Department of Health & Social Care

Impact Statement: Adult Social Care System Reform

Statement of impact for the white paper, People at the Heart of Care: adult social care reform (December 2021)

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Contents

Summary

1. The white paper, People at the Heart of Care (December 2021), sets out measures government will take to reform the adult social care (ASC) system in England. The reforms apply to England only as adult social care is fully devolved in Scotland, Wales, and Northern Ireland.

2. The white paper can be thought of as making two overarching announcements. First, it sets out an ambitious 10-year vision for how government will transform support and care in England[1]. The vision puts people at its heart and has three objectives:

    i. People have choice, control, and support to live independent lives.

    ii. People can access outstanding quality and tailored care and support.

    iii. People find adult social care fair and accessible.

3. Second, the white paper sets out how the government will spend £1.7 billion over the next three years on proposals which include but are not limited to:

    - Providing more training and qualifications to the workforce
    - Providing wellbeing, mental and occupational health (OH) support to the workforce
    - Transforming the role that housing plays in adult social care and increasing the range of new supported housing options available
    - Driving adaption of technology
    - Kick starting a change in the services provided to unpaid carers
    - Helping local areas innovate in terms of the support and care they provide, providing more options that suit peoples' needs and individual circumstances
    - Improving the delivery of care and support services, including assisting local authorities (LAs) to better plan and develop the support and care options available

4. This impact statement considers the potential effects of this £1.7 billion investment in system reform.

[1] Social care is devolved in Wales, Scotland, and Northern Ireland.

1. Background

1.1. What is adult social care?[2]

1.1 Adult social care covers a wide range of activities to help people who are older, or living with disability or physical or mental illness, to live independently and stay well and safe. It can include 'personal care', such as support for washing, dressing, and getting out of bed in the morning, as well as wider support to help people stay active and engaged in their communities. Social care includes support in people's own homes (home care or 'domiciliary care'); support in day centres; care provided by care homes and nursing homes ('residential care'); 'reablement' services to help people regain independence; providing aids and adaptations for people's homes; providing information and advice; and providing support for friends and family carers.

1.2 Social care is often broken down into two broad categories of 'short-term care' and 'long-term care'. Short-term care refers to a care package that is time limited with the intention of maximising the independence of the individual using the care service and eliminating their need for ongoing support. Long-term services are provided on an ongoing basis and range from high-intensity services like nursing care to lower-intensity community support. Both long and short-term care are usually arranged by a local authority (LA) and could be described as 'formal' care.

1.3 In England, LAs are responsible for assessing people's needs and, if individuals are eligible, funding their care. However, most social care services are delivered by independent sector home care and residential care providers, which are mainly for-profit companies but also include some voluntary sector organisations. Many people will also have this care organised and purchased by their LA, though many people with disabilities directly employ individuals ('personal assistants') to provide their care and support.

1.4 There are over a million adults who use social care services in England[3] who not only rely on it for daily tasks such as washing and eating meals, but also depend on it for their dignity, wellbeing, and independence. Care users are supported by a 1.56 million[4] strong social care workforce, representing 5.6% of the 27.2m[5] people aged 16 and over in employment in England. Meanwhile, many millions more receive informal care from a friend or relative, such that there were an estimated 7.6 million over 16s providing some form of unpaid care in 2019,[6] including 2.1 million people aged over 65.[7]

[2] Key facts and figures about adult social care | The King's Fund (kingsfund.org.uk)
[3] Figure includes short and long-term users and combines state-funded and self-funded care
[4] Skills for Care. Skills for Care. The size and structure of the adult social care sector and workforce in England (skillsforcare.org.uk) as at Sept 2021.
[5] ONS. A07: Regional labour market summary - Office for National Statistics (ons.gov.uk). Published September 2021.
[6] NHS Digital. *Health Survey for England 2019 [NS].* Published December 2020. Note, figure does not include child carers.
[7] See footnote 6

1.2. Adult social care reforms

1.5 On 7 September 2021, the government announced a £5.4 billion investment over three years for adult social care.[8] At the Spending Review in October 2021, the government announced that this investment will be used for:[9]

- **Charging reform:** £3.6 billion to pay for a cap on care costs, an extension to the means test, and to support progress towards local authorities paying a fair cost of care, which together aim to remove unpredictable care costs.
- **System reform:** £1.7 billion to implement improvements across social care in England, including an investment of at least £500 million in the workforce

1.6 This impact statement focusses on the potential effects of that £1.7 billion investment in system reform. The impact of charging reform measures is considered separately in the published Social Care Charging Reform Impact Assessment[10].

System Reform White Paper

1.7 System reform measures are set out in a white paper, *People at the Heart of Care* (December 2021). The white paper outlines more than 20 individual measures, each aimed at addressing the wide-ranging challenges facing the social care sector. The white paper groups these measures under the following themes:

- **Providing the Right Care, in the Right Place at the Right Time** – this covers measures related to housing, technology, and new and innovative models of care. It also covers measures related to prevention, of falls and preventable illnesses for example, to ensure people remain healthier for longer.
- **Empowering those who draw on care, unpaid carers, and families** – this covers measures to address information failures amongst those who draw on or provide care. It also covers measures aimed at improving support for unpaid carers.
- **Our strategy for the social care workforce** – this covers workforce specific measures, including training and development and wellbeing support.
- **Supporting local authorities to deliver social care reform and our vision** – this covers measures to improve LA capacity and capability for delivering better care.

1.8 This impact statement has been produced by the Department for Health and Social Care (DHSC) to complement the white paper *People at the Heart of Care* (December 2021) and the *Evidence Review for Adult Social Care reform* (December 2021)*[11].* The white paper sets out the government's priorities for investment in social care and describes where the money will be used,

[8] Our Plan for Health and Social Care - GOV.UK (www.gov.uk), published September 2021.
[9] HMT, 'Autumn Budget and Spending Review 2021', published October 2021.
[10] Impact Assessment template (publishing.service.gov.uk)
[11] Evidence review for adult social care reform - GOV.UK (www.gov.uk)

while the evidence review outlines current trends and challenges in adult social care in England based on available data and evidence. The key challenges identified in the evidence review are summarised in Table 1 below.

1.9 The purpose of this impact statement is to describe the rationale for the proposed reforms, which constituents of the social care system could be affected, and how. DHSC want those people and organisations that could potentially be impacted by the measures, including LAs, providers and people who draw on care and support, to start to understand how the reforms could affect them. Going forward the government will continue to work with the sector and others to inform and shape policy.

