individual's health and wellbeing at low intensities,<sup>52</sup> most research suggests that caring, particularly at higher intensities, is associated with poorer physical and mental health.<sup>53</sup> Research finds that, after considering age and other sociodemographic factors, carers are 16% more likely than non-carers to live with 2 or more long-term health conditions.<sup>54</sup>

Caring can adversely affect a person's employment, particularly when caring for many hours a week. A greater number of carers who are providing care for 10 or more hours a week report having had to reduce their hours, find a new job or reduce responsibility at work as a result of caring compared to those providing less intensive care.<sup>55</sup> In fact, evidence finds that for some groups of carers, caring for 10 or more hours per week is significantly associated with an increased probability of that person having to leave employment, for example amongst female carers aged between 50 and State Pension Age<sup>56</sup>.

This evidence does not specifically relate to D2A and is included for wider context only. As set out above, an analysis of the impact of long-term caring responsibilities is not in the remit of this impact assessment.

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<sup>51</sup> [Brimblecombe, N., Fernandez, J.-L., Knapp, M., Rehill, A., & Wittenberg, R. \(2018\). Review of the international evidence on support for unpaid carers. Journal of Long-Term Care, September, 25–40.](#)

<sup>52</sup> [Brimblecombe, N., Fernandez, J.-L., Knapp, M., Rehill, A., & Wittenberg, R. \(2018\). Review of the international evidence on support for unpaid carers. Journal of Long-Term Care, September, 25–40.](#)

<sup>53</sup> [Brimblecombe, N., Fernandez, J.-L., Knapp, M., Rehill, A., & Wittenberg, R. \(2018\). Review of the international evidence on support for unpaid carers. Journal of Long-Term Care, 25–40](#)

<sup>54</sup> PHE, 2021, [Caring as a social determinant of health.](#)

<sup>55</sup> NHS Digital, 2020. [Health Survey for England 2019](#)

<sup>56</sup> King, D. and Pickard, L, 2013, [When is a carer's employment at risk? Longitudinal analysis of unpaid care and employment in midlife in England.](#) Health & Social Care in the Community, 21: 303- 314.

## Benefits

### Carer discharge involvement

A Carers UK report identified that 25% of the carers they surveyed had experienced hospital discharge for a person that they care for between March 2020 and March 2021. Using this, we estimate that approx. 2m carers in England experienced discharge for a patient between March 2020 – March 2021. This has been derived by assuming that 25% of the 7.7m unpaid carers (paragraph 112) experienced hospital discharge for someone they care for.

The Carers UK survey also found that 56% of the carers that experienced a hospital discharge for the person they care for were not involved in decisions about the person's discharge. Applying this to our estimate in paragraph 117, we estimate that approx. 1m unpaid carers over the age of 16 experienced a hospital discharge but were not involved in decisions about the discharge.

The estimates in paragraphs 117 and 118 do not include unpaid carers under the age of 16 (due to limited data on this group). The 2011 Census indicates that approx. 2% of unpaid carers were aged under 16.<sup>57</sup>

A duty will be introduced requiring a trust responsible for adult hospital patients to involve any carer of the patient, where appropriate, in discharge planning. This should be done as soon as is feasible after it begins making any plans relating to discharge. Hospital discharge guidance also sets out that all patients (or their representative or advocate if they lack capacity) should be given information and advice when discharged, including who they can contact if their condition changes, how their needs will be assessed and the follow up support they will receive. Between March 2020 – March 2021, we estimate that approx. 1m unpaid carers experienced a hospital discharge for the person they care for, but were not involved in decisions about the person's discharge (paragraph 118). Therefore, once this duty is introduced, we anticipate that approx. 1m additional unpaid carers will be involved in discharge planning per year. We estimate that there will be an additional cost to the system of approx. £13m for our lower estimate, £32m for our central estimate and £64m per year for our upper estimate. This is due to the additional number of carers that trusts will need to identify and involve in discharge planning. The lower estimate assumes that it takes a case worker a tenth of a day to identify and involve each carer, a quarter of a day for the central estimate and half a day for the upper estimate. We also assume that each case worker is on a band 6 NHS wage rate which translates to £31,365 per year (2020/21 prices). Additionally, we applied a 30% cost uplift to account for non-wage costs (this captures costs such as pensions and national insurance contributions). We anticipate that there would not be a consultation cost for carers involved in this process. An extra time commitment is unlikely because the involvement process would streamline the overall engagement that carers have with trusts. This would lead to better support and planning for carers, which would save carers' time.

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<sup>57</sup> [Census carer intensity by age and gender.xlsx](#)

Costs:

Benefits:

### *Better arrangements for unpaid carers*

It should be noted that any increase in time spent on unpaid care may be partially offset by the fact that without D2A, patients would experience longer hospital stays that can lead towards loss of independence and functional decline such as muscle deterioration, which in turn could require more unpaid care provision under the baseline. However, we do not have any evidence to validate the relation between loss of independence and the time spent on unpaid care and so this assumption is subject to a high degree of uncertainty.

The introduction of a duty requiring the involvement of carers (and patients) in discharge planning should lead to the identification of support that carers need prior to taking on caring responsibilities, including signposting them to carers' assessments and other support. This should have a positive impact on the wellbeing of unpaid carers (which we are unable to quantify/monetise).

### *Better quality care for the care receiver*

The introduction of a duty requiring the involvement of carers (and patients) in discharge planning should lead to better quality care for unpaid care receivers. Those caring for these individuals would be receiving better support and preparation for these responsibilities. This would help carers to provide better quality care to the receiver of care.

### *Total impact*

Table 1 indicates the quantified costs and benefits associated with the D2A legislation change. We estimate that option 2 would incur total costs of £9.3bn over ten years and benefits of £16.9bn with a Net Present Value of £7.6bn. These estimations assume that 100% of local areas will comply with D2A guidance. Please note that all quantified costs and benefit below are under the assumption that the government funds 6 weeks of recovery services for those who are entitled. This has not been agreed and other D2A options may be taken into consideration.

In addition to these quantified costs, there could be non-monetised benefits, mainly improved patient outcomes, an additional reduction in long-term care requirements and public health benefits due to more efficient allocation of NHS resources. Additionally, option 2 would lead to less variation in how discharge assessments would be carried out across local areas. This could lead to less ambiguity around roles and responsibilities which can potentially reduce waiting times and uncertainty for care patients.

Option 2 is expected to lead to a positive NPV as all local areas would adopt D2A principles and realise the associated net benefits. However, the risk that option 2 may jeopardise flexible working arrangements, and coordination between different stakeholders involved in the D2A process, is considered so high that the negative consequences would outweigh the benefits. Our discussions with health and social care stakeholders, based on their experiences of implementing a range of approaches to discharge and D2A models during the pandemic, indicate that the most effective way to support patient outcomes is to enable local innovation, partnership and creativity to drive discharge models, rather than central prescription and mandating a single approach.

**Table 1 - Estimated Costs and Benefits of Option 2, in £m, Central Estimate**

<b>Total costs and benefits in £m (2019/20 prices) - Option 2 Central Estimate</b>					
<b>Year</b>	<b>Total One-Off</b>	<b>Total Recurring</b>	<b>Total</b>	<b>PV (2020 Base Year)</b>	<b>Annual Equivalent</b>
	<b>various</b>	<b>2022-2031</b>	<b>2022-2031</b>	<b>2022-2031</b>	<b>2022-2031</b>
<b>Costs</b>					
<b>NHSE</b>	<b>£0.31</b>	<b>£0.00</b>	<b>£0.31</b>	<b>£0.29</b>	<b>£0.03</b>
Familiarisation	£0.31	£0.00	£0.31	£0.29	£0.03
<b>LAs</b>	<b>£0.02</b>	<b>£0.00</b>	<b>£0.02</b>	<b>£0.02</b>	<b>£0.00</b>
Familiarisation	£0.02	£0.00	£0.02	£0.02	£0.00
<b>Private providers</b>	<b>£0.06</b>	<b>£0.00</b>	<b>£0.06</b>	<b>£0.06</b>	<b>£0.01</b>
Familiarisation	£0.06	£0.00	£0.06	£0.06	£0.01
<b>Voluntary and community providers</b>	<b>£0.00</b>	<b>£0.00</b>	<b>£0.00</b>	<b>£0.00</b>	<b>£0.00</b>
Familiarisation	£0.00	£0.00	£0.00	£0.00	£0.00
<b>Health and ASC sector</b>	<b>£0.00</b>	<b>£11,700</b>	<b>£11,700</b>	<b>£9,300</b>	<b>£1,100</b>
Coordination cost	£0.00	£2,300	£2,300	£1,800	£200
Carer involvement costs	£0.00	£200	£200	£200	£30
Provision of recovery services	£0.00	£9,000	£9,000	£7,200	£800
<b>Total Costs</b>	<b>£0.39</b>	<b>£11,700</b>	<b>£11,700</b>	<b>£9,300</b>	<b>£1,100</b>
<b>Benefits</b>					
<b>NHSE</b>	<b>£0.00</b>	<b>£12,000</b>	<b>£12,000</b>	<b>£9,500</b>	<b>£1,100</b>
Freed NHS capacity	£0.00	£12,000	£12,000	£9,500	£1,100
<b>Care Receivers</b>	<b>£0.00</b>	<b>£9,300</b>	<b>£9,300</b>	<b>£7,400</b>	<b>£900</b>
Less long term care provision	£0.00	£9,300	£9,300	£7,400	£900
<b>Total Benefits</b>	<b>£0</b>	<b>£21,300</b>	<b>£21,300</b>	<b>£16,900</b>	<b>£2,000</b>
<b>Net Benefit</b>	<b>-£0.39</b>	<b>£9,600</b>	<b>£9,600</b>	<b>£7,600</b>	<b>£900</b>



### **Option 3 (Preferred option) – Revoke legislative requirements to assess pre-discharge**

Under Option 3, we would revoke existing legal requirements which require relevant needs assessments to be carried out pre-discharge. This proposal was developed jointly with health and social care partners.

Through repealing Schedule 3, the system of discharge notices and associated financial penalties set out in the Care Act will also be removed. This provision does not change existing legal obligations on NHS bodies to meet health needs, and local authorities are still required to assess and meet people's needs for adult social care. Nor does it alter the thresholds of eligibility for continuing healthcare, funded nursing care or support through the Care Act.

Additionally, a duty will be introduced that requires trusts responsible for adult hospital patients to involve the patient and any carer, including young carers of the patient where appropriate in discharge planning. This should be done as soon as is feasible after it begins making any plans relating to discharge.

Each local area would implement their own approach to hospital discharge that best met local needs, taking into account market structure and capacity as well as the ASC sector's financial situation. For the purpose of this assessment, we assume that between 50% and 100% of local areas would choose to follow D2A principles under option 3. The following assessment is based on various assumptions around the delivery of these services, mainly assuming that patients will be entitled to 6 weeks of state-funded recovery services post discharge. This has not been agreed. As local areas might choose to implement other ways to embed D2A practices, impacts might differ from the estimated impacts illustrated in the assessment below.

The assessment below illustrates the potential costs and benefits under the assumption that between 50% (low scenario) and 100% (high scenario) of all local areas would choose to follow D2A principles, with a central estimate of 75%. (The impact under the high estimate therefore equals the impact under option 2).

The assessment is based on the same assumptions as outlined under option 2, mainly assuming that patients will be entitled to 6 weeks of state-funded recovery services post discharge. This has not been agreed. As local areas might choose to implement other ways to embed D2A practices, impacts might differ from the estimated impacts illustrated in the assessment below.

The following impacts have been identified for this option:



## **Familiarisation costs**

### **NHSE**

There is a one-off cost for NHS staff who would need to familiarise themselves with any changes to discharge legislation. As D2A has been implemented nationally during the Covid-19 pandemic, we do not expect local areas to require a substantial amount of familiarising themselves with the implications of the proposed change (although there may be some differences in approach post-pandemic). However, we assume that each senior hospital manager would need to familiarise themselves for approx. 30 minutes with guidance and would disseminate the information within their teams, including directing staff to respond to new approaches and best practice.

According to NHSE's monthly workforce statistics, there were 11,459 senior managers employed by Trusts and CCGs<sup>58</sup>. Multiplying this number with the average hourly wage rate for NHSE senior managers of £42 and the estimated familiarisation time of 0.5 hours, this translates to a one-off familiarisation cost for NHSE of £0.3m. We assume that this would be required irrespective of the take up of D2A by local areas.

### **LAs**

There is a one-off cost for local authority managers who would need to familiarise themselves with any changes to discharge legislation and guidance. We assume each senior local authority manager would need to familiarise themselves for approximately 30 minutes with guidance and would disseminate the information within their teams, including directing staff to respond to new approaches and best practice.

According to the Skills for Care's weighted workforce estimates, in 2019/20, there were 700 senior local authority managers<sup>59</sup>. Multiplying this number with the average hourly wage rate for local authority senior managers of £43 and the estimated familiarisation time of 0.5 hours, this translates to a one-off familiarisation cost for local authorities of £0.02m. We assume that this will be required irrespective of the take-up of D2A by local areas.

### **Private Providers**

There is a one-off cost for senior managers of private providers who would need to familiarise themselves with any changes to discharge legislation and guidance. We assume that one senior manager from each private care provider would need to familiarise themselves for

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<sup>58</sup> <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/november-2020>

<sup>59</sup> Skills for Care's weighted workforce estimates, 2019/20

approximately 15 minutes with guidance and would disseminate the information within their teams.

According to the CQC register, in 2020/21 there were 12,900 private providers in England.<sup>60</sup> We multiply this number with the average hourly wage rate for independent provider senior managers of £16 and the estimated familiarisation time of 0.25 hours. This translates to a one-off familiarisation cost for private providers of £0.06m.

#### Voluntary and community providers

There is a one-off cost for senior managers of VCS providers who would need to familiarise themselves with any changes to discharge legislation and guidance. We assume that one senior manager from each private care provider would need to familiarise themselves for approximately 15 minutes with guidance and would disseminate the information within their teams.

According to the CQC register, in 2020/21 there were 856 VCS providers in England. We multiply this number with the average hourly wage rate for independent provider senior managers of £16 and the estimated familiarisation time of 0.25 hours. This translates to a one-off familiarisation cost for VCS providers of £4,200.

### **Monetised ongoing costs**

#### Provision of recovery services outside of hospital

As explained in paragraph 61, we use SALT data and CPEC projections for self-funders to estimate the amount of patients that would be entitled to additional state funding for recovery services. We estimate that if 75% of local areas followed D2A principles, approximately 120,000 patients would be entitled to additional funding for recovery services annually. This would translate to annual cost to the ASC sector of approx. £0.6bn assuming a 75% take-up under the central scenario.

#### Coordination cost

Under paragraphs 78-80, we describe the coordination costs we anticipate if local areas were to take up D2A. This is the additional burden on the ASC sector to determine who would be responsible for intermediate care provision and to coordinate these provisions after discharge and the assumptions made when quantifying the cost. If we assumed that the ASC sector deployed case managers (responsible for approximately 10 patients at any time) and whose services would be required for 1-6 weeks post discharge (with a central estimate of 3.5 weeks),

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<sup>60</sup> <https://www.cqc.org.uk/about-us/transparency/using-cqc-data>

this would translate to an additional cost of between £15m and £190m with a central estimate of £80m annually.

## **Monetised ongoing benefits**

### *Freeing up NHS capacity*

As explained in paragraphs 80-85, D2A would lead to a significant reduction in the amount of time that patients need to stay in acute hospital settings for those awaiting their long-term care assessments. This would translate to annual benefit of between £550m and £1100m with a central estimate of £800m annually.

### *Reduced self-funder spend on recovery services*

As mentioned in paragraph 61, if local areas followed D2A guidance, some self-funders would be entitled to additional funding for recovery services for up to 6-weeks. These patients would have paid for their onwards care themselves without D2A. This would lead to an annual saving for self-funders of £0.6bn (central estimate).

## **Additional costs and benefits identified in response to the government amendment introduced in the final stages of the Bill process to include carers in discharge planning**

### *Carer involvement cost*

Under paragraphs 117-120, we describe the unpaid carer involvement costs we anticipate due to an introduction of a new duty. The new duty introduced means that patients and carers, including young carers, should be involved from an early stage in discharge planning, where appropriate. We anticipate that approx. 1m additional unpaid carers will be involved in discharge planning per year. We estimate that there will be an additional cost to the system of approx. £13m for our lower estimate, £32m for our central estimate and £64m per year for our upper estimate. This is due to the additional number of carers that trusts will need to identify and consult with. The lower estimate assumes that it takes a case worker a tenth of a day to identify and consult with each carer, a quarter of day for the central estimate and half a day for the upper estimate. We also assume that each case worker is on a band 6 NHS wage rate which translates to £31,365 per year (2020/21 prices).

### *Total impact*

In total, if local areas chose to follow D2A principles under option 3, we would expect this to be associated with costs of between £3.9bn and £9.6bn with a central estimate of £6.5bn and benefits of between £8bn and £17bn with a central estimate of £13bn over a 10-year appraisal period. For the central scenario (assuming a 75% take-up of D2A principles by local areas), the total net impact would be £6.2bn with an annual equivalent of £0.7bn. Table 4 below provides a detailed breakdown of the illustrative costs and benefits under the central estimate. Please note that all quantified costs and benefit below are under the assumption that the government funds

6-weeks of recovery services for those who are entitled. This has not been agreed and other D2A options may be taken into consideration.

In addition to these quantified costs, there could be non-monetised benefits, mainly improved patient outcomes, an additional reduction in long-term care requirements and public health benefits due to more efficient allocation of NHS resources and less discharge notices. The scale of these benefits would likely be lower than under option 2, due to a lower uptake of D2A principles.

Overall, revoking current requirements will create flexibility for local areas to adopt discharge processes that best meet the needs of the local population, including the D2A model. It will also facilitate closer collaboration between health and social care systems and enable better outcomes for people following their stay in acute care by allowing individuals to recover in an environment that is familiar to them while they receive reablement support in the community.

**Table 4 - Illustrative Costs and Benefits of Option 3, Central Estimate**

<b>Total costs and benefits in £m (2019/20 prices) - Option 3 Central Estimate</b>					
	<b>Total One-Off</b>	<b>Total Recurring</b>	<b>Total</b>	<b>PV (2020 Base Year)</b>	<b>Annual Equivalent</b>
<b>Year</b>	<b>various</b>	<b>2022-2031</b>	<b>2022-2031</b>	<b>2022-2031</b>	<b>2022-2031</b>
<b>Costs</b>					
<b>NHSE</b>	<b>£0.31</b>	<b>£0.00</b>	<b>£0.31</b>	<b>£0.29</b>	<b>£0.03</b>
Familiarisation	£0.31	£0.00	£0.31	£0.29	£0.03
<b>LAs</b>	<b>£0.02</b>	<b>£0.00</b>	<b>£0.02</b>	<b>£0.02</b>	<b>£0.00</b>
Familiarisation	£0.02	£0.00	£0.02	£0.02	£0.00
<b>Private providers</b>	<b>£0.06</b>	<b>£0.00</b>	<b>£0.06</b>	<b>£0.06</b>	<b>£0.01</b>
Familiarisation	£0.06	£0.00	£0.06	£0.06	£0.01
<b>Voluntary and community providers</b>	<b>£0.00</b>	<b>£0.00</b>	<b>£0.00</b>	<b>£0.00</b>	<b>£0.00</b>
Familiarisation	£0.00	£0.00	£0.00	£0.00	£0.00
<b>Health and ASC Sector</b>	<b>£0.00</b>	<b>£8,100</b>	<b>£8,100</b>	<b>£6,500</b>	<b>£800</b>
Coordination cost	£0.00	£1,000	£1,000	£800	£100
Carer involvement costs	£0.00	£200	£200	£200	£20
Provision of recovery services	£0.00	£6,800	£6,800	£5,400	£600
<b>Total Costs</b>	<b>£0.39</b>	<b>£8,100</b>	<b>£8,100</b>	<b>£6,500</b>	<b>£800</b>
<b>Benefits</b>					
<b>NHSE</b>	<b>£0.00</b>	<b>£9,000</b>	<b>£9,000</b>	<b>£7,100</b>	<b>£800</b>
Freed NHS capacity	£0.00	£9,000	£9,000	£7,100	£800

<b>Care Receivers</b>	<b>£0.00</b>	<b>£7,000</b>	<b>£7,000</b>	<b>£5,500</b>	<b>£600</b>
Less long term care provision	£0.00	£7,000	£7,000	£5,500	£600
<b>Total Benefits</b>	<b>£0</b>	<b>£16,000</b>	<b>£16,000</b>	<b>£12,600</b>	<b>£1,400</b>
<b>Net Benefit</b>	<b>-£0.39</b>	<b>£7,800</b>	<b>£7,800</b>	<b>£6,200</b>	<b>£700</b>

If we assume there was a 50% uptake of D2A guidance in local areas, we estimate the NPV for a 10-year appraisal period to be approximately £4.6bn. The annual equivalent is around £0.5bn.

If we assume there was a 100% uptake of D2A guidance in local areas, we estimate the NPV for a 10-year appraisal period to be approximately £7.3bn. The annual equivalent is around £0.9bn.

We have considered the risk of revoking responsibilities of NHS bodies and LAs currently set out in legislation during the discharge process. It should be noted that although our preferred option would enable local areas to adopt discharge processes that best met local needs, it would not change existing legal obligations on NHS bodies to meet health needs, and local authorities would still be required to assess and meet people's needs for adult social care.

In addition to the separate duties to meet health and social care needs, discharge guidance would set out expectations for how the existing legislative duty for NHS bodies and LAs to cooperate<sup>61</sup> applied to discharge practice. As set out above, this guidance would be co-produced with health and social care partners and stakeholder organisations.

Having carefully weighed up the costs, benefits and risks, we have therefore concluded that this is the most effective option to facilitate the safe and timely discharge of patients, and which empowers the health and social care sectors to work together collaboratively.

## Direct costs and benefits to business calculations

We expect two impacts on social care providers:

First, there will be small one-off familiarisation cost for providers of approx. £70,000, of which 94% are expected to fall on providers from the private sector.

<sup>61</sup> Set out in section 82 to the NHS Act 2006: In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

Second, we expect to see an increased demand for domiciliary care services. We are currently unable to quantify this impact, as it will vary significantly by local area and will depend on commercial decisions and local market conditions.

The total quantified impacts on businesses are therefore minimal and fall well below the BIT threshold of £5m annually, although we cannot exclude the possibility that some providers will see greater impacts than that due to changes in demand for their services.

## **Risks and assumptions**

Establishing the exact effect on the various sectors under the preferred option is difficult because in the absence of mandatory legislation to follow D2A principles, each local area will develop their own approach to hospital discharge that best meets individuals' needs. The illustrative assessment is based on various assumptions about the potential uptake of D2A and the delivery options for post-discharge recovery services. A high level of uncertainty remains around these parameters. In particular:

- All quantified costs are based on the assumption that patients will be entitled to 6 weeks of state-funded recovery services post discharge. As other D2A options could be implemented, the illustrative impacts could over- or underestimate the true impacts.
- We assume that 100% of LAs would follow D2A principles under option 2 and between 50% and 100% of all local authorities would follow D2A principles under option 3.
- We assume that the number of patients entitled to recovery services would increase by 3% annually due to an increase in user numbers (based on 18/19 data). This might underestimate the true costs and, to a lesser extent, benefits of the preferred option. It would therefore overestimate the NPV.
- We assume that the proportion of people receiving each type of recovery services post discharge will be the same as in 18/19. This could significantly underestimate the benefits associated with the proposed option as it is expected that more people will be discharged to their homes and less to residential or nursing care, with associated financial benefits.
- Various other assumptions have been made about the ways of implementing D2A which might not hold true, including assumptions around the required coordination and familiarisation time. As implementation might take different forms in practice, this might under- or overestimate the true NPV.

The key costs and benefits are based on a preliminary review conducted by NHSE. These figures are preliminary and might be subject to revision when a more robust evaluation of D2A has been completed. This includes an assertion that some of the impacts can be fully attributed to D2A and were not caused by other reasons that have so far not been controlled, for example the reduced length of stay and freed up NHS capacity that we have entirely attributed to D2A.

## **Impact on small and micro businesses**

We expect two impacts on social care providers:

First, there will be small one-off familiarisation cost for providers. As the legislative change will not impose or remove any regulations for providers, we expect the time allocated to familiarisation to be very small. We therefore do not think that this will constitute a disproportionate impact on small and micro businesses.

Second, we expect to see an increased demand for domiciliary care services from providers of all size. Approximately, 89% of domiciliary care providers are small and micro businesses, compared to 77% of residential care providers.<sup>62</sup> Therefore, most of this additional demand will likely be taken on by small and micro businesses. However, whether these businesses decide to take on additional clients will ultimately a commercial decision being made by providers. While we are unable to assess the impacts in further detail, as they will vary significantly by local area and will depend on commercial decisions and local market conditions, we expect businesses to benefit from an increase in demand overall.

## **Wider impacts**

### *Equalities Assessment*

Policy measures in the Health and Care Act have undergone an equalities assessment as appropriate.

### *Competition and innovation*

The proposed change would not impose any regulations or restrictions directly on social care providers which might affect competition. However, if local areas chose to adopt D2A, there could be some changes in demand for social care services and potentially on the provider market structure and consumer choice.

As discussed above, there could be a small reduction in care home demand in the medium- to long-term. At the same time, we would expect to see an increase in domiciliary and other care services that are aimed at maximising individuals' independence.

As emphasised throughout the IA, the impact on the market (and therefore competition) will depend critically on the local models that areas choose to implement D2A. Throughout the pandemic, we have observed that providers and local authorities have flexibility to adjust to significant changes to the market structure, based on local circumstance, e.g. meeting an increase in domiciliary care by greater involvement from the voluntary and community sector.

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<sup>62</sup> [The size and structure of the adult social care sector and workforce in England \(skillsforcare.org.uk\)](https://skillsforcare.org.uk)

The CMA has flagged in their 2017 care home market report that there is currently a lack of transparency around care fees on the care home market, which, combined with pressures for individuals to make fast decisions, affects competition on price and quality of care packages<sup>63</sup>. This is particularly relevant for self-funders, who pay on average 41% more for their care home fees and, in most cases, organise their care packages independently.

By promoting recovery services and enabling assessments to be made at a point of optimal recovery, D2A supports the 'Home First' principle whereby people can return home and live independently for as long as possible (if that is their choice and they are able to do so). This should result in fewer people being discharged directly into care homes from hospital for the first time. It may be appropriate, however, for some people ultimately to move into a care home once they have had a chance to return home and explore their options with family and their wider informal network; having ascertained the financial implications of different options.

The focus of D2A to enable patients to have greater choice and time with regards to their onwards care packages should reduce the existing information asymmetry that currently prevails on the care home market. The benefits on the competitiveness of the sector will be stronger in areas where local authorities play a bigger role in coordinating onwards care packages.

### Innovation

While we do not expect a significant impact of the proposed change on innovation, additional demand for domiciliary care services could open up new opportunities for domiciliary care providers to invest in innovative approaches and technology.

### Other wider impacts

We do not foresee any other wider impacts.

## **A summary of the potential trade implications of measure**

We do not foresee any impact on trade as a result of this change.