Problems in the social care system and rationale for intervention

1.10 Adult social care faces some well-documented challenges. These include a rising demand for social care, unsustainable local markets, variations in the quality and safety of care, low take up rates of new technology, high vacancy and turnover rates in the workforce and the system being complex and difficult to navigate for those who need it. The measures set out in the white paper are the next steps that the government wants to take in addressing these challenges.

1.11 The following table provides more detail on the challenges faced by the social care system:

Table 1 - Problems in the social care system

Challenge	Description
Increased demand	It is a good thing that positive advances in health and social care have enabled people to live longer and fuller lives. Between 2018 and 2040, the number of adults aged 85 and over is projected to increase by a further 77% (from 1.4 million to 2.4 million)[12]. Amongst younger age groups too, there is continuing progress in terms of better diagnosis, longer life expectancies and higher rates of survival of premature babies. Not only are people living longer but care needs are also becoming more complex. Amidst rising demand for social care and a suite of competing responsibilities, LAs have sought to protect social care spending, but it has inevitably taken some of the strain. The significant and growing demand for care inevitably puts pressure on both formal and unpaid carers, and families and communities who also play an essential role. The government must therefore plan ahead to ensure that people's needs are met both now and in the future.
Provider market	High quality, personalised care and support needs a vibrant, responsive market of service providers. The Care Act 2014 places a duty on LAs to ensure that their local care market is healthy and diverse. However, there is variability in the culture and strategic leadership across different localities, which impacts the quality and choice of services available for people. In many LAs, there is evidence of low fee rates and cross-subsidy between care home residents paying for themselves, and those who are funded by their LA[13].

[12] ONS, 'National population projections: 2018 based', published October 2019.
[13] CMA, 'Care homes market study: Final report', published November 2017.

Challenge	Description
	Uncertainty over future funding can stifle provider investment and, along with low fee rates, can result in poor workforce conditions, inadequate quality care, market fragility and pose a threat to continuity of care.
Variation in quality and safety of care	The primary mechanism for monitoring quality is the Care Quality Commission's assessment regime of care services, which looks at five key questions, including safety, leadership and whether services are responsive to peoples' needs.[14] As of November 2021, 84% of all social care settings were rated 'good' or 'outstanding'. However, 14.3% of providers have a 'requires improvement' rating and a further 1.4% are rated as inadequate[15]. There is also geographic variation, with evidence of poorer quality care in less prosperous areas where LAs often pay lower rates for care and self-funders are less affluent[16]. Several LAs have 100% of social care services rated 'Good' or 'Outstanding', while others have around 65%.
Recruitment and retention challenges in the workforce	In 2020/21, there were an estimated 1.56 million jobs in adult social care employers, with a further 110,000 NHS jobs providing adult social care[17]. Those who draw on care and support particularly value continuity of care and want to get to know their carers, so their needs are well understood. However, the social care workforce suffers from very high levels of staff turnover (overall annual staff turnover rate in 2020/21 was 30%), particularly amongst frontline care workers and nurses. Vacancy rates are also persistently high, particularly for regulated professional roles such as nurses, social workers, and registered managers[18]. There is a prevalence of poor mental health and burnout is high amongst the social care workforce, especially following the huge sacrifices they made during the COVID-19 pandemic. 26% of care home workers were likely to be experiencing some form of depression at the start of this year, and 27% likely experiencing an anxiety disorder (compared to 20% and 18% at the national average)[19]. A significant part of the adult social care workforce is not registered and there is a lack of differentiation between roles and responsibilities within a flat career structure. There are often limited opportunities for progression.
Information failures in navigating the system	Individuals find it hard to understand what they are entitled to or how to access care and support. Most people think the NHS provides social care services, whilst just under half (47%) wrongly think social care is free at the point of need[20]. A recent Social Care Institute for Excellence (SCIE) survey found greater awareness of some social care settings than others, with 98% of over 65s aware of care homes compared with 66% aware of extra care housing, 40% of shared lives housing and 56% of supported living[21]. People often do not know where to start when looking for information and advice about care and support; meanwhile, others find that the volume of information available is overwhelming and poorly tailored to their own circumstances. A lack of

[14] CQC, 'The five key questions we ask', updated July 2018.
[15] DHSC analysis of Care Quality Commission, Care Directory with Filters, published November 2021.
[16] Using CQC data | Care Quality Commission
[17] Skills for Care, 'The State of the Adult Social Care Sector and Workforce in England', published October 2021.
[18] See footnote 16.
[19] ONS, 'Depression and anxiety among adults in selected care occupations: Great Britain', published February 2018.
[20] Ipsos MORI, 'State of the State 2017-2018', published October 2017.
[21] Social Care Institute for Excellence (SCIE), 'A place we can call home: A vision and a roadmap for providing more options for housing with care and support for older people', published November 2021.

Challenge	Description
	knowledge and understanding can result in people drawing on the wrong type or amount of support, which may impact on their wellbeing as well as put further pressure on unpaid carers, affecting their health, wellbeing, and employment.
Inequalities in the adoption of technology	During the COVID-19 pandemic, the use of digital technologies transformed the delivery of care and helped people stay connected with friends and family. These digital tools supported people's care through remote monitoring, ensured care teams had the right information at their fingertips and helped services to identify those in need. Looking ahead, in a recent survey 90% of care providers said they will continue to use technology as they have during the pandemic[22]. Although technology has been a lifeline for millions of people, it has also laid bare inequalities in access. Recent research by Age UK highlighted that the older population are still less likely to be digitally included; among those aged 75+, more than 40% do not use the internet[23]. Office for National Statistics data shows that 14.9% people with a disability have never used the internet, compared to 6.3% of the UK population[24]. Recent research has shown that 23% of care home staff cannot access the internet consistently at work. In addition, 45% of providers express concern that care staff lacked digital skills[25]. This could slow the adoption of otherwise beneficial technology that could help to improve quality of care.
Limited choice of housing options	Many people with care and support needs live in homes that do not provide an adequately safe or stable environment, and within which care and support cannot be fully effective - whether for older people or those of working age with a physical or learning disability, for autistic people, or for those with long term mental health conditions. Some peoples' care and support needs mean that specialised housing is likely to offer the best option for them. Projected demand for supported housing in England is estimated to increase by 125,000 by 2030.The government therefore wants to provide more people with this option. However, most people will continue to live in mainstream housing, and the government needs to ensure more people can adapt their homes to meet their needs where necessary. Around 1.9 million households in England are home to someone with a health condition that requires an adaptation to their home to support everyday tasks like washing and using the bathroom, cooking, or getting out and about easily. In 2019/20, 53% of households requiring an adaption did not have all the adaptations needed, a rise from 45% in 2014/15.[26]
Lack of integration of health and care services	The health and care systems too often treat discrete episodes of mental or physical illness rather than considering a person's care needs holistically. This means that opportunities for prevention may be missed and people may go into hospital when they could be better cared for at home, causing people to lose their independence and choice. A lack of join up between services can lead to problems, including: • Confusion in accessing care and uncoordinated care: multiple visits may have to be made to see different professionals, resulting in people having to tell their story multiple times.

[22] Ipsos MORI, Institute of Public Care and Skills for Care, 'NHSX Adult Social Care Technology Innovation and Digital Skills Review', published December 2021.
[23] Age UK, 'Digital inclusion and older people - how have things changed in a Covid-19 world?', published March 2021.
[24] ONS, 'Internet Users UK: 2020',published April 2021.
[25] Ipsos MORI, Institute of Public Care and Skills for Care, 'NHSX Adult Social Care Technology Innovation and Digital Skills Review', published December 2021.
[26] MHCLG, 'English Housing Survey 2019-20, published July 2021.

Challenge	Description
	• Discontinuity of care and disjointed transitions between care settings; from childhood to adulthood, from NHS to social care, from GP to hospital. • Worse outcomes: individuals have a worse experience of care and their conditions escalate until potentially requiring emergency admission. • A lack of consistency identifying unpaid carers across health and care and providing them with the right information and support.

Measures announced in the white paper

1.12 As noted above, the white paper outlines more than 20 individual measures, summarised in the table below. Throughout this document, for convenience, the measure numbers used in this table will be referenced:

Table 2 – Summary of measures

Theme	Measures
Providing the Right Care, in the Right Place at the Right Time	1. Invest at least £300 million over the next three years to embed the strategic commitment in all local places to connect housing with health and care and drive the stock of new supported housing. 2. Invest at least £150 million of additional funding over the next three years to drive digitisation across the sector; including encouraging caretech that enables preventative care and independent living. 3. Launch a £30 million Innovative Models of Care Programme to support local systems to build the culture and capability to embed into the mainstream innovative models of care. This is intended to work for a changing population with more options for people that suit their needs and circumstances. 4. Fund a new service to make minor repairs and changes in peoples' homes, to help people remain independent and safe. 5. Increase the upper limit of the Disabled Facilities Grant (DFG). 6. Continue to invest in the Care and Support Specialised Housing (CASSH) fund with an additional £213 million available over the next three years
Empowering those who draw on care, unpaid carers, and families	7. Invest at least £5 million to test and evaluate new ways to help people navigate local adult social care systems. 8. A national website providing information and simple explainers about adult social care reform.

Theme	Measures
	9. Invest up to £25 million to work with the sector to kick start a change in the services provided to support unpaid carers. 10. A new obligation for Integrated Care Boards and NHS England to involve carers when commissioning care for the person they care for. 11. DWP will launch Local Supported Employment to identify effective ways LAs can support autistic people and people with learning difficulties into employment. 12. BEIS will introduce a Carer's Leave entitlement of 5 days of unpaid leave per year for eligible employees
Our strategy for the social care workforce	13. A Knowledge and Skills Framework (KSF), career pathways and linked investment in learning and development to support progression for care workers and registered managers. 14. Funding for Care Certificates, alongside significant work to create a delivery standard recognised across the sector. This is intended to improve portability, so that care workers do not need to repeat the Care Certificate when moving roles. 15. Continuous Professional Development (CPD) budgets for registered nurses, nursing associates, occupational therapists, and other allied health professionals. 16. Investment in social worker training routes. 17. Initiatives to provide wellbeing and mental health support and to improve access to occupational health. 18. A new digital hub for the workforce to access support, information and advice, and a portable record of learning and development 19. New policies to identify and support best recruitment practices locally.
Supporting local authorities to deliver social care reform and our vision	20. From 2022 to 2025, the government will provide £3.6 billion to reform the social care charging system, enable all LAs to move towards paying providers a fair rate for care and prepare local care markets for implementing reform. 21. The government will provide more support to LAs, including specific support to strengthen their market shaping and commissioning capabilities. In total the government will provide an increase in improvement funding of more than £70 million over the next three

Theme	Measures
	years, to ensure that LAs are well set up to deliver the vision for reform. 22. The government will introduce a duty for the Care Quality Commission (CQC) to independently review and assess LA performance in delivering their adult social care duties under Part 1 of the Care Act 2014. 23. The government will put in place new legal powers for the Secretary of State for Health and Social Care to intervene in LAs to secure improvement where there are significant failings in the discharge of their adult social care functions under Part 1 of the Care Act 2014. 24. The government will establish an adult social care data framework by spring 2022 and improve the quality and availability of data nationally, regionally, and locally.

1.13 The government recognises that there are many possible combinations of policies amongst those presented in the white paper that could be bundled to form the basis of options. The package presented in the white paper is government's preferred combination of proposals that combine to kick-start the reform journey over the next 3 years and move the system towards achieving the government's 10-year vision. Funding for proposals beyond the three-year period is subject to future Spending Reviews. More detail is provided in Sections 2 to 5 on the rationale for specific measures and the options considered during policy development.

1.3. Policy objectives

1.14 The vision for adult social care outlined in the white paper is centered around achieving three key objectives:

i. People have choice, control, and support to live independent lives.

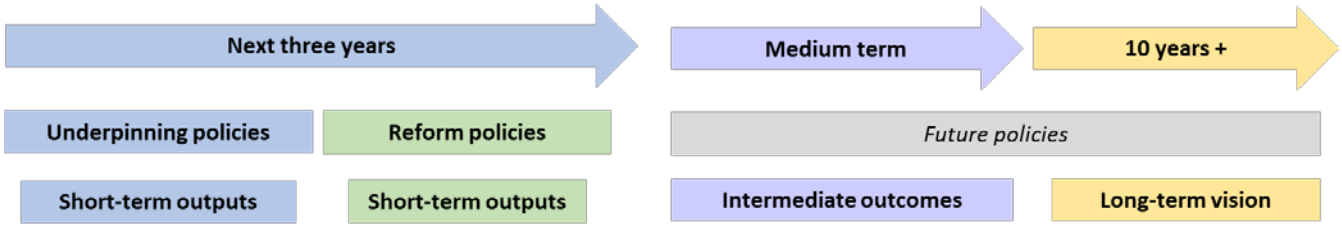
ii. People can access outstanding quality and tailored care and support.

iii. People find adult social care fair and accessible.