## **Monitoring and Evaluation**

Government is committed to evaluating the policies it implements as part of a Post Implementation review (PIR). We are considering how best to undertake a PIR in relation to

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<sup>63</sup> [Care homes market study: final report \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)



discharge and will work closely with NHS England and local government partners to develop a comprehensive evaluation plan. We maintain regular contact with these stakeholders and collect a range of data relating to hospital length of stay, which will enable us to monitor how safely and efficiently patients are being discharged from hospital, and whether this discharge is effective (see 'policy objectives' for a list of metrics that will be collected). We will use these datasets to monitor progress over time (e.g. monitor the change in hospital beds occupied by patients with non-urgent health care needs).

We will use the results of evaluations and reports to shape policy and guidance on hospital discharge policy, including D2A. We are also exploring the development of materials to support LAs to implement D2A, which would be based on close working with a sample of LAs to identify best practice. This work would also feed into discharge guidance and best practice.

While a detailed evaluation plan is still to be developed, some of the key evaluation questions we aim to answer by reviewing external evaluations and making use of data collected nationally are:

- d. What impact does D2A have on hospital length of stay, patterns of delays and pathway destinations?
- e. How many patients are discharged on each pathway and are they judged to have been discharged onto the most appropriate pathway to meet their needs?
- f. What impact does D2A have on long-term care packages?
- g. What impact does D2A have on patients' recovery duration and overall wellbeing?

We will draw on this evidence base to develop guidance and good practice and will continue to collect data on discharge.

# Annex B – Regulatory Impact Assessment – Provider Payments

<b>Title: Power for the Secretary of State to make payments to Social Care Providers</b>  <b>IA No:</b> 9577 <b>RPC Reference No:</b> RPC-DHSC-5082(1) <b>Lead department or agency:</b> DHSC <b>Other departments or agencies:</b> Ministry of Housing, Communities and Local Government (MHCLG)	<b>Impact Assessment (IA)</b>
	<b>Date:</b> 27/10/2022
	<b>Stage:</b> Final
	<b>Source of intervention:</b> Domestic
	<b>Type of measure:</b> Primary legislation
	<b>Contact for enquiries:</b> <a href="mailto:Andrew.Ficinski@dhsc.gov.uk">Andrew.Ficinski@dhsc.gov.uk</a>
<b>Summary: Intervention and Options</b>	<b>RPC Opinion:</b> GREEN

Cost of Preferred (or more likely) Option (in 2019/20 prices)			
Total Net Present Social Value	Business Net Present Value	Net cost to business per year	Business Impact Target Status Qualifying provision
N/A	N/A	N/A	

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

The Secretary of State for Health and Social Care currently has a power to make payments to not-for-profit social care providers but does not have the authority to provide payments directly to profit-making providers. This does not reflect the reality of the social care market which is largely made up of private profit-making providers. This places social care on a different footing to publicly provided healthcare and other sectors and is a barrier to providing direct support to such providers. The challenges this presented to DHSCs ability to support the care sector became very apparent during the pandemic. The interventions required during the Covid-19 pandemic provide strong evidence of the need for an option to provide direct financial support from HMG to the sector in response to future unique circumstances.

**What are the policy objectives of the action or intervention and the intended effects?**

Amendments to the existing legislation will allow the Secretary of State to provide financial assistance to all social care providers providing services in England, in a fast and flexible way, to respond to any emergency situations that arise or to account for unique situations.

There is no practical change arising directly from this legislative amendment as the power to provide financial assistance remains discretionary. Rather, the power could be used in future, as required, to provide essential support to the social care sector to address problems arising from any unexpected or emergency situations such as those we have seen during Covid-19.

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

- Option 1: Do Nothing: If the power remains unchanged, all direct support to social care providers from HMG would continue to be routed via Local Authorities.
- Option 2: Amend existing legislation by introducing a new power for the Secretary of State to make payments directly to any social care providers (with an assumption this will include a bespoke delivery mechanism) ('preferred option'): broadening existing powers will streamline future support mechanisms and ensure government is better prepared to respond to emergency situations or unique needs facing the sector in future.
- Option 3: Introduce a new power for the Secretary of State to make direct payments, with clearly prescribed purposes for which this power may be used: this would broaden existing powers but place clear limitations on how it could be used. While this increases certainty around future potential uses, it will reduce the flexibility of the power to be used to deliver policy as required.

**Will the policy be reviewed?** It will be reviewed. The review date has not been determined yet.

Is this measure likely to impact on international trade and investment?	No			
Are any of these organisations in scope?	MicroYes	Small Yes	Medium Yes	Large Yes

What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? <b>N/A</b> (Million tonnes CO <sub>2</sub> equivalent)	<b>Traded:</b> <b>N/A</b>	<b>Non-traded:</b> <b>N/A</b>
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*I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.*

Signed by the responsible Minister:



Date:

27/10/2022

# Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base	PV Base	Time Period	Net Benefit (Present Value (PV)) (£m)		
2019/20	2022	10 years	Low: N/A	High: N/A	Best Estimate: £0

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

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

There are no costs or benefits associated with this option. This is the baseline against which all other options are appraised.

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

N/A

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

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

There are no costs or benefits associated with this option. This is the baseline against which all other options are appraised.

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

N/A

Key assumptions/sensitivities/risks	Discount	N/A
N/A		

### BUSINESS ASSESSMENT (Option 2)

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

# Summary: Analysis & Evidence

Policy Option 2

Description:

## FULL ECONOMIC ASSESSMENT

Price Base	PV Base	Time Period	Net Benefit (Present Value (PV)) (£m) N/A		
2019/20	2022	10 years	Low: N/A	High: N/A	Best Estimate: N/A

COSTS (£m)	Total (Constant Price)	Transition Years	Average (excl. Transition)	Annual (Constant)	Total (Present Value)	Cost
Low	N/A		N/A		N/A	
High	N/A		N/A		N/A	
Best Estimate	N/A		N/A		N/A	

There will not be any direct costs associated with the legislative change.

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

Once the power was used there could be the following indicative costs:

**DHSC:** There could be a one-off cost of £0.2m to the BSA (that would be passed on to DHSC) to develop a system for the future processing of payments and an ongoing cost to process payments of between £0.04m and £1.3m over a ten-year period.

BENEFITS (£m)	Total (Constant Price)	Transition Years	Average (excl. Transition Price)	Annual (Constant)	Total (Present Value) £0.0	Benefit
Low	N/A		N/A		N/A	
High	N/A		N/A		N/A	
Best Estimate	N/A		N/A		N/A	

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

There will not be any direct benefits associated with the legislative change.

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

Once the power was used, there could be the following indicative benefits:

- **Local Authorities:** We would expect a reduction in the administrative burden for Local Authorities as they will need to process fewer payments.
- **Societal benefits:** Providing funding directly to providers will reduce the time taken for HMG to provide support to providers when needed, which is especially valuable in unique or emergency situations when speed is a priority (for example in Covid-19) or to directly deliver funding to implement a specific policy. This will enable faster delivery of whatever change/improvements is needed in social care services and potentially better value for money as the allocation would be more closely aligned with national priorities.

Key assumptions/sensitivities/risks	Discount rate
The extent to which the power will ultimately be used is uncertain and will depend on the policies and situations that the power is being used to fund. All costs and benefits that would come into effect under use of the power have been derived based on hypothetical scenarios and are therefore for illustrative purposes only. The true impacts could differ from these estimates.	3.5

### BUSINESS ASSESSMENT (Option 3)

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

# Evidence Base

## Problem under consideration and rationale for intervention

Throughout the Covid-19 pandemic, it has been necessary for HMG to provide urgent support to the social care sector, through measures like the Infection Control Fund (ICF). The ICF has supported a range of Covid-related measures including funding to ensure staff can self-isolate at home on full pay, hiring additional staff to limit movement between care settings, cohorting staff and residents, providing private transport and accommodation where needed for infection control, and supporting safe visiting. This has demonstrated the need for mechanisms that allow government to respond flexibly to rapidly changing scenarios, sometimes with financial support, as we have seen in the pandemic. While delivery was possible via local authorities, the process could be more streamlined and targeted, making it less burdensome with the existence of a direct power to provide financial assistance.

Beyond this, the current limitations which prevent the Secretary of State making direct payments mean that HMG cannot provide payments directly that implement specific policies that sit outside of the regular funding of social care services. This is a barrier to innovation and improvement that can be applied on a national, rather than a local, level.

Existing legislative powers set out in s149 of the Health and Social Care Act 2008 (and associated sections) allow the Secretary of State to make payments to, or for the establishment of, not-for-profit providers of social care in England. The Secretary of State currently does not have the authority to provide such payments directly to profit-making care providers. Publicly funded adult social care in England is commissioned by local authorities who maintain contracts directly with private profit-making providers, who will in turn provide services to both users who are publicly funded, and those who fund their own care. Local authorities fund the care they arrange through a mixture of central government grant funding, locally raised council tax and business rates, means-tested user contributions and income from the NHS.

The social care market is largely made up of private profit-making providers— according to the CQC, more than 90% of providers are profit-making organisations. The Secretary of State's existing power under s149 d therefore significantly restricts the ability to provide payments effectively where they are needed. This could lead to delays in emergency situations. In the absence of any direct power to make payments to all providers, support for Covid-19 was provided via local authorities. This placed an additional burden on local authorities, added an additional administrative step between the source and delivery of additional funds, and reduced the control HMG had over how funds could be distributed and used.

Using the Covid funding as an example, the amount of time between distributing funding to LAs and them subsequently transferring the funding to providers was often four weeks or even longer. In this emergency situation, that delay led to provider concern and lack of confidence in

the level of funding that would be available to them to carry out particular crucial measures to prevent the spread of the virus.

Legislative changes proposed in the Health and Care Act 2022 will widen the existing power, allowing the Secretary of State to make direct payments to all social care providers, regardless of whether they are profit-making or not-for-profit bodies. This will ensure the power can be used to deliver direct support to the whole sector where required. It will also place social care on the same practical footing as publicly provided healthcare, and other sectors, where no such distinction is made. For example, powers granted by the Infrastructure Act 2015 to the Secretary of State for Transport to support promotion or improvement of transport services do not make any distinction between profit or non-profit organisations. The proposed legislative changes will streamline future financial support for social care and will ensure that HMG is better prepared to respond to emergency, or implement specific policy, in future.

## **Rationale and evidence to justify the level of analysis used in the IA (proportionality approach)**

Legislation will put in place a legal power that can be used to deliver any future payment as required. As such, there is no immediate practical change arising from this legislative change.

Most of the impacts associated with any future use of the power, including the level of funding provided to social care providers as well as operational costs and benefits, will be determined on a case-by-case basis. This may range from individual payments to address small scale concerns, to financial support delivered to the whole sector. In order to illustrate the potential order of magnitude of these impacts, we have explored a hypothetical case study (using evidence from an actual funding example as well as evidence provided from the likely future service provider). However, due to the high level of uncertainty surrounding the extent and details of future use of the power, the case study serves an illustrative purpose only, and cannot be upscaled with a reasonable amount of robustness.

## **Description of options considered**

**Option 1: Do Nothing:** If the power remains unchanged, any direct support to social care providers from HMG would need to be provided by alternative means. This could still be achieved in a wide variety of ways, but would retain the current administrative burden and delay caused by not being able to pay providers directly.

Alternative methods of payment include:

a) Payments could continue to be routed via local authorities through alternative legal methods (such as s31 of the Local Government Act, used to provide the Infection Control Fund during Covid 19). It is possible to effectively deliver financial support to the sector using this method, however it may present a number of barriers that can inhibit a fast and flexible response in an urgent situation. While this option could result in lower costs for DHSC, as there would be no

need to put in place any central infrastructure, it would reduce the speed at which payments could be made and place a greater burden on local authorities, as set out below.

b) Future payments could be made under common law powers, however, the scope of this approach is unclear. The limits of such power are uncertain as the common law does not provide a clear legal basis in the same manner as an express statutory power. The existence of the current s149 power (limited to non-profit providers) might further suggest that it may not be possible to rely on a broader common law power to make payments. As such, a power to make payments under this approach would be unclear in scope and carry an increased risk of legal challenge. Creation of an explicit statutory power would remove this risk and provide clarity as to the legal basis of the power granted to the Secretary of State.

c) Payments could be made under existing Article 149 powers. However, this would limit support to the sector to be made only to non-profit providers of social care. As raised above this does not reflect the reality of the social care market and would mean that any payments that could be made in this way would not offer sufficient support to meet the policy objective. An ability to provide funds to only very limited parts of the sector may also increase the risk of any payment being invalid under subsidy control rules.

**Option 2: Introduce a new power for the Secretary of State to make payments directly to any social care providers (with an assumption this will include a bespoke delivery mechanism) ('preferred option'):**

Under the preferred option, legislative changes in the Health and Care Act 2022 will widen the existing powers for the Secretary of State to make payments to not-for-profit social care providers, allowing direct payments to be made to any social care providers. This legal mechanism will more accurately reflect the market, putting social care on an equal footing with healthcare, and can be used to deliver direct support to the sector as required. This change will streamline future support mechanisms and ensure Government is better prepared to respond to emergency situations facing the sector or to implement specific policy.

While there is no legal obligation to put an operational mechanism in place for the power, we are scoping a potential mechanism in advance to ensure it could be used swiftly and efficiently implemented if required.

We have set out some indicative costs for such a mechanism below, based on estimates provided by the NHS Business Services Authority (BSA). However, such a system will be subject to further development and agreed funding and we would not seek to implement it until needed.



### **Option 3: Introduce a new power for the Secretary of State to make direct payments, with clearly prescribed purposes for which this power may be used**

Prescribing specific purposes or further limitations on how a power of direct payments would be used in statute would provide clarity around what the impact of the measure would be, as it may be that the number of recipients, or types of funds that could be provided would much more narrowly defined.