1.15 The white paper provides more detail on these objectives and describes the impact that the realisation of these objectives would have on the lives of those who draw on care and support, on those providing unpaid care and on those who work in social care.

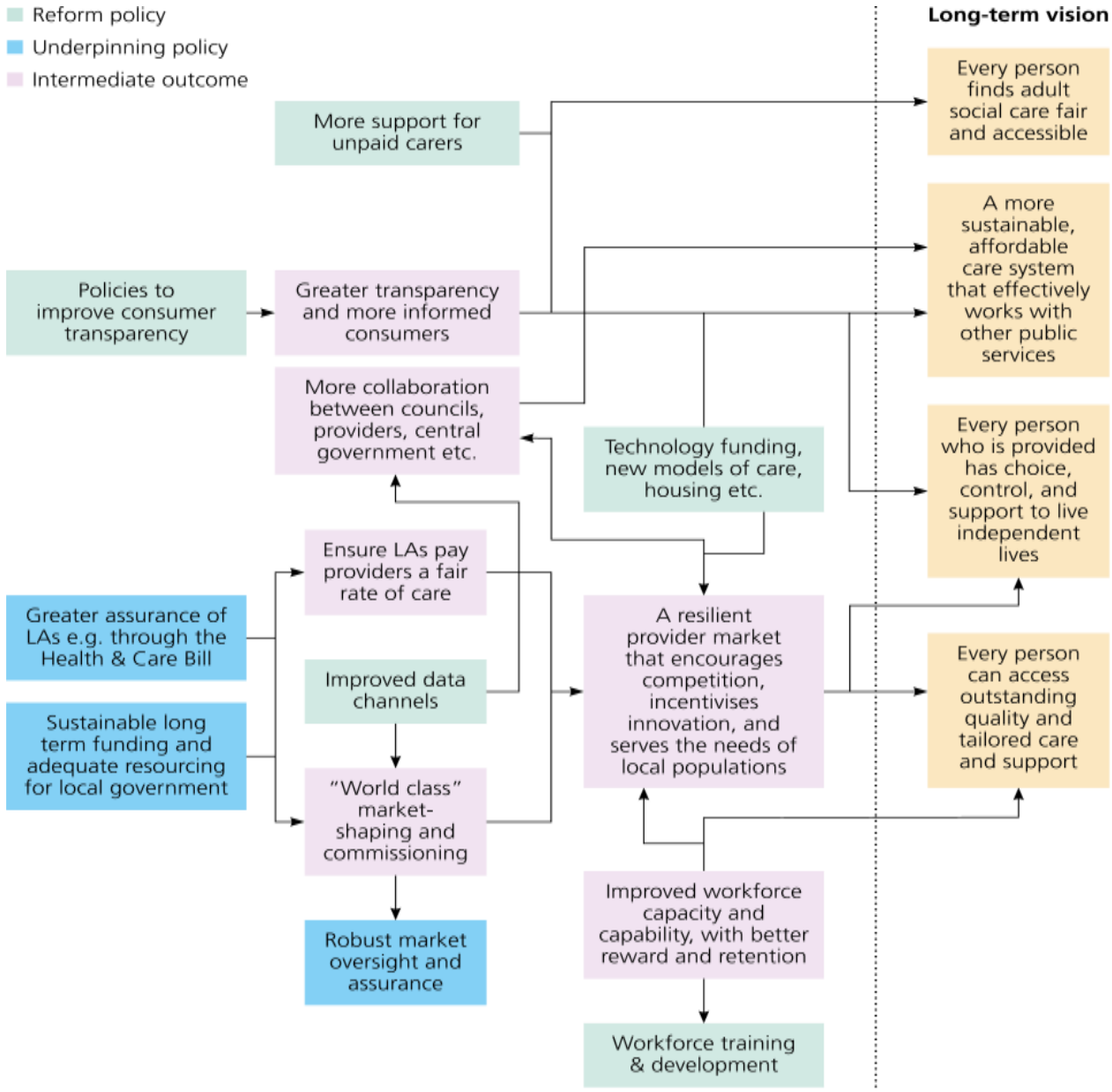
1.16 To realise this vision, several intermediate outputs and outcomes will be necessary. Those individual measures announced in the white paper are anticipated to start delivering these intermediate outputs and outcomes, and act as a first step in achieving the white paper vision:

Figure 1: Simplified logic map of how policies in next three years lead to reform



1.17 The intermediate outcomes that the government wants to achieve are set out in the following logic map showing how policies relate to expected reform outcomes included in the white paper:

Figure 2: Logic map showing how policies relate to expected reform outcomes



1.18 These outcomes are initial and high level so as to cover the reform package as a whole. Each of the measures discussed in this impact statement will have separate and more specific objectives, which are being developed and refined as policy development progresses.

1.4. Scope of this impact statement

1.19 This impact statement is not intended to provide a full options appraisal but rather it supports the white paper by explaining the rationale for, and potential effects of, the reform measures the white paper commits to. It provides a summary of the policy context and proposals but does not seek to duplicate the detail set out in the white paper. The focus is on measures being funded over the next three years. This impact statement does not attempt to account for the effects of the ambitious 10-year vision for adult social care.

1.20 Note that each of the measures are at different stages of development. Some policies are more advanced, while others require further development. There are also several proposals related to pilot schemes and testing. This explains why, at this stage, a full quantitative assessment of costs and benefits has not been feasible.

1.21 In line with best practice, policy makers will continue to work with analysts when further developing proposals. Specific impact assessments and/or business cases will be developed as required. The government will continue to work with the sector and others to further inform, shape and implement policy.

1.22 In this paper, DHSC has sought to ensure that:

- the policy rationale and mechanism for realising benefits for each proposal is set out clearly
- the potential types of costs and benefits, and to which stakeholders, are described
- any early risks, evidence gaps and assumptions are made clear
- potential impacts to small and micro businesses are also considered

1.23 Overarching policy risks and assumptions are discussed in Section 6, while monitoring and evaluation considerations are discussed in Section 7.

2. Providing the right care, in the right place, at the right time

Opportunities for Improvement[27]

- Many people live in unsuitable homes that do not provide a safe environment for care and support to be effective.
- Older and disabled people are more likely to be digitally excluded, and many care home staff cannot access the internet and lack digital skills.
- Insufficient innovation of new models that have the potential to transform the ways care and support is provided.

2.1 The white paper groups together policies focused on housing and innovative models of care, and technology. The logic map for how measures are intended to work together is outlined in Figure 3 below:

Figure 3: How policies link to long-term vision

2.1. Housing and models of care

Summary of reform proposal (including rationale)

2.2 Evidence suggests that many people with care and support needs live in homes that do not provide a safe or stable environment, and within which care, and support cannot be effective - whether for older people or those of working age with a physical or learning disability, for autistic people, or for those with long term mental health conditions.

2.3 For some, supported housing could be the best model of care encouraging better health, greater independence, and closer connection with friends, family, and community. However, most people will continue to live in mainstream housing, and the government needs to act to ensure they can

[27] Evidence review for adult social care reform (publishing.service.gov.uk)

adapt the homes of such people to meet their needs as necessary. Around 1.9 million households in England are home to someone with a health condition that requires an adaptation to their home to support everyday tasks like washing and using the bathroom, cooking, or getting out and about easily. In 2019/20, 53% of households requiring an adaption did not have all the adaptations needed, a rise from 45% in 2014/15[28]. To keep pace with demographic pressures, the number of supported housing units in England for older and younger people would need to increase by 35% and 17% respectively between 2015 and 2030. The total number of units would need to rise from 550,000 in 2015 to over 700,000 in 2030[29]. Therefore, an important priority for the government in reforming adult social care is to grow investment in both grant-funded and private supported housing to incentivise their supply.

2.4 Discussions with the sector suggest that the primary reasons for a current lack of supply of supported housing is eroded investment confidence which has significantly reduced the viability of housing with care and support (HWCS) schemes. These discussions indicate that this follows the removal of a ringfence for funding in 2010, the need for LAs to manage their overall expenditure, and a focus by LAs on funding statutory care duties.

2.5 The interventions proposed by government in its social care reform white paper seek to address these issues. The vision for social care reform is to enable more people to remain in their own homes for longer, with high-quality, personalised models of care that provide care and support to meet their needs and preferences. The government is seeking to embed the following enabling changes in the system:

- Long-term funding confidence for housing providers
- Strong leadership and partnership that sees the local provision of health, care, and housing services as a coherent system
- Housing that better meets future care and support needs delivered within a complex wider housing market. For changes to be embedded they need to extend beyond the adult social care system.

2.6 The government aims to actively shape the specialist housing market – to establish and consolidate local strategic leadership and create the right incentives for local areas and housing providers to invest, including in new and innovative models of provision. The government is investing at least £300 million over the next three years [measure 1] to:

- Enable all local areas to agree a plan embedding housing in broader health and care strategies, including investing in jointly commissioned services,
- Boost the supply of supported housing, coupled with driving innovation in how services are delivered alongside housing where possible,

[28] MHCLG, 'English Housing Survey 2019-20, published July 2021.
[29] Wittenberg R and Hu B (2017), Projected demand for supported housing in Great Britain 2015 to 2030, CPEC

- Increase local expenditure on services for those in supported housing. This could increase investor confidence regarding future investments in supported housing.

2.7 The government will also continue to invest in the CASSH Fund, with £213 million for the next three years to provide capital grants for the development of supported and specialised housing for older people and disabled adults [measure 5].

Innovative Models of Care Programme

2.8 Examples of new models of care have been implemented at a local level through innovations such as the establishment of micro-providers or the Shared Lives programme. But such interventions have tended to remain relatively small in scale. Local systems find it difficult to develop innovative ways of delivering care because of the time, cost and risk involved[30]. The Innovative Models of Care Programme will seek to enable innovation and create partnerships that support the sharing of knowledge across the sector (offering the dual benefit of increasing efficiencies by reducing duplication and helping successful innovations to embed quickly). The programme will be underpinned by evaluation, so that we can scale and embed successful models across the sector and learn 'what works' to help local systems to implement successful innovations.

2.9 The programme [measure 3] aims to support LAs (together with partner providers) to develop, commission and deliver new models of care for people living in non-residential settings. As part of the programme, the government intends to convene innovation partnerships, based on a number of agreed innovative models. These will provide expert support, building LA and provider capacity, skills and knowledge sharing into the process.

2.10 While the specifics of the programme are still being developed, broadly the programme will seek to:

- Strengthen the evidence base around the impact of innovative models of care
- Support wider implementation of innovative ways of commissioning and delivering care and support by addressing key barriers outlined in the earlier section.
- Test scalable interventions
- Spread best practice. For instance, innovation partnerships could make it easier for local systems to support and learn from each other, while resourcing the development of delivery plans and reducing duplication required by local areas to invest in new models.
- Strengthen the evidence base around the impact of government programmes to support innovation in Adult Social Care.

[30] New-models-of-home-care.pdf (kingsfund.org.uk)

Supporting the Disabled Facilities Grant (DFG)

2.11 The current Disabled Facilities Grant (DFG) of £573m a year funds home adaptations. Grants can be provided for a range of interventions, including downstairs bathrooms, grab rails and stairlifts up to a £30,000 limit. There is strong evidence that home adaptations support individuals to remain in their own homes and can reduce, prevent, or delay the need for more intensive packages of care and support[31]. This proposal provides funding for several key reforms to the DFG. Namely:

- Increasing handyperson services.
- Raising the upper funding limit; and
- Revisiting the means test to ensure consistency with related policies.

2.12 The government is proposing to additionally fund the provision of practical support for home adaptations and repairs and hands-on advice for those in need of home adaptations [measure 4]. This service will 'troubleshoot' minor problems and prevent their escalation, making sure that DFG interventions can be focused on those who would benefit most, and reducing waiting times by speeding up assessments. The white paper states that the government will also raise the upper limit on individual grants, as the existing upper limit has not kept pace with increases in the costs of some common adaptations [measure 5]. This means that those requiring more complex adaptations (particularly for children) should face lower costs and should be more likely to apply for adaptations which will benefit them and have knock-on benefits for others.