However, the policy objective of this power is to allow the Secretary of State discretion to respond flexibly to circumstances, including emergency or unique circumstances, as they arise. Restricting the use of the power in this way would prevent it being used to respond to unexpected situations that fall outside of the prescribed uses, but nevertheless requires a direct payment to be made to providers to support them. Furthermore, to place restrictions around the provision in this way would once again place social care on a different footing to healthcare, where the equivalent power under s149 of the 2008 act does not include any prescribed specific uses.

#### **Policy objective**

#### **Summary and preferred option with description of implementation plan**

The existing legislative power set out in the Health and Social Care Act 2008 will be amended by the Health and Care Act 2022. This will allow the Secretary of State to make payments to qualifying bodies which are engaged in—

- (a) the provision in England of social care services, or
- (b) the provision to other persons of services that are connected with the provision in England by those other persons of social care services.

Payments may be made for the purposes of the provision of social care services or the establishment of qualifying bodies engaged in these activities.

The Secretary of State can direct some other specified bodies, or make arrangements with any other body, to provide assistance under this power. It is under this power of direction that we are exploring the option of delivering any funding via the NHS BSA as a Special Health Authority. While this BSA mechanism is in its draft stages, and has not been confirmed as our preferred approach, we have used the BSA model as the assumed method of delivering any funds for the purposes of this assessment.

The new expanded power will come into effect at the same time as the Act.

The Secretary of State is responsible for operation of the power and any funding distributed under it. DHSC officials are working with the NHS BSA to design an operational capability that could make any future payments that are to be routed through this legal power (this role would be delegated to the BSA). This capability will be stood up as required but will be available from the time that the Act comes into effect.

Legislation will simply put in place a legal power that can be used to deliver any future payment as required. As such there is no direct practical change arising from this policy change. Any future use of the power, and any funding for policies that may make use of it, would be subject to all usual procedures around government spending to ensure outcomes offer value for money, with clear indicators of success. Any payment made under this power can be subject to any number of criteria and requirements for the use of funds, against which assurance can be conducted.

The need for a power allowing direct payments has been made clear throughout the response to the Covid-19 pandemic. However, the power would not necessarily be limited to emergency circumstances. A wide range of policies could make use of the power, in any area where a financial payment needs to be made to the sector to support a specific policy outcome.

### **Monetised and non-monetised costs and benefits of each option (including administrative burden)**

The proposed legislative change will put in place a legal power that can be used to deliver any future payments to the sector as required.

Once the power is used to provide any kind of financial assistance, it could have some impacts on the following stakeholders:

- **Care providers:** Care providers would benefit from the proposed change overall as any money provided using the power could be allocated directly to them. While there may be some additional operational costs for those providers to process the funding they receive, we assume for the purpose of this assessment that they would not differ from any cost or burden associated with funds provided by other means, such as via a local authority, under the baseline. According to the 2020 Skills for Care sector report<sup>1</sup>, there are approximately 18,000 social care providers operating in England, of which we assume that approximately 90% (16,400) are privately run<sup>2</sup>.

While it is possible that not all social care providers will be in scope to receive a particular payment, depending on the individual terms attached to that payment, these figures likely underestimate the true number of affected providers, as the change would also enable payments to providers outside of CQC's remit, as well as non-traditional providers not accounted for in the CQC or other official statistics.

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<sup>1</sup> [Size and Structure 2020 \(skillsforcare.org.uk\)](https://www.skillsforcare.org.uk)

<sup>2</sup> Own calculations, based on the [CQC register](https://www.cqc.gov.uk/register).

Payments can also be made to any qualifying bodies providing services that are connected with the provision of social care services. This could be interpreted widely and could, for example, include transportation companies or catering companies who provide services to care providers. Funds can be paid to these bodies under the power and they would therefore benefit from additional income.

- **Local Authorities:** There are 152 local authorities operating in England who provide social care services. While this power will not be used to replace or change regular social care provision funded by local authorities there may be some small administrative savings to these local authorities against the 'Do Nothing' scenario, where future funds would otherwise be allocated through these LAs. (see ICF case study below). Direct intervention in the social care market may have tangential effects on the market shaping duties placed on local authorities by the Care Act 2014. To mitigate any impact, we have committed to consultation with the Secretary of State for Housing, Communities and Local Government whenever payments may impact on local authorities and their duties.
- **DHSC / NHS BSA:** Once payments are made, there will be an ongoing administrative cost to DHSC and their service provider (presumably BSA) to maintain an operational mechanism that can be stood up again for further use as required

## **Direct costs and benefits as a result of the legislative change**

We do not expect any direct costs and benefits as a result of the proposed legislative change.

## **Costs and benefits associated with future use of the power**

As there remains a high level of uncertainty surrounding the practicalities of how (and when) this power will be used, we are unable to quantify the total societal impacts of a future use at this stage. The evidence below provides some indication of potential future impacts. It should be noted that the actual costs and benefits could vary significantly from the impacts illustrated below as these are based on hypothetical scenarios (informed by one historic case study).

### **Costs**

#### **Private care providers and other qualifying bodies**

##### *Familiarisation costs*

There will be a one-off familiarisation cost for private care providers once the power is used as the process for applying for and receiving funding can change in some circumstances. However, this kind of familiarisation would apply for any new funding process, including when funding is provided by local authorities under the baseline, and so would not constitute an additional burden.

Payments made to other qualifying bodies will be in far more exceptional and limited circumstances and will be more likely to take the form of services offered in their normal line of business. For example, this may be to fund essential services like transport that may be

provided by a third party and not the social care provider themselves. As such we do not expect other qualifying bodies to familiarise themselves with the overarching legislative change.

### Operational Costs

Under the 'do nothing' option, if new money was made available to providers, they would receive this money via Local Authorities. Under the proposed change, they will receive this via one centralised body, expected to be the BSA.

If the new process was more burdensome than the process providers would currently have to follow to receive emergency funding, there would be an additional operational cost for care providers.; DHSC is currently working with the BSA and stakeholders to develop the details of this process, including decisions on how payments will be processed and what the reporting requirements for providers will be (if any). The impact on providers will depend critically on these details. Until the process has been agreed, we are therefore unable to quantify the impact on providers reliably.

However, for the purpose of this assessment, we assume that on average, the proposed change will not introduce an additional burden on providers, as the direct provision of payments reduces the number of stakeholders involved in the allocation process compared to the baseline, where funds from DHSC would be allocated via local authorities. As every local authority follows a different allocation and reporting process, centralising this function should lead to genuine efficiency benefits. Such benefits would be particularly large for a small number of providers who operate across various LAs and who otherwise would have to engage with multiple LAs.

While we have confirmed this assumption with stakeholders from the provider market, these stakeholders have also emphasised that the ultimate impact will depend crucially on the following criteria:

- a. How efficiently local authorities would process payments under the baseline. Anecdotal evidence suggests that the burden for providers can vary significantly from one local area to another;
- b. What reporting standards will be put in place by DHSC;
- c. Whether DHSC / BSA have the capacity to process payments in a timely and efficient manner.

We will be engaging with stakeholders from the provider market to make sure that the process we will implement takes sufficient account of these criteria and considers experiences made with other funding mechanisms in the past and that it minimises the burden on providers as much as possible.

### **Local Authorities**

There could be an additional resource cost on local authorities linked to consulting with DHSC and BSA on interactions payments might have with their funding of the sector and their market shaping duties under the Care Act. This could include data exchange, meetings with DHSC and

maybe meetings with the providers themselves. However, we expect this to be minimal, and only in the case of policies that used the power intensively; and routed enough money into the system to affect LA's market shaping powers. If that were the case, then the impact assessment of that policy would need to explore this interaction (and we would argue not the IA of the power itself).

## **BSA / DHSC**

### Implementation cost

If we were to put in place an operational mechanism, which would remain optional under the legislation, then there would likely be a one-off cost to develop a system that will be used to make future payments under the new power. The BSA have estimated that if they were to provide operational capability, this would be a one-off cost of approximately £200,000 which would be incurred in the year of implementing the change.

### Operational Costs

There will be an operational cost for DHSC and the body who will assess the eligibility of care providers and process and distribute future payments under the new change. DHSC has engaged with the BSA, to enquire how high these costs could be in a range of hypothetical scenarios (for example paying a small number of providers over a long period of time, versus paying all providers at once).

BSA estimate that their annual operational cost includes the cost of supporting and hosting their system at approximately £35,000 annually and an additional cost to process the payments of between £8,000 and £100,000 per year depending on how many individual payments will need to be processed. These costs include staff effort associated with assuring the eligibility of providers and the quality of the services they provide as well as staff costs for meetings with DHSC and also any comms or sector engagement that might be required. In the case of the ICF example, where payments were made to about 22,000 providers through two schemes, each divided into 2 tranches, the associated costs would have been towards the upper end of £100,000.

If we assumed that the power was going to be used once over a 10-year appraisal period, this would translate into a total cost to BSA of between £40,000 and £150,000 depending on the number of payments that have to be made.

If we assumed that the power was going to be used five times over a 10-year appraisal period, this would translate into a total cost to BSA of between £220,000 and £730,000 depending on the number of payments that have to be made.

If we assumed the power was to be used on an annual basis over those same ten years, then total cost to the BSA would vary between £430,000 and £1.5m depending on the number of payments that have to be made.

## **Wider societal costs**

There may be some detriment to reducing the role of local authorities in providing payments. Local authorities work very closely with social care providers and might therefore have insights into providers' operations that enable a more accurate assurance of eligibility and quality criteria. Equally, there may be a better understanding on the part of a local authority of how best to distribute payments within a local area. Under the proposed change, there is therefore a small risk that any payment may be slower or less efficient within a given local authority area, than if provided by that local authority. However, any such circumstances would be an exception and would not be the case on a national basis.

In addition, there is a chance that payments made to providers could impact or inhibit local authorities' market shaping activities, as it could reduce the control a local authority has over support to meet pressures facing the market.

Any detrimental impact on the role of local authorities can be mitigated in the design of any scheme that uses the power to make payments. Even when the Secretary of State is making a payment directly, it may still be sensible to collaborate with local authorities when making payments in specific cases, which would mitigate this issue. To further mitigate any risks in this area, we have committed to consultation with DLUHC in any instance where the use of the power may have an impact on local authorities.

## **Benefits**

While it is still unclear to what extent the power will be used, we expect the change to enable faster and easier provision of social care services overall. To understand the potential impacts more clearly, we have illustrated the associated costs and benefits using the operation of the Adult Social Care Infection Fund (ICF) as a case study below.

The ICF was established in May 2020 to support adult social care providers, including those with whom the local authority does not have a contract, to reduce the rate of COVID-19 transmission in and between care settings, and to support wider workforce resilience. To date there have been two funds: an initial £600 million followed by a further £546 million payment, bringing the total funding for COVID-19 IPC measures to care providers to over £1.1 billion. Each of these funds was paid in two instalments

As DHSC could not pay providers directly, ringfenced funding was allocated to local authorities on condition that they passed on a significant portion of this funding (70% in ICF1, and 80% in

ICF2) to providers in their geographical area. Local authorities had discretion over how to allocate the remaining portion of funding (30% in ICF1, and 20% in ICF2), either to provide further support to directly funded providers or support the wider adult social care sector.

Local authorities were required to ensure that providers were spending this funding in line with grant conditions, and that they were completing the Capacity Tracker at least once per week. They also had to put in place their own assurance and auditing processes to ensure that funding was not misspent.

While it is unclear how exactly the ICF would have been allocated under the proposed legislative change, it is expected that some of the benefits outlined below could have been realised:

### **Social Care Providers, workforce and users**

While the existence of a legislative power may not lead to any additional money being paid to providers by default, social care providers will benefit from faster, more effective payments made under the power. Prompt financial support paid to providers when urgent care delivery or supporting activity is needed should drive higher quality patient care and enable HMG to further safeguard against any disruptions to care.

Providing payments from the single point of central government will also enable consistency across payment schemes, ensuring that processes and conditions are applied uniformly for all eligible providers regardless of location. This may address regional imbalances arising from different local government processes or circumstances, for example in a situation where a single local authority would need to process significantly more payments simply because of the amount of social care providers in their area. It may also be the case that payments made using the power, which can be made to any provider of Adult Social Care, could include providers who sit outside the ordinary scope of local authorities.

While it is difficult to quantify the impact of the power to make direct payments to individual users, or members of the social care workforce, it can be presumed that they will benefit from faster and more effective implementation of any financial support provided using the power.

### **Local Authorities**

#### Reduced administrative burden

While the role of local authorities providing regular funding for social care would not be changed by this power, it would have significant impact in reducing the burden on local authorities resulting from ad hoc payments like those of the ICF.

The ICF mechanism, where payments had to be made via local authorities rather than directly to providers, was associated with administrative burden for providers and local authorities.

Local authorities reported that for the second ICF, (which was allocated to a broader range of providers with more frequent reporting) there was a significant administrative burden, with some LAs allocating between 1-2 FTE admin staff to manage the grant over the grant period (of approx. 6 months). Local authorities reported the following administrative burdens: writing and agreeing grant agreements with providers; ensuring that funding was being spent in line with grant conditions, and in some cases interpreting guidance from DHSC; checking that providers are complying with grant conditions; conducting assurance on monthly reports from providers; and undertaking further assurance and auditing at the conclusion of the fund. If the proposed legislative change had been in place, and the BSA had administered the payments rather than LAs, the net benefit to the 152 LAs would have been between £2.2m and £4.4m, or between £15,000 and £30,000 per local authority.

If we assumed that the power was going to be used for a similar scheme as the ICF once over a 10-year appraisal period, this would translate into benefits for LAs of between £2.2m and £4.4m. If we assumed that the power was going to be used five times over a 10-year appraisal period, this would translate into benefits to LAs of between £11m and £22m and to between £22m and £44m if we assumed the power was used on an annual basis over those same ten years. As explained above, we estimate that a centrally managed payment system, administered by DHSC/BSA, would be associated with significantly fewer operational costs, due to the potential for efficiency savings. The overall financial implications of facilitating these payments is therefore expected to be much lower under the proposed change.