Summary of affected groups

2.13 All these proposals are targeted at the intersection of housing provision, health and social care (particularly care provided outside institutional settings). They aim to increase the range of care and support that can be offered to individuals in the community. It is expected that individuals who need some combination of long-term care, support, and housing services will be the primary beneficiaries of these interventions. This includes both older people and disabled working age adults.

2.14 There could also be impacts on a wider range of groups including local government, the health system, and unpaid carers. More detail has been provided for each proposal below. For both housing activities and the new Innovative Models of Care Programme it is not currently possible to precisely identify who will be affected, as the focus and membership of partnerships has not yet been established and the precise activities to connect housing with health and care have not yet been determined.

Activities to shape the specialist housing market:

2.15 The housing interventions seek to drive increased confidence in the social supported housing market, stimulating a positive cycle of further innovation and private investment. Local approaches, provided they are developed well and with the right knowledge and support, could lead to better

[31] Falls prevention: cost-effective commissioning - GOV.UK (www.gov.uk)

joined-up work at a local level and encourage change in local planning and commissioning for social care and housing.

2.16 The intended outcome of these interventions is to increase the number of individuals who can live in supported housing. This could have knock-on impacts for the individual, anyone who provides them with paid and/or unpaid care and the wider health and care system. The costs of administering and evaluating these interventions will likely fall to central government.

Innovative Models of Care Programme:

2.17 The ultimate beneficiaries are intended to be the individuals whose needs are met through new models of care. There may also be impacts on the health and social care workforce who may work together in different ways to deliver these models of care. Most financial costs are likely to be borne by the programme and participating LAs. Participating LAs could benefit from access to expertise and funding through the programme. Benefits for local and central government are expected if the programme builds an evidence base to support effective and efficient commissioning of care services in future.

2.18 The programme will provide targeted business support to care providers in local areas that are part of innovation partnerships. There may be opportunities for new, or existing, care providers to provide services in different ways as part of this programme. At this stage, innovation partnerships have not been established and therefore it cannot be defined exactly what the impacts on local care markets could be.

Supporting the Disabled Facilities Grant (DFG)

2.19 Individuals with health or care needs may benefit from improved access to practical support for repairs and adaptations and reduced costs from home adaptations that are above the current DFG upper limit. Costs could accrue to LAs in the form of staff costs and administration costs, which are likely to be funded by the government through an increased budget for the DFG.

Description of potential costs

2.20 The announced funding involves spend by government over the years 2022/23 to 2024/25 of at least £300 million, to connect housing with health and care and drive the stock of new supported housing, and £30m for the Innovative Models of Care Programme.

2.21 At this stage, more specific cost breakdowns and estimates of any wider costs to society have not been developed. For all these interventions, there are at least likely to be familiarisation costs for local systems. The government intends to provide information and advice to make it as easy as possible to understand the changes. Further possible costs relating to each proposal are described below.

Activities to shape the specialist housing market

2.22 The interventions could ultimately impact what care and support is commissioned (and the associated costs to providers, LAs, and other actors in the system) over a longer time horizon.

Innovative Models of Care Programme

2.23 Detail on programme delivery is currently being developed, but the government expects to deliver through innovation partnerships to provide expert support and to build LA and provider capacity, skills and knowledge sharing into the process.

2.24 The largest programme costs will be the spend on implementing new models of care. The white paper details that risk-sharing funding will be provided by government to participating LAs to mitigate the additional costs arising from system change. This funding is included in the programme budget but there may also be costs to participating LAs. Specific costs will depend on the model of care being implemented but may include spending on workforce, technology, or new services.

Supporting the Disabled Facilities Grant (DFG)

2.25 No significant costs beyond the funding provided by government are expected.

Description of potential benefits

Activities to shape the specialist housing market

2.26 These interventions are anticipated to result in two main benefits: potential improvements in individual health, and benefits associated with scalable innovations and the improvement of knowledge in the adult social care (ASC) sector.

2.27 Supported housing could benefit individuals through increasing quality of life and ability to live independently. Working age individuals may find that supported housing makes them more able to enter the job market and remain employed. For older adults, supported housing may enable them to retain their independence for longer while lessening the need for care.

2.28 More widely, savings could potentially accrue to the NHS and social care system through reduced demand. Increased commissioning of supported housing could delay, reduce, or prevent the need for residential, nursing or home care. Supported housing could also lead to healthcare savings, for example, by reducing loneliness or enabling individuals to make more appropriate use of healthcare services which can reduce the number of trips to the GP or hospital. One study[32] found that i) hospital stays reduced to a median of 1-2 days for those in extra care housing compared to 5-7 days for those who live in the community ii) over a 12-month period, total NHS costs reduced by 38% for extra care housing residents iii) routine GP appointments for residents fell by 46% after

[32] Holland C., et al. (2015). Collaborative Research between Aston Research Centre for Healthy Ageing (ARCHA) and the ExtraCare Charitable Trust. Aston University. https://www2.aston.ac.uk/migrated-assets/applicationpdf/lhs/245545-final%20report1.pdf

a year and iiiv) residents who required inpatient care remained in the hospital for half of the average time.

2.29 The potential benefits could be greater for adults with a disability or mental ill-health. For those with significant mental health issues an inpatient place for a month can cost over £13,000 but supported housing can cover all housing costs for less than half that[33]. For people with learning difficulties or multiple complex needs, supported housing is an important part of a longer-term package to enable them to live independently and be part of their community.[34]

Innovative Models of Care Programme:

2.30 The evidence base, nationally and internationally, suggests that new models of care could deliver benefits compared to current prevalent models. For instance:

- Somerset Council pooled a council and NHS fund of £75,000 a year to support the set-up of micro-providers of care services to deal with issues of providing care in a vast rural area. Currently 867 micro-providers[35] support around 6,000 people with tasks such as personal care, social contact, and maintaining their usual routine. The outcomes included: creation of 728 local jobs, reduction in hospital stays and a 43.6% increase in uptake of direct payments. Direct payments allow people control and choice over their care. Additionally, the council surveyed 125 micro-providers and calculated a saving of around £2.9 million a year against commissioned home care services. Surveys also show showed higher satisfaction scores for micro-providers compared to traditional providers.