Through these 152 local authorities, over 22,000 individual provider locations received allocations of the second ICF. These providers have reported considerable differences in reporting requirements between local authorities, and that the measures allowed under the ICF have also significantly varied. If this grant had been administered centrally by NHS BSA, this variation would not have existed. These benefits are going to be primarily realised by those providers who operate across more than one local Authority. It is estimated that this is the case for approx. 10% of all social care providers operating in England, which in the case of the ICF would translate to approx. 2,000 individual providers who would have benefitted from the proposed change significantly.

## **Wider societal benefits**

### Value for money for DHSC

Making payments directly to providers would mean DHSC could achieve better value for money. Payments and clawback of funding in the ICF were done through a two-step process. Local authorities firstly have to claw back any unspent funding from providers, and then this unspent funding is returned to DHSC. Any operational mechanism, such as could be delivered via the NHS BSA, would enable a higher standard of assurance and auditing, in which they could follow



up with any potentially fraudulent claims at a provider level, which DHSC is currently unable to effectively operationalise.

### Increased ability to implement new social care policy across England

As set out above, the uses of this power do not need to be limited to emergency circumstances, and it can be used to make payments to facilitate any support to the sector that sits outside of regular social care funding, provided by local authorities. This could allow direct payments to be made across England to introduce specific innovation, such as making payments to providers to allow them to take up a new technology, or to support development of new or innovative systems of care. Making direct payments will allow a clearer line between DHSC policy development in social care and the delivery of this policy by social care providers. A national view provided by HMG, rather than a local view provided by local authorities, is important in this kind of policy development to ensure that innovation benefits the care sector effectively across the UK.

### **Direct costs and benefits to business calculations**

N/A.

### **Risks and assumptions**

#### *Risks*

Legislation does not put in place any specific use for the power. A risk assessment should be made on a case by case basis as proposals for any use are put forward.

There remains a risk that a direct payment from HMG may undermine local authority strategy in how they are providing regular funding to the sector, although we would expect the design of any payments would align with, and complement, local government strategy. Equally there may be individual cases where a local authority is better placed to deliver a certain payment scheme, e.g. where payments should be dependent on local circumstances, (although this would not be ruled out as an option by the existence of this power). Funding through LAs will therefore remain an option if local knowledge is important to achieve intended outcomes. To mitigate any risk of undermining the role of local authorities in funding social care, and potential adverse effects on outcomes, we will work with the Ministry of Housing, communities and Local Government to develop a clearance process which will ensure impacts on local authorities are robustly considered.

The power will allow payments to be provided to social care providers based outside of England, for the purposes of providing social care services in England. In some cases, this may have tangential benefit on a provider's overall service provision across multiple nations. This

could, in highly exceptional cases, lead to a market incentive on providers based in Devolved Administrations providers to provide some level of social care service in England in order to access additional specific funds. This risk is being discussed with Devolved Administration governments and should be considered on a case by case basis as policy proposals are put forward. Any risk may be mitigated with specific conditions placed on any individual payment initiative.

Any payments made using the power will be limited by the usual checks and controls placed on government spending. Any use of the power must be aligned with the principals set out in HMT guidance on managing public money and will be subject to the governance and rules relating to transparency set out in that guidance. Any funding provided to DHSC to support a policy that makes use of the power will be subject to HMT approval as part of any spending round.

It remains possible that the power could be used in such a way as to facilitate HMG intervention in the social care market in situations where there are more appropriate, market based, solutions available. In this circumstance, direct payments may potentially indirectly impact on competitiveness in the market, for example if payments were paid to relieve pressures or provide benefits that would otherwise put certain providers at a disadvantage. In turn this may inhibit innovation in the market as providers strive to outperform competitors, for example a government payment that allow the uptake of a specific technology may discourage providers from taking up alternative technology that may prove to be more beneficial. Mitigation against disproportionate market impacts should be considered in the development of any policy put forward that makes use of the power. Any payments will also be subject to rules set out in international obligations regarding subsidy control, such as the WTO Agreement on Subsidies and Countervailing Measures and the UK-EU Trade and Cooperation Agreement. If any payment under the power is shown to qualify as a subsidy that is in breach of these legal obligations, these agreements put in place a number of limitations to ensure that the payments are proportionate and necessary. The development of any policy intending to make use of the power, even in emergency circumstances, would be considered in light of these legal obligations.

As with any sector funding it is standard practice for the Department to consider what conditions should be attached to ensure appropriate use of the funds provided as well as a robust assurance mechanism. For the purposes of the example used in this document, the NHS BSA has a well-established Provider Assurance function which conducts post payment verification on a wide variety of activities. Any assurance around payments could include both pre-emptive measures to ensure those receiving funding are legitimately entitled to it; and follow up to ensure that any terms are complied with.

### *Assumptions*

Operational capability provided by the BSA is based on assumptions around the number of payments that will need to be made every time the power is used. Operational costs may change in the event that a future use of the power emerged that fell outside of this range.

Indicative costs are provided on the assumption that the power will be used between 1 and 10 times over a ten-year period. These are hypothetical scenarios and the true number might differ from the assumptions made.

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Indicative costs are provided on the assumption that the power will be used between 1 and 10 times over a ten-year period. These are hypothetical scenarios and the true number might differ from the assumptions made.

### **Impact on small and micro businesses**

The legislative power will allow payments to be made to any body providing social care, regardless of size. Any individual use of the power may include or exclude SMBs depending on the criteria applied, an assessment will be made on these grounds on a case by case basis. According to the 2020 Skills for Care sector report, approximately 15,400 (85%) of the 18,200 social care providers in England are small and micro businesses<sup>3</sup>.

However, we do not expect any additional costs on businesses as a result of the legislative change, including on small and micro businesses and therefore no disproportionate impact.

We do expect that social care providers will benefit from faster, more effective payments made under the power as prompt financial support would be paid to providers when urgent care delivery or supporting activity is needed. If small and micro businesses face greater capacity constraints and might therefore come under more financial pressure in situations of high demand, they would disproportionately benefit from the proposal.

### **Wider impacts**

Legislation does not state a set use for the power. It would be expected that any future payments made under the power would be of benefit to social care providers and may, directly or indirectly, be of benefit for those who work in care, or those who receive care from those providers. The extent of any wider impact or benefit should be examined on a case by case basis.

DHSC has committed that this power is not intended to be used to change or replace the role of local authorities in providing regular funding for social care.

There could be a wider impact on the structure of the market for social care providers as self-employed individuals who provide care and those employed directly by the people they care for are exempt from receiving additional funds provided under this power. Any associated risk would be mitigated by the design of any future payments, it is not HMG's intention to provide funding to boost certain providers' commercial opportunities relative to their competitors.

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<sup>3</sup> Based on "[The size and structure of the adult social care sector and workforce in England, 2020](#)", Skills for Care (2020), where small and micro businesses are defined as organisations with less than 50 employees.

This provision has undergone a full equalities assessment.

## **Monitoring and Evaluation**

Government is committed to evaluating the policies it implements as part of a Post Implementation review (PIR). The exact details of the PIR for this provision will be set out at implementation of the Act, following the introduction of secondary legislation. This is because the provision is an enabling power and the details of the final policy will not be finalised until the secondary legislation stage. This means that the specific plans for the PIR cannot be finalised until the final form of the policy, and the specific outcomes it is likely to affect, are known. The power will therefore not be reviewed until opportunities to exercise the power have arisen.

In order to inform the PIR, appropriate monitoring and evaluation will be put in place to ensure effective provision, and appropriate use, of any individual payments on a case by case basis. There may be some reflection on the nature of the legislative power itself as part of this process. If developed, the effectiveness of the BSA operational mechanism will be assessed on an ad hoc basis in response to how it delivers any individual payment or set of payments and within the framework of the regular oversight of the Secretary of State over the organisation.

# Annex C – Regulatory Impact Assessment – Enhanced Assurance

<b>Title:</b> Health and Care Act 2022 – Enhanced Assurance <b>IA No:</b> 9578  <b>RPC Reference No:</b> RPC-DHSC-5082(1) <b>Lead department or agency:</b> The Department of Health and Social Care (DHSC) <b>Other departments or agencies:</b> The Ministry for Housing, Communities and Local Government (MHCLG) The Care Quality Commission (CQC)	<b>Impact Assessment (IA)</b>
	<b>Date:</b> 27/10/2022
	<b>Stage:</b> Final
	<b>Source of intervention:</b> Domestic
	<b>Type of measure:</b> Primary legislation
<b>Contact for enquiries:</b>	

<b>Summary: Intervention and Options</b>	<b>RPC Opinion:</b> GREEN
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## Cost of Preferred (or more likely) Option (in 2019 prices)

Total Net Present Social Value	Business Net Present Value	Net cost to business per year	Business Impact Target Status Non qualifying provision
Not Applicable	Not Applicable	Not Applicable	

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

Adult Social Care (ASC) provides vital support and care to people who depend on it for their health and wellbeing. Currently, while local authorities have a legal duty to provide ASC, there is not a regular means for evaluating what they are doing well and what needs to improve. There is a lack of data available with which local populations can hold local authorities to account and we therefore cannot be sure that people who rely on ASC support are getting the high-quality care they deserve. The National Audit Office (NAO)'s 2021 report on the adult social care market in England recognised that current accountability and oversight arrangements are ineffective. In particular, the report highlights the Department of Health and Social Care (DHSC)'s lack of visibility of the effectiveness of local authority commissioning and states that the Department is unable to evaluate spending, or the extent of additional funding needed.

The need to ensure that ASC is of a high-quality regardless of where a person lives is becoming increasingly important as demographic change results in more people turning to social care, a trend expected to continue for the foreseeable future. The COVID pandemic has further amplified the importance of ASC delivering safe and effective care and support.

By introducing a new duty for the Care Quality Commission (CQC) to review and make an assessment of local authorities' delivery of their adult social care functions under Part 1 of the Care Act 2014, and creating new powers of intervention for the Secretary of State where he or she considers a local authority is failing to discharge its functions, government is taking action to ensure that the system can deliver the right kind of care and the best outcomes, with the resources available.

**What are the policy objectives of the action or intervention and the intended effects?**

Through the Health and Care Act 2022, DHSC intends to amend the Health and Social Care Act 2008 and the Care Act 2014 to:

- Create a duty for the CQC to review and make an assessment of local authorities' delivery of their Care Act 2014 adult social care functions.
- Enable the Secretary of State to take action, where he or she is satisfied that a local authority is failing or has failed to discharge its functions to an acceptable standard.

The creation of a role for the CQC in reviewing the performance of local authorities in delivering their ASC functions is part of a wider new assurance framework for social care, which will provide greater transparency in the system and focus on driving improvements in outcomes and experience for service users and their families, reducing unwarranted variation so people can expect high quality care and support, regardless of where they live.

The assurance framework will be informed by the Care Act 2014 and the emphasis it places on personalisation and choice, prevention and ensuring access to a range of high quality, appropriate services. Enhanced assurance will mean the government can better understand what the system needs at any one time and offer a wider range of support to local authorities, spot where systems are failing, and intervene where needed.

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

Preferred option: Enhanced assurance of Local Authority delivery of ASC statutory duties under Part 1 of the Care Act 2014 This model would provide increased assurance of the existing delivery model for ASC. The Act will introduce a new duty for the CQC to review and make an assessment of local authorities' performance in delivering their statutory duties under Pt 1 of the Care Act 2014. Following the review, the CQC will publish a report setting out the details of its assessment. The functions under the Care Act 2014 that will be subject to review, (referred to as *regulated care functions* in the Act sections) will be prescribed in secondary legislation.

Following assessment under the new duty, if CQC considers that a local authority is failing to discharge their functions to an acceptable standard, the CQC must inform the Secretary of State and recommend any special measures which it considers the Secretary of State should take. It is intended that as part of its review function, the CQC will also work with local government and DHSC to identify and share best practice, in order to support sector-led improvement.

Introducing CQC assessments is not intended to replace or duplicate the functions of local democracy and accountability but rather support their effectiveness by introducing an assessment by the CQC, working on a clear, statutory basis with local authorities to ensure that the ASC system is consistently delivering the right kind of care, and the best outcomes with the resources available. The CQC's oversight of social care providers, coupled with its experience of appraising local systems, means it will be well placed to consider the provision and commissioning of social care by local authorities within the context of increasing health and care integration. This option thus builds on existing structures and relationships between local authorities, national government and the CQC to establish enhanced oversight and appropriate levers for action should they be needed.

**Discounted options:**

- 1. Do nothing:** Do nothing would retain the status quo whereby there is no regular, independent means by which local authorities' performance in meeting their statutory ASC duties is assessed, leaving local populations and the Secretary of State lacking effective levers by which to hold local authorities to account or take appropriate action when failings are identified and improvement required.
- 2. Develop an assurance framework based on increased data collection alone without CQC assessment:** DHSC intends to improve the quality and availability of data across the health and social care sector by introducing a new assurance framework for ASC. This will be achieved through changes to data collection and the frequency of doing so. This will support local authorities, providers and consumers to access ASC data, while minimising the burden on data providers. Building on improvements made by existing tools implemented during the pandemic, better data access will improve the understanding of capacity and risk in the system. During COVID, improved data has enabled DHSC to spot where the sector is struggling and to offer targeted support.

While improved data collection and use alone would enable a better understanding of the system, and enhance local populations' ability to hold their local authority to account, the continued absence of effective levers would mean that DHSC would be unable to act to support the embedding of best practice across the system, while eliminating poor practice and inefficiency. In effect, issues could be identified without sufficient leverage to resolve them.

- 3. Create a new Arm's Length Body (ALB) to assess LAs' ASC services.** This option would entail establishing a new ALB to undertake the review of local authorities' performance instead of the CQC. This would create significant cost and add an additional body into the already complex environment of health and social care oversight, particularly in the context of ongoing integration. It would also require significantly more legislative changes than adapting the regulatory powers of the CQC. DHSC does not see a rationale for creating a new body when the CQC can perform this function.