- Shared Lives is a care and support service that matches people aged 16+ who want to live independently in their community with Shared Lives carers. People move in with their carers and are supported within the context of the carer's home and family. CQC rates Shared Lives as 95 percent good or outstanding, compared to 82 percent and 72 percent for other forms of social care and residential care homes, respectively. An independent cost comparison found that Shared Lives services were significantly less costly for people with learning disabilities or mental ill health compared to other forms of regulated social care[36]. Additionally, over 80 percent of those involved felt Shared Lives supported them to have friends and improved their physical and emotional health. Based on comparisons undertaken in conjunction with several LAs, Shared Lives estimates that its services are £30,000 per year less expensive than comparative care for people with learning disabilities.[37]

- The Buurtzorg Model was founded in 2006 in the Netherlands. The Buurtzorg model involves small, autonomous, neighbourhood-based teams that provide a range of care and support services to people in their homes, taking advantage of both informal and formal support

[33] nmhdu-factfile-3.pdf (networks.nhs.uk)
[34]Mencap (2018). Funding Supported housing for all: specialised supported housing for people with a learning disability. Available at: https://www.mencap.org.uk/sites/default/files/2018-
[35] Micro-providers are providers of very small, **community-based** care and support services. A micro-provider has eight or fewer paid or unpaid workers and must be totally independent of any larger organisation.
[36] Shared Lives Plus, 2019. Personalised Care and Shared Lives. NHS_Report_Final_-Shared_Lives.pdf (coalitionforpersonalisedcare.org.uk)
[37] Work by Shared Lives and LAs – shared with DHSC.

networks. A 2014 KPMG case study found that although the hourly costs of delivering care were higher, Buurtzorg accomplished lower monthly costs per patient and shorter duration of care. Hospital admissions were 30% less frequent and typically shorter. Patient satisfaction scores were 30 percent above the national average.[38]

2.31 Realising benefits as a result of the proposed funding will be dependent upon the success of the new models of care that are tested and funded. The government is designing the programme in consultation with the sector to help ensure it addresses the key barriers to embedding innovation.

Supporting the Disabled Facilities Grant (DFG):

2.32 The funding is intended to expand the number of people eligible to receive DFG grants, but grants will continue to be based on a needs assessment.

2.33 Evidence suggests that adaptations in the home can be cost effective. By preventing falls and delaying or reducing the need for higher levels of social care, they deliver savings elsewhere in the health and social care system. For instance, one estimate suggests that for every £1 spent on Home Assessment and Modification, there is a return on investment of £3.17, of which £2.17 is a return for social care and £1 to the healthcare system. The social return is higher if quality of life benefits for individuals are included.[39]

2.34 The DFG reforms could also have benefits for the social care system and carers. In 2015, research by Foundations, the national body for Home Improvement Agencies, found that home adaptations delay the move to residential care by four years.[40] This is particularly important because the GP Patient Survey in 2020 showed that high intensity caring led to more physical problems so reduced dependence on carers could improve their health and wellbeing. [41]

2.35 The proposal will also provide more handyperson services to support the DFG. Evidence suggests these are cost-effective at reducing negative physical and mental health outcomes for older people.[42] Accidental falls are a significant cause of premature health decline and associated reduced independence amongst older people.

Small and micro businesses

2.36 The interventions are not expected to have a significant impact on small or micro businesses, although some LAs may choose to undertake market shaping activity as part of their innovation partnerships, which may have an impact on providers in the local social care market. The support provided is likely to be varied (for example, R&D and service design, user consultation or support

[38] KPMG (2015). The added value of buurtzorg relative to other providers of home care: a quantitative analysis of home care in The Netherlands in 2013.
[39] Public Health England, 2018, A Return on Investment Tool for the Assessment of Falls Prevention Programmes for Older People Living in the Community, Available at: A Return on Investment Tool (publishing.service.gov.uk)
[40] Foundations 2015, Linking Disabled Facilities Grants to Social Care Data. Available at: http://foundationsweb.s3.amazonaws.com/4210/foundations-dfg-foi-report-nov-2015.pdf
[41] GP Patient Survey. (2020). http://www.gp-patient.co.uk/analysistool?trend=0
[42] Small But Significant: The Impact and Cost Benefits of Handyperson Services
Adams S *Care and Repair England, London.* 2018 and Safe at Home: A Preventive Handyperson Service in Devon
Evans S *Housing Learning and Improvement Network, London.* 2011

with recruitment and development of frontline staff) and is likely to be provided by businesses of any size.

2.37 Where small businesses provide any of the additional services to be procured through the additional government funding e.g., additional handy person services, such businesses could benefit from increased demand for their services.

Risks and assumptions

2.38 The benefits of both spend on specialist housing and innovative models of care depend on which projects are supported (which itself depends on interaction with local systems, bids for funds and the work of innovation partnerships). They may achieve, exceed, or fail to meet the social benefits of similar schemes described above. Failure is a risk associated with trying a new, innovative method but this should inform the development of government's future approach.

2.39 There are three key interdependencies between the spend on activities to shape the specialist housing market, innovative models of care and DFG which would impact the expected costs and benefits of the policies:

- **Alignment with wider reforms:** The benefits of these proposals will be impacted by the wider reform programme – particularly those aligned to integration, the fair cost of care and the improvement offer for adult social care – which aim to support a functioning, stable social care market. The impact of any of these reforms would be limited in the absence of a stable social care market.

- **Accompanying capital funding for CASSH:** CASSH funding is important for the development of specialist housing schemes that underpin the innovative models which the spend on activities to shape the specialist housing market focusses on.

- **Challenges of the wider supported housing and housebuilding policy landscape:** Issues of land availability, planning, and market dynamics; and regulation on affordable and social rents and those relating to Housing Benefit provisions, are outside the scope (and influence) of this programme.

2.40 Funding for activities to shape the specialist housing market, innovative models of care and DFG has been confirmed for the next three years. However, many of the potential interventions that could be funded should have impacts over longer time horizons, for instance the delivery of more units of HWCS could have benefits over decades.

2.2. Digital and technology

Summary of reform proposal

2.41 Digitisation is expected to play a significant role in achieving the government's ambitions for adult social care reform, seeking to drive up the quality and safety of care while supporting people to live with greater choice and independence.

2.42 NHSX (now part of NHS England from November 2021[43]) aims to drive the digitisation of adult social care services through an ambitious programme of transformation that aims to achieve a widespread increase in digital maturity across the sector.

2.43 Although the pandemic response saw unprecedented digital working in the social care sector, the starting point remains challenging. Providers face barriers in achieving digitisation, often not having sufficient resources, capability, or capital to invest[44], meaning levels of digitisation in the social care sector lag far behind that of the NHS.[45] Many providers face infrastructural limitations on achieving greater digitisation. For example, analysis of care home connectivity showed that 62% were using slow internet connections not suitable for the needs of a small business; that 1.5% care homes have at best poor connections available in their geographic area, and up to 7.6% may have had no internet connection at all[46]. Taken together, these factors have contributed to low levels of digitisation, with around 40% of providers having a digital social care record, growing at an annual rate of ~3%.

2.44 The impact of low levels of digitisation is felt by people, care staff, providers, and the wider system:

- Research by the Local government Association (LGA) found that only 29% of social care professionals felt they have digital access to the information they need from health care providers.[47,48] This lack of real-time information sharing between social care providers and NHS partners can lead to safety issues, such as in relation to medications management, and impacts upon the quality and personalisation that people experience in their care.

- Falls among older people can have a devastating impact on these people and their families. Falls cost the NHS around £2 billion per year[49] and contribute to approximately 40% of care home admissions[50]. Technology is available today that can prevent falls and other avoidable

[43] Major reforms to NHS workforce planning and tech agenda - GOV.UK (www.gov.uk)
[44] Research commissioned by NHSX found that 57% of providers feel budget is the main obstacle to implementation of digitisation, this was closely followed by concerns around care staff lacking digital skills (45%). Ipsos MORI, Institute of Public Care and Skills for Care, NHSX Adult Social Care Technology Innovation and Digital Skills Review, published December 2021; page 187.
[45] The Kings Fund, Shaping the future of Digital Technology in Health and Social Care, published April 2021; page 38.
[46] NHSX and NHSD Care home connectivity data –overview, published May 2020.
[47] GfK/Social Care Institute for Excellence, 'Social workers and information technology', published 2017; page 3.
[48] Local Government Association 'Social Care Digital Maturity Assessment', published 2017; page 21.
[49] Falls: applying All Our Health, gov.uk (2020)
[50] BMJ Open Quality, *Reducing Falls in a Care Home*, 2017

incidents that cause significant harm to people. However, without the basic digital enablers in place in social care, providers are not likely to be able to adopt these technologies at scale.

- Without large scale adoption of digital social care records and adequate cyber security measures for all social care providers, it will not be possible to achieve the government's vision for a fully integrated health and social care system.

2.45 Addressing these challenges will require coordinated government intervention and support but, if successful, the government's commitment to spend at least £150 million over the next three years [measure 2] to drive digitisation across the sector could deliver system-wide benefits, creating the foundations for preventative care and supporting an unprecedented level of integration between social care and the NHS.

2.46 The theory of change focuses on delivering improved outcomes for people: both supporting independence for those living in their own homes and communities; and improving the quality and safety of the care people receive, including those drawing on care in care homes. These outcomes are delivered by putting proven care technologies into the hands of care staff and people and families drawing on care and support. There are further benefits around safety and personalisation that can be achieved through adoption of digital social care records that put information at the fingertips of all professionals involved in a person's care.

2.47 The three-year programme of digital transformation [measure 2], includes:

- **Scaling care technologies that deliver proven benefit.** To support care providers to adopt proven technologies which can transform care, the initial focus will be on ensuring the 20% most vulnerable people in care homes have access to falls prevention technology, delivered through funding to ICSs.

- **Increasing the adoption of digital social care records (DSCR).** government's ambition is for at least 80% of CQC registered providers to have a digital social care record in place by March 2024.

- **Ensuring the necessary infrastructure is in place, with appropriate cyber security practices.** For those care homes lacking the necessary up-to-date infrastructure to enable digital working, the government aims to ensure they have access to fibre upgrades enabling high speed connections. To support this improved infrastructure, we will also be building on the success of the Better Security Better Care programme to deliver practical cyber security support and drive-up compliance of the Data Security and Protection toolkit, ensuring digitisation does not put the social care sector or NHS at risk.

- **Building digital skills for the future**. The government will be providing a comprehensive digital learning offer to support a step-change in digital skills and confidence. This will include training and online resources, alongside guidance on using technology in all care settings. Decision-makers with digital leadership will be targeted to drive cultural change across the sector.

2.48 The government wants to be ambitious but realistic as it works to deliver greater digitisation in the sector over the next three years. While other technology areas – such as electronic medication administration records (eMAR) and technology for detecting bed sores – have demonstrated benefits to people drawing on care, the government has chosen to initially focus on falls prevention technology, which has a strong evidence base. The types of technology that the care system can deploy are likely to be expanded as evidence about the most effective products grows.

Summary of affected groups

People drawing on care and support

2.49 There are already at least 1.7m people using technology to support their care and independence[51] with significant benefits to both working age and older adults who draw on care and support. Increased access to technology can support people to live more independently with more control over their health and care. They can also benefit from improved safety and quality of care using digital tools to prevent avoidable incidents and identify escalation of need.

2.50 Although technology has been a lifeline for some people during the pandemic, the government recognises that there continue to be inconsistencies in access to digital infrastructure across different groups of people drawing on care and support. The government wants to ensure technology can positively support the wellbeing of people and enable them to create stronger connections between them and their care networks. DHSC has assessed the impact on different protected characteristics in line with the Public Sector Equality Duty. Equalities impact will continue to be considered as policies are further developed.

Families and unpaid carers

2.51 As described in Section 3.1, DHSC estimates that in 2021 there were 7.7m unpaid carers aged 16+ in England. Research commissioned by NHSX showed that families and unpaid carers want easier access to information, support, and advice to help them in their caring role, including information about available digital and consumer technologies and apps to support their wellbeing.[52] The same research showed that whilst awareness around the technologies which are available is more limited, the majority of unpaid carers surveyed were open to making greater use of technology to support the care they deliver.

2.52 There is also evidence that families and unpaid carers have improved peace of mind when technology is routinely used to provide them with real-time reassurance about their loved one's health and wellbeing, particularly if they do not live close to the person they are caring for.[53] In addition, greater access to real-time information through digital tools can enable families and unpaid carers to provide accurate and timely support to their loved ones.

[51] Ipsos MORI, Institute of Public Care and Skills for Care, NHSX Adult Social Care