Is this measure likely to impact on international trade and investment?

No

Are any of these organisations in scope?	Micro No	Small No	Medium No	Large No
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)	Traded: N/A		Non-traded: N/A	
<b>Will the policy be reviewed?</b> It will be reviewed from time to time. <b>If applicable, set review date:</b> Ongoing/				

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

Signed by the responsible Minister:  Date: 27/10/2022

# Summary: Analysis & Evidence

# Preferred Option

## Description:

### FULL ECONOMIC ASSESSMENT

Price Base Year 2019	PV Base Year 2021	Time Period Year 10 years	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: N/A

COSTS (£m)	Total Transition (Constant Price) 10 Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate	£0.3m		£4.7m	£40m

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

The costs and benefits of the scheme, both direct and indirect, will be highly dependent on the detail of the approach (scope, frequency, intensity etc) which is yet to be determined. We want to design the system in partnership with service users and their families, local government and the CQC and intend to set out the scope of the local authority ASC functions that will be subject to review in secondary legislation, following further stakeholder engagement. The figures that feature in the full economic assessment case are therefore only a subset of the direct costs. Additional detail on further monetised costs that are not included in the full economic assessment of the preferred option can be found in the indicative cost section. We will be able to provide enhanced cost estimates and analysis of benefits and impacts when we present our proposals for secondary legislation and this Impact Assessment will be updated then.

The monetised costs of the assurance framework will fall to the Government. The direct costs which feed into the stated total costs and fall to DHSC will occur through the administrative costs to CQC and LAs of assessment, along with familiarisation costs.

The indicative costs that are not included in the full economic assessment are the direct costs to DHSC through intervention/support and the indirect costs to local authorities through the short term and longer-term costs of improvement of their adult social care outcomes as a result of receiving intervention/support. These improvement costs are the opportunity costs of LAs needing to reallocate funds to social care services. These costs have been included in the indicative cost section as they contain more uncertainty as the size of these costs will depend heavily on the scale of intervention and level of support offered.

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

N/A

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

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

N/A



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

Care Users – as a result of improved local authority performance in delivering their ASC functions under Part 1 of the Care Act 2014, and thus an improvement in adult social care outcomes, we anticipate that the assurance framework should lead to an improvement in the quality of care provided to care users.

Workforce – support for an improved offer to the workforce by promoting best practice staff rewards, recognition and skills development including minimum training standards.

NHS – while we can't calculate exactly the type and level of savings that may be made, it is plausible that an improvement in care quality (resulting from the introduction of the assurance framework) could lead to fewer hospital admissions and/or better commissioning practices which will likely include its relationship with the health sector.

<b>Discount rate (%)</b>	3.5% (costs)
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**Key assumptions/sensitivities/risks**

As the transitional costs are sensitive to the scale of intervention/support in local authorities and we cannot accurately determine this until the scheme has commenced, we have not included these costs in the full economic assessment of the preferred option. Instead, we have included the levels of intervention/support to local authorities that we anticipate that there may be in the indicative cost section as these are very uncertain.

We intend to co-design the system with the sector with a focus on what will help local authorities to improve their services where needed – until that work is complete, our figures are subject to change. We expect to provide greater detail as operational policy is developed. The long-term improvement costs are also included in the indicative costs section as they are the most uncertain but have chosen to include them to give an order of magnitude under a potential scenario.

No further sensitivity analysis on this area of spend has been conducted, but given its overall cost is large, any increase/decrease to it would also be of similar magnitude.

**BUSINESS ASSESSMENT (Preferred Option)**

<b>Direct impact on business (Equivalent Annual) £m: N/A</b>			<b>Score for Business Impact Target (qualifying provisions only) £m: N/A</b>
<b>Costs: N/A</b>	<b>Benefits: N/A</b>	<b>Net: N/A</b>	

# Evidence Base

## Problem under consideration and rationale for intervention

Demographic change has resulted in more people turning to social care and we expect this trend to continue for the foreseeable future. State funded social care is essential for protecting and supporting the most vulnerable members of society, and a responsible government needs to understand how it is operating.

There exists an argument for greater oversight by central government on equity grounds, given the regional variation in care quality outcomes. Local authorities are responsible for commissioning care in their area. Analysis of CQC data shows significant local authority and regional variation in provider quality ratings.

The CQC's report: '*State of health care & adult social care in England 2019/20*' highlighted the following:

- 3 per cent of care homes (512 homes, covering nursing and residential homes and accounting for just under 23,000 beds) have never been rated better than 'requires improvement', and a further 8 per cent (1,216) have had one 'good' or 'outstanding' rating but are currently rated as 'inadequate' or 'requires improvement' (accounting for just over 42,000 beds).
- For community social care, 3 per cent (212, providing services to more than 9,000 people) have never been rated better than 'requires improvement', and a further 5 per cent (393, providing services to more than 18,000 people) have had one 'good' or 'outstanding' rating, before falling back to 'inadequate' or 'requires improvement' by 31 March 2020.

An enhanced assurance system should help to improve care outcomes in underperforming areas with an aim to alleviate these regional differences, promoting greater equity in the quality of care provided to users across the country.

### **Focus on local authorities**

ASC provision is devolved to local authorities, which are responsible for undertaking critical functions (mostly set out in the Care Act 2014) including commissioning, eligibility assessments and delivering services themselves. Whilst the challenges facing social care are undoubtedly complex and cannot be attributed to a single factor or cause, we believe that, because of their duties in relation to social care services, there is merit in increasing assurance specifically in relation to local authorities.

A number of independent reports have identified concerns in relation to delivery of the Care Act 2014, including:

- The 2018 Public Accounts Committee (PAC) report on the ASC workforce highlighted that four-fifths of local authorities were paying below sector benchmark costs.
- The 2019/20 CQC State of Health Care & Social Care report highlighted workforce concerns and outlined the need for a focus on career progression, securing the right skills, recognition and investment in training.
- In 2021 Age UK reported claims that two million over 75s in England are digitally excluded despite a move to move more ASC services and activities online, which suggests some people may lack the information or advice needed to make informed decisions about their care.
- In 2020 the NAO report on the response to Covid-19 highlighted concerns that local authorities failed to increase fee rates paid to care providers despite receiving an additional £3.2bn funding for the Covid-19 response.

Whilst these issues cannot be solely attributed to local authority performance, we believe introducing enhanced assurance around their key ASC responsibilities will support the delivery of the Care Act and ultimately lead to better outcomes for service users. A number of reports have identified issues with a lack of oversight and assurance in relation to LA ASC responsibilities:

- The 2017 Competition & Markets Authority (CMA) 'Care Homes Market Study' report recommended introducing independent oversight of local authorities' commissioning practices and the promotion of greater transparency.
- The 2018 CQC 'Beyond Barriers' report recommended that government should support improved planning and reformed commissioning at a local level through introducing new legislation to allow CQC to regulate local systems and hold them to account for how people and organisations work together to support people to stay well.
- Most recently, the 2021 NAO report on the ASC market in England described how they regard current accountability and oversight arrangements to be ineffective. It notes that DHSC lacks visibility of the effectiveness of local authorities' commissioning.

#### Further economic rationale:

There also exist further economic rationale for intervention aside from the equity improvement stated above.

The NAO's 2021 report on the ASC market in England recognised that whilst funding to local authorities is highlighted as an issue that needs to be considered, DHSC lacks visibility of the effectiveness of local authority commissioning and is unable to evaluate

spending or the extent of any additional funding needed. This means that DHSC may be unable to provide assurance to HM Treasury or the taxpayer that future additional funding provided to local authorities will be spent effectively on improving ASC services.

The economic case for ensuring that local authorities meet their responsibilities, including access to care, also rests in part on the general case for publicly funded social care. Since insurers do not offer private insurance for social care costs, many who develop care needs in later life, or whose adult children have care needs, lack the means to pay for it and the burden of care would fall unequally and inequitably without social insurance. In addition, alongside private benefits from consuming social care (e.g. improved quality of life), there are benefits to wider society from knowing that social care exists and can be accessed. Since these benefits are not considered in private decisions over how much social care to provide and consume, there would be an under-consumption of care without government intervention, i.e. meaning that some people who need care will not be able to access it.

Another rationale arises from the fact that Ministers and local authorities are both democratically accountable, but the current responsibilities and powers do not match where accountability falls, even though the public place a clear value on high and equal quality of care. This creates a market failure known as the principal-agent problem, with the differing priorities between the principal (central government) and an agent (local authorities) resulting in outcomes that do not fully reflect public preferences. The assurance framework aims to create the levers needed to address this.

To tackle the issues described above, we propose introduction of measures to provide greater oversight of local authority ASC activities and a means to enable improvement where poor performance is identified. We will introduce a CQC-led local authority assessment function, which requires the additional powers that we are seeking to obtain through the Health and Care Act 2022 as follows:

- Creating a new duty for the CQC to review and make an assessment of the performance of local authorities' delivery of their adult social care functions, and
- Creating new powers for the Secretary of State to intervene where he or she is satisfied that a local authority is failing or has failed to discharge its functions to an acceptable standard

The policy is not about centralising control of ASC, it is about delivering high-quality ASC and clarifying government's role in supporting local systems to realise that aim; the precedent of minimal central oversight and levers over the last decade has demonstrated that the status quo is not working for service users and local areas.

## **Rationale and evidence to justify the level of analysis used in the IA (proportionality approach)**

Please note that the monetised estimates set out in this document have been made in advance of detailed policy design. The duties and powers to be taken under the Act are high level enabling powers with the detailed scope of the local authority functions to be reviewed and assessed to be set out in secondary legislation. This is a deliberate decision to allow DHSC to work in partnership with the CQC and the sector in developing the most effective system to meet the needs of care users. This will also facilitate broader engagement to inform system design and implementation. The costs and benefits of the preferred option set out below represent an indicative estimate of what the potential impacts of the assurance framework could be, and the related magnitude of spend associated with this (largely based on proxies and historic spend of similar schemes). We will be working with the necessary stakeholders to work up this detail over time.

## **Description of options considered**

**Preferred option: Enhanced assurance of Local Authority delivery of ASC statutory duties under the Care Act 2014:** this model would provide increased assurance around the existing delivery model for ASC. We would introduce a new duty for the CQC to assess local authorities' performance in delivering their statutory functions under the Care Act 2014, with the local authority functions that are to be reviewed and assessed to be set out in secondary legislation. Following assessment under the new duty, if the CQC considers that a local authority is failing to discharge its functions to an acceptable standard, the CQC must inform the Secretary of State and recommend any special measures which it considers the Secretary of State should take. It is intended that as part of its assessment function, the CQC will also work alongside the sector and DHSC to identify, share and embed best practice across the sector.

The CQC's oversight of social care providers, coupled with its experience of appraising local systems, means it is well placed to consider the provision and commissioning of social care by local authorities within the context of increasing health and care integration. This option thus builds on existing structures and relationships between local authorities, national government and the CQC to establish the appropriate levers for action should they be needed.

### **Discounted options:**

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

Do nothing would retain the status quo whereby there is no regular, independent means by which local authorities' performance in meeting their statutory ASC duties is assessed, leaving local populations and the Secretary of State lacking effective levers by which to hold local authorities to account or take appropriate action when failings are identified and improvement required.

This option includes the costs of the Regional Assurance team which currently exists in DHSC as well as the funded partners programme, with their continuation dependent on securing future funding. This option also includes current CQC activity - while we recognise that there may be improvements achieved from the ongoing work by CQC, an assurance system will go further to provide additional improvements to these, as well as potential cost reductions of current spend. We will work with the CQC to ensure functions complement each other where possible.

### **Option 2: Develop an assurance framework based on increased data collection alone without CQC regulation**

As part of the new assurance framework for ASC, DHSC intends to improve the quality and availability of data across the health and social care sector. This will be achieved through changes to the data collected and the frequency of doing so. This will support local authorities, providers and consumers to access ASC data, while minimising the burden on data providers. Building on improvements made by existing tools implemented during the pandemic, improved data access will improve the understanding of capacity and risk in the system.

While improved data collection and use alone would enable a better understanding of the system, the absence of regulatory change would mean that the public would need to interpret data without the benefit of the independent assessment of the quality of care that can be provided by the CQC. This lack of independent analysis would not allow service users and their families to make informed choices about the care they should seek. Further, where poor performance was suggested by the data, there would remain few levers by which the Department could act to make sure best practice is adopted across the system, eliminate poor practice and inefficiency. In effect, issues would be identified without sufficient leverage to resolve them.

### **Option 3: Create a new Arm's Length Body (ALB) to regulate ASC**

This option would entail establishing a new ALB to undertake the review of local authorities' performance instead of the CQC. This would create significant cost and add an additional body into the already complex environment of health and social care oversight, particularly in the context of ongoing integration. It would also require significantly more legislative changes than adapting the regulatory powers of the CQC. DHSC does not see a rationale for creating a new body when the CQC can perform this function.

### DfE precedent - background

DHSC is not seeking to replicate inspection and oversight models adopted for other care settings. DHSC has drawn upon the models of Children's Social Care (CSC) and Special Educational Needs and Disabilities (SEND) for early modelling purposes and as such the models are described below for background information only.

- **Children's Social Care (CSC):** The framework for Inspecting Local Authority Children's Services (ILACS) evaluates the effectiveness of local authority services and arrangements to help and protect children. Through ILACS, Ofsted investigates the experiences and progress of children at risk, in care and care leavers and evaluates the effectiveness of leaders and managers and the quality of professional practice.
- **SEND:** CQC and Ofsted jointly inspect local authority areas to assess how well they fulfil their responsibilities for children and young people with special educational needs and disabilities.

### **Policy objective**

Millions of people are born with, or will develop at some point in their lives, a need for help with everyday tasks to support their dignity and independence. Alongside support provided by families and friends, the care system in England helps to meet these needs by providing taxpayer-funded care to those with assets and income below set thresholds. However, significant care inequalities still exist and demand for care is set to rise in coming decades.

Our goal is to build a more sustainable ASC system in which people are treated with dignity and respect. In support of this objective, we propose to introduce a new assurance framework for social care, which will drive improvement in outcomes and experience for service users and their families, and help reduce unwarranted variation so people can expect high quality care and support, regardless of where they live. It will be rooted in the Care Act 2014 and the emphasis it places on personalisation and choice, prevention and ensuring access to a range of high quality, appropriate services.

### **Summary and preferred option with description of implementation plan**

The Health and Care Act 2022 will provide for high-level enabling legislation before the Department undertakes further system design work with the CQC and the sector. Secondary legislation will specify the local authority ASC functions under Part 1 of the Care Act 2014 that will be subject to the new review and assessment duty. It is the intention of DHSC to engage with stakeholders in support of implementing an effective operational model for both assessment and intervention.

Alongside the assessment regime, DHSC is further developing its approach to sector improvement support. The improved availability of data and sector intelligence will enable local authorities to better understand their own performance, benchmark against their peers, and identify good practice to support their own improvement. DHSC intends to engage with local authorities on how best this can be supported. Where issues are identified, either through the CQC assessment process or through improved local data and intelligence, the Department envisages a range of options and levers to be utilised to support improvement, which will be based upon a graduated approach appropriate to the issues identified. Thus, the overarching approach to enhanced assurance of ASC would involve strengthened monitoring, sector-led improvement, a targeted offer of support to those who need it, building to intervention directed by DHSC where system-wide and persistent failure is putting the dignity, safety and wellbeing of local people at risk. Intervention would be tailored to the local authority under review, taking account of its individual circumstances and capacity to improve. The aim would be to support local authorities to get back on track as quickly as possible through sustainable change.

The introduction of the assurance framework is intended to be a phased process, beginning with the development of effective data collection platforms and processes to improve the quality, timeliness and accessibility of ASC data. This data will be supplemented by intelligence from the regional teams established in response to the Covid-19 pandemic and which DHSC intends to retain, subject to agreed funding. Subject to funding agreement at the next Spending Review, the proposals for the assurance framework are expected to begin roll out from 2022/23, beginning with improved data, with the CQC assessment framework coming onstream in 2023/24.

DHSC will use the time before implementation to assess costs, impacts and risks, pilot our planned approach, and work with system partners to develop robust and effective solutions to address these. DHSC is initially working with the CQC, the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and will seek to extend stakeholder engagement to make sure thinking is informed by service users, providers and sector voices. The phased approach provides for a realistic delivery timescale that will avoid creating disruption in the system.

## **Monetised and non-monetised costs and benefits of each option (including administrative burden)**

**Please note that the detailed operational policy of the assurance framework is yet to be developed (will not go live until 2023/24). Therefore, whilst we have sought to monetise those areas that we have more certainty over (included within the full economic assessment estimate), an indicative costs and benefits section is set out below to show additional monetised costs and**



**benefits - these contain more uncertainty and are highly dependent on the detail of the approach, some of which will be set out in secondary legislation.**

***All of the figures stated below are undiscounted.***

### **Costs:**

The following section sets out the costs of an assurance framework that feature in the full economic assessment of the preferred option and the approach taken to monetise them. The costs considered are the direct costs to DHSC through the administrative costs to CQC and local authorities of assessment and the associated familiarisation costs.

To estimate the costs, it is assumed that all local authorities will be assessed remotely (i.e. monitoring) on a regular basis (at least once a year) but that there will be a more in-depth, physical on-site assessment of a local authority once every four years. This is an assumption, not the final implementation model for this proposal. In addition, the administrative costs set for assessment have been phased-in during the first three years of operation, to reflect the fact that the first two years will be designated for piloting, before being fully rolled out in Year Three and maintained thereafter. These costs in Year One are 25 per cent of full annual costs, and at 50 per cent in Year Two, to represent a ramping up of the pilots. Operational policy (including frequency of assessment and whether timing of in depth assessment will be part of a routine programme of assessment or risk based) will be developed collaboratively with system partners over the coming months and we will be able to develop more robust cost estimates based on an enhanced understanding of how frequently local authorities will be assessed (remotely and physically). Further detail on the implementation model will be developed collaboratively over the coming months and years before the framework goes live (2023/24).

### **Direct Costs:**

#### ***Administrative assessment costs***

The administrative costs of assessment cover the annual cost to CQC staff for monitoring the data received from local authorities as well as conducting the assessments, alongside the time taken for local authorities to prepare for their assessment.

We have assumed that a CQC monitoring team will be made up of five people, with an annual wage and on-costs of £100,000 per person. This cost is reduced by 20 per cent since this activity will be carried out by CQC, an existing organisation.

The assessment costs to CQC are estimated using the cost of a Commissioner Review at £36,743, as indicated by DfE's estimates for Children's Social Care, applying our judgement in that an in-depth review would seem significantly more expensive than this model, and so scaling this up to the factor of three. As mentioned above, we are assuming that assessment will occur once every four years for a local authority, on average, however operational policy will be developed with system partners over coming months.

To estimate the cost for a local authority to prepare for their assessment, we have assumed that a team is comprised of five administrative staff, six heads of services and eleven senior managers (one Director of Adult Social Services (DASS) and ten Board members). Administrative staff along with heads of services will work towards preparation for a week, whereas senior managers will only contribute four hours each, across the same time period. The wages used are £868 per week for a head of service and £434 per week for administration staff as derived from the annual figures in the Office for National Statistics (ONS), Annual Survey of Hours and Earnings (ASHE) dataset. The average hourly wage of £42.90 is used for 'Senior Management' in local authorities as stated in the Skills for Care Adult Social Care-Workforce Dataset (ASC-WDS). On-costs of 20 per cent are added to these wages.

Adding together these three elements, the cost of assessment overall therefore total £44m across the ten-year period.

### ***Familiarisation costs***

There will be an initial transitional cost to local authorities to familiarise themselves with the new legislative changes. In addition to this initial cost, given the nature of the system, we have assumed that local authorities may need to dedicate more time each year to either refamiliarise themselves with the Care Act 2014 guidance or to plan for their next steps - this reoccurring cost therefore forms part of the average annual costs.

We are assuming that familiarisation of the changes will require four hours of time from 11 sector experts for each local authority, using the average hourly wage of £42.90 (plus on-costs) for 'Senior Management' in Local Authorities stated in the Skills for Care Adult Social Care-Workforce Dataset (ASC-WDS) – this is likely to represent an underestimate given the wage for a sector expert will be at the upper-end of any 'senior management' band. The initial familiarisation cost totals £0.3m over the ten-year period (though only occurring in the first year), with the refamiliarisation costs totalling around £3m.

### ***Total monetised costs***

Table 1 below summarises the quantified costs set out above, totalling £47m over the ten-year period.

**Table 1: Total monetised costs over ten-year period, undiscounted**

Costs (£m), undiscounted	Year										Total	
	1	2	3	4	5	6	7	8	9	10		
Assessment Costs	1	3	5	5	5	5	5	5	5	5	5	44
Familiarisation Costs	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3
Planning/Refamiliarisation Costs	0.0	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	3.1
Total	2	3	5	5	5	5	5	5	5	5	5	47

As mentioned above, the quantified costs set out in the table only represent a proportion of the overall costs likely to be incurred as a result of an assurance system. However, given that the other costs are highly dependent on the detail of the approach, and their uncertainty relative to those monetised above, these costs have not been included as part of the full economic assessment of the preferred option. The next section, after the benefits detailed directly below, demonstrates an illustrative estimate of what the scheme may look like, based on a number of assumptions.

**Benefits:**

The new assurance measures should support improved quality of care and access. The CQC will assess performance against published quality statements providing a clear expectation of standards. Assessing performance alongside the scope for potential intervention, will provide a lever to drive improvements across the sector. Regular reviews of local authority commissioning practice will provide insight into how good commissioning works, allow for best practice to be shared and help root out inefficiencies and bad practice. This will also provide the means by which future investment delivers priorities set by central government. The main benefits of an assurance framework include:

- Improved quality of care to care users
- An improved offer to the adult social care workforce
- NHS savings as a result of adult social care spend
- Improved equity outcomes in care provided

We have not monetised the benefits in the full economic assessment of the preferred option. Instead, a break-even analysis to specify the improvement in QALY per care user needed to offset the direct and indicative costs has been added to the next section. The non-monetised benefits, which we believe to be significant in size, are included directly below.

## **Non-monetised benefits:**

### ***Benefits to the NHS***

Given the close integration of the health and care systems in England, any additional funding for the ASC system (that leads to increased spending in ASC) is likely to have beneficial impacts for the NHS. Support from local authorities provided to individuals in the community has the potential to reduce the number of unnecessary GP consultations, ambulance call outs and A&E attendances, whilst the right amount of investment in the ASC market can ensure there is the right level of capacity, limiting the number of delayed bed days in hospital. Based on 2018 analysis by Forder and colleagues at Personal Social Services Research Unit (PSSRU), for every £1 spent on adult social care there is an average saving to the NHS of 20p. Given the anticipated scale of spending to improve services, the magnitude of these savings could be sizeable. This figure represents the average return from historic adult social care interventions. Since we cannot calculate the specific savings that may arise from the introduction of an assurance framework, it is likely that those realised could differ somewhat from this estimate– it is for this reason that we have chosen to include this figure as part of the non-monetised benefits section and not part of the full economic assessment.

### ***Benefits to care users***

CQC provider inspections:

In 2017, the CQC published a report on its impact on quality and improvement in health and social care. The report claimed that there is evidence of wide-ranging and positive changes following CQC inspections. In its post-inspection survey, 69 per cent of respondents (1,928 out of 2,803) stated specific changes that they had made, or were planning to make, because of the inspection process. Nearly half of respondents to its post-inspection survey (45 per cent, 1,027/2,803) reported that they had made changes to their services that they would expect to lead to improvements to the safety of the care they provide.

The same report highlighted improvements in quality on provider re-inspection. By the end of 2016:

- 79 per cent (492 out of 622) of adult social care services originally rated 'inadequate' had improved their overall rating
- Out of 11 hospital providers or locations originally rated 'inadequate', six had improved to 'requires improvement' and three had been re-rated as 'good'
- 78 per cent (91 out of 116) of general practices rated 'inadequate' had improved their rating – 56 moved to good and 35 moved to 'requires improvement'.

The CQC are currently consulting on a new strategy which includes proposals to enhance their approach to regulation and assessment of quality. Inspection remains key to these proposals, albeit there will be shift from a set schedule of inspections to a more flexible, targeted approach.

DfE's improvement and intervention programme for Children's Services suggests both non-statutory support and statutory intervention tools can drive service improvement.

With respect to non-statutory support, DfE's Partners in Practice programme – where high-performing councils offer additional resource to under-performing peers – has been shown to benefit both councils involved. More specifically, a DfE-commissioned evaluation of the Lincolnshire Partners in Practice highlighted enhanced professional skills, efficacy and morale of a wide range of staff working with children and young people.

DfE's formal intervention for children services programme has also driven service improvement. Since 2011, the Department has issued:

- Improvement notices to 51 LAs, 41 of which are now closed
- 31 Statutory directions to 40 LAs, 22 of which are now closed

DfE also undertakes Special Educational Needs and Disability (SEND) reviews, which are inspection of the local area that sit outside of ILACS. An independent review of SEND inspections (2020) found that:

- Area leaders and frontline professionals were clear in focus groups that the existence of an inspection framework had raised the profile of SEND within their areas.
- Frontline professionals said that an increased focus on SEND at a strategic level had a knock-on effect on the quality of services. Inspectors agreed that inspection had helped put SEND on the agenda' and described it as a 'real lever for improvement'.

However, we recognise that Adult Social Care services form a greater proportion of LA spend than either Children's Social Care or SEND, and therefore, whilst they provide useful precedent, we are not proposing to replicate either of these regimes as part of increasing ASC assurance.

MHCLG has used its intervention powers to improve governance systems and, where appropriate, child protection arrangements and financial management. Since 2010, the Secretary of State has intervened formally in 4 local authorities.

### ***Benefits to the Adult Social Care Workforce***

An assurance framework should result in an improvement in the overall offer to the Adult Social Care workforce in the medium to long term. For example, by promoting best practice on recruitment and retention, staff rewards, recognition and skills development including minimum training standards. Given the costs of these are included as part of the long-term improvement costs calculation, it is appropriate to state that they would also form part of the benefits too (though not quantified).

### **Value for money implications:**

Whilst the benefits cannot be quantified, in our judgement the proposal offers value for money for the taxpayer. According to internal DHSC analysis based on historical evidence, government spending on social care in general generates at least £4 in benefits for every £1 spent.

Though not considered as a non-monetised benefit, there is likely to be an equity gain from the provision of care and improved life outcomes provided to those who previously qualified for care but did not receive it. This broadening of care provision should arise as an improvement of services occurs.

### **Indicative monetised costs (not included in the full economic assessment of the Preferred Option):**

This section outlines some additional costs, and details the approach taken to monetise them. These costs are not included in the full economic assessment of the preferred option as their cost, over a ten-year period contain more uncertainty and are highly dependent on the detail of the approach (scope, frequency, intensity), some of which will be set out in secondary legislation. The figures shown in this indicative section may therefore be refined further in the course of the development of operational policy planned implementation. These indicative costs have been combined with those that feature in the economic assessment of the preferred option, to demonstrate a possible unit cost scenario, in the unit cost modelling section below.

### **Indicative direct costs:**

#### ***Indicative administrative intervention costs***

The above section outlines the direct costs to DHSC through assessments and familiarisation of the policy change. The indicative costs which would be a further direct cost to DHSC come from intervention and/or support and are detailed here. For the purpose of making an illustrative assessment of the potential costs, it is assumed that as part of the assurance framework, all LAs will be assessed once every four years. Of those assessed each year, 15 per cent are assumed to require some form of intervention/support.

The intervention/support methods considered here include both statutory and non-statutory support. Statutory intervention refers to advisors and other forms of mandated improvement support, while non-statutory support refers to improvement panels, support provided by a sector expert, such as a former Director of Adult Social Services. However, since the finalised non-statutory support options will be determined by the outcomes that we are seeking to improve, the options considered are only for an illustrative purpose.

The overall costs associated with each support option are highly influenced by the scale of intervention. The indicative estimates assume that of those requiring intervention/support, 75 per cent will be offered support from a sector expert and improvement panel, while a smaller proportion of 25 per cent will be intervened in using a statutory method.

To estimate an example of a cost for non-statutory support, it is assumed that a sector expert provides support to a LA, one day per week, annually. Using the annual equivalent rate of pay as £82,700 for 'senior management' in the ASC-WDS, this equates to £16,540 per LA, for a year. Applying this cost through the scale of intervention, this is estimated to cost £0.6m over the ten-year period.

To provide an indication for the possible cost of an improvement board, it is assumed that a board is comprised of one lead commissioner and three other commissioners. The cost is estimated using the daily rate for a lead commissioner as £800 and £700 for a commissioner, and the assumption that the board meets twelve times annually. Applying this cost through the scale of intervention, this is estimated to cost £0.3m over the ten-year period.

The considered cost of commissioner support per LA is based on the equivalent cost of DfE's CSC regime at £55,956. Applying this through the scale of intervention, this is estimated to cost £0.2m over the ten-year period.

Adding together these three elements, indicative administrative costs associated with intervention (both statutory and non-statutory) total £1m over the ten-year period.

### **Indicative indirect costs:**

While we are not yet able to identify how many local authorities will be identified for intervention/support, it is likely that those that are will face financial pressures to comply with subsequent recommendations for improvement as a result. The indirect costs to local authorities will come through the short term and longer-term costs of improvement of their adult social care outcomes as a result of receiving intervention/support. These costs represent the opportunity cost of LAs needing to reallocate resources away from other areas of spend, in order to fully meet their obligations as per the Care Act (2014). The significant net benefits of the Care Act were analysed in an Impact Assessment published at the same time<sup>67</sup>The cost of this will be met from their general settlement, the quantum of which to be determined in the Spending Review.

### ***Short term indirect costs***

The short-term costs to LAs refer to the fixed cost of immediate action taken to respond to intervention/support that may arise as a result of a routine assessment in a local authority. As this is likely to only impact a handful of different local authorities annually, the associated costs will not reoccur annually, causing these costs to make up part of the illustrative transitional costs. Examples of these responsive actions include investing in prevention programmes and creating new policy and leadership capacity to design and implement system reforms.

These costs are dependent on the scale of intervention as they rely on the number of interventions that occur in all local authorities annually. An indicative estimate for the short-term improvement cost per local authority uses a central estimate of £7m, which is based on a range from DfE's CSC. This cost is likely to differ depending on the method by which a local authority is intervened/supported with. This is further shown in the unit cost modelling section below. However, if we apply this cost through the scale of intervention, it is estimated to total £200m over the ten-year period.

### ***Long term indirect costs***

To produce an indicative estimate of the long-term improvement costs that may be incurred by local authorities, we compared each local authority's unit cost with the median unit cost of 15 comparable local authorities that had better outcomes than themselves, across a range of outcomes for 13 areas of ASC spend. To identify a local authority's most comparable neighbours, various demographic and socio-economic

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<sup>67</sup> [The Care Act 2014: Regulations and guidance for implementation \(legislation.gov.uk\)](https://www.legislation.gov.uk)



factors were considered, including population and unemployment rate. In addition, neighbours are also considered by local authority type (for example, Metropolitan Districts and London Boroughs). The outcomes considered vary across the 13 areas of spend. For example, the proportion of adults with learning disabilities in paid employment is one of the four outcomes considered for the spend on community care for adults aged 18-64 with learning disabilities. The outcomes and the number of outcomes considered differ across the various areas of spend, ranging from one to five outcomes, with only Social Care-Related Quality of Life (SCRQoL) remaining consistent across all areas.

This method produces an estimate for the long-term improvement costs of local authorities as it indicates the cost associated with a local authority raising its outcomes to a benchmark level, as set by their comparable neighbours. Implementing this produces the indicative costs of long-term improvement as £295m over the ten-year profile. As we have included all local authorities within this estimate, it may represent an overestimate of costs. Please note that as well as some local authorities needing to increase unit costs to reach the median of their 15 comparable local authorities, others can reduce their current spend and achieve efficiency savings, with this methodology capturing the net effect of these movements.

### **Break-even analysis**

To estimate the size of the benefits needed to offset the costs, we have estimated the break-even point for one of the outcomes that the enhanced assurance system aims to deliver – the improvement in care outcomes for care users.

The cost per average care user on long-term social care support has been estimated by dividing the discounted direct and indicative costs by the discounted projected number of care users on long-term social care support (based on modelling commissioned by DHSC from the Personal Social Services Research Unit).

The costs have been discounted using the standard Social Time Preference Rate (STPR) of 3.5%. A discount rate of 1.5% has been applied to the number of care users as generators of QALYs. This is to reflect the fact that, when valuing health outcomes, only the time preference component of the STPR is relevant, and not the component which adjusts for the diminishing marginal utility of additional wealth as a result of economic growth in future years, as the utility of an additional year of life is assumed to stay the same, irrespective of income level.

The average present cost per discounted user is estimated to be £66.10. This has then been divided by £60,000 - which is the monetary value of 1 Quality Adjusted Life Year

(QALY), established using Willingness-to-Pay techniques – to determine the number of QALYs per care user above which the intervention would show a net economic benefit. This value is 0.0011 QALY.

Although it has not been possible to quantify the benefits of this specific intervention, Forder and colleagues (2018)<sup>68</sup> analysed the impact of social care services on the quality of life of service users. The estimates they produced indicate that the marginal cost of generating one additional QALY in social care was approximately £20,000 in 2018 prices.

Given that the estimated short- and long-term improvement costs outlined above qualify as increased spending in ASC of £396m, we can divide this by £20,000 to arrive at an indicative estimate of the potential additional QALYs generated. Although we would expect the marginal cost per additional QALY to increase with total expenditure, an additional investment of £396m in total over 10 years represents just 2% of the *annual* expenditure on adult social care by local authorities in 2019/20 of £16.9bn, and therefore this dynamic effect is likely to be negligible. Applying the methodology outlined above for the costs - dividing the total costs by the number of care users and by the marginal cost of 1 additional QALY established by Forder – we estimate that the indicative short and long term improvement costs are likely to lead to an increase of 0.0032 QALY, indicating that the benefits for care users in terms of improved social care-related quality of life alone are likely to significantly outweigh the costs of the intervention. This conclusion remains true even if we use a lower assumed value per QALY, such as the £25,000 value used by the National Institute for Clinical Excellence to appraise the Value for Money of new treatments.

This breakeven analysis does not include the other non-monetised benefits – as stated above – linked to the enhanced assurance system and so it is an underestimate of the value of the benefits linked to the intervention.

### **Unit costs modelling (as an alternative approach to the ‘Preferred Option’ cost estimates):**

The above indicative cost section uses a scale of intervention that is based on assumptions to provide an indicative estimate of what the scheme could look like. To demonstrate the costs from an alternative perspective, this section uses both the costs

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<sup>68</sup> Forder (2018) ‘The impact and cost of adult social care: marginal effects of changes in funding’ QORU Discussion Paper, <https://www.pssru.ac.uk/pub/5425.pdf>

that feature in the full economic assessment of the preferred option and the indicative cost section to outline a possible range of unit costs that may be incurred.

The table below demonstrates the range of transitional costs that are possible, per local authority, in addition to the familiarisation cost that is already considered as part of the full economic assessment. The initial familiarisation cost is the cost for a local authority to become familiarised with the policy changes and is the minimum transitional cost that will be incurred. The other costs in the table show the possible range of transitional costs, per local authority, if further intervention/support is required, as set out in the indicative cost section. This range shows that as the intervention method becomes more intense, the associated cost reflects this. In other words, given that non-statutory support is the least intensive support method, its associated cost is the lowest of all intervention methods considered, and vice versa.

In addition to the familiarisation costs and the direct administrative costs of the intervention/support method, it is assumed that a local authority chosen for intervention/support would incur a short-term cost of improvement. We assume that this cost of £7m will be incurred in full by a local authority intervened in using statutory methods but only by a proportion of 50 percent for any local authority supported using non-statutory methods, as shown in the table below.

**Table 2: Range of possible transitional costs, per local authority**

<b>Range of possible transitional costs (per local authority)</b>	
Minimum cost (familiarisation costs ONLY)	£2,265
Minimum cost plus non-statutory support	£3,518,805
Minimum cost plus improvement board (statutory) support	£7,037,065
Minimum cost plus commissioner (statutory) support	£7,058,221

In addition to transitional costs, there are a range of unit annual costs which are likely to be incurred – these are shown in the table below. The unit annual cost of assessment is 25 per cent of the actual cost since it is assumed that a local authority will only be assessed every four years. Similarly, the cost for a local authority to prepare in advance of an assessment will only occur every four years on average (with some receiving more

frequent CQC engagement because of risks identified via routine monitoring or assessment).

As mentioned in the familiarisation cost section, in addition to the initial cost of familiarisation, we are assuming local authorities will want to repeat this process and dedicate time each year to plan for further actions as a result of the policy change (so the refamiliarisation costs). The long-term improvement costs have been estimated using an aggregation of all LAs, as explained in the illustrative cost section, therefore making the figure listed as the unit cost more of an average, since this cost would differ across most local authorities depending on their (and their most comparable neighbours') unit costs and outcomes. This cost will only occur after a local authority has been assessed and further action has been taken, if required.

**Table 3: Annual unit cost scenario**

<b>Annual Unit Costs</b>	
Routine assessment (25% of actual cost given scheduled to occur every four years)	£27,557
Local authority preparation in advance of assessment (25% of actual cost given scheduled to occur every four years)	£2,780
Refamiliarisation costs	£2,265
Long-term improvement costs (only occur once transition has occurred)	£2,276,316

In addition to both the transitional and unit annual costs, there is a fixed cost incurred irrespective of the number of local authorities affected, which is the monitoring team within CQC as part of the routine assessment arm of the process (c. £400k per year).

### **Direct costs and benefits to business calculations**

The assurance framework is intended to influence local authorities' commissioning behaviour and thus any impact on business (private providers of care services) will be indirect. The scale and magnitude of the impact on local authorities will depend on which will require action, of which we anticipate that this is most likely be a subset of the total. None of these provisions have an intention of affecting business and any impacts (even though indirect) would be unintended consequences.

## **Risks and assumptions**

The ultimate objective of enhanced assurance is to promote improved quality of care, service improvements and greater efficiency.

DHSC is undertaking analysis on metrics and key lines of enquiry to assess how some fundamental metrics, such as the risk of financial failure by a local authority within monitoring, as well as metrics linked to each key line of enquiry could be applied in considering how and when local authorities were assessed or supported through other aspects of the assurance framework, such as through a DHSC-based regional support teams.

It should also be noted that the modelling of costs and impacts are partly based on precedent from DfE's SEND and CSC local authority assurance regimes. Whilst these provide helpful precedent for us to build on, it should be noted that our ASC assurance framework is expected to diverge from the SEND and CSC examples - in terms of proposed aims and operational policy, including the scale of intervention, which we expect to be less intensive than that used in CSC.

The transitional costs set out are sensitive to the scale of intervention/support in local authorities – since we cannot accurately determine this until the scheme has commenced, we have included the levels of intervention/support to local authorities that we anticipate may arise.

In addition, the long-term improvement costs are the most uncertain out of those monetised, but we have included them to give an order of magnitude. No sensitivity analysis has explicitly been conducted given we would not be informed enough to know what proportion they could increase/decrease by, but given its overall cost is large, a change in either direction would also be so. As noted in the detailed costs section above, however, DHSC has produced a version of the cost with the 15 costliest local authorities removed, as well as identified the services in which there are likely to be greater potential for efficiency savings, or equally those that are most costly.

## **Impact on small and micro businesses**

No businesses or voluntary organisation will be directly affected. As stated in the 'Direct costs and benefits to business calculations' section, any impacts of the assurance system will be indirect and unintended consequences of the system.

## **Wider impacts**

As stated in the 'Direct costs and benefits to business calculations' section, any impacts of the assurance system will be indirect and unintended consequences of the system. Such indirect impacts could include competition impacts in the provider market, altered future decisions relating to informal care (if formal care quality improves) and the opportunity costs on local authority services from shorter and long-term improvement costs. However, we are unable to make an assessment of the scale or magnitude of these impacts given the uncertainty in the design of the assurance system at this stage.

## **A summary of the potential trade implications of measure**

We do not anticipate that there will be any trade implications of the measure.

## **Monitoring and Evaluation**

Government is committed to evaluating the policies it implements as part of a Post Implementation review (PIR). The exact details of the PIR for this provision will be set out at implementation of the Act, following the introduction of secondary legislation. This is because the provision introduces a new duty and the details of the final policy will not be finalised until the secondary legislation stage. This means that the specific plans for the PIR cannot be finalised until the final form of the policy, and the specific outcomes it is likely to affect, are known.

As part of system design, DHSC will consider the basis for ongoing monitoring and evaluation, including how best to evaluate long-term effectiveness of the assurance framework. This will include establishing the best means for ongoing monitoring of the programme, incorporating considerations of issues such as how intervention can be underpinned by a theory of change. Given the scale of the assurance framework, consideration will be given to establishing a long-term evaluation programme including process and impact research.

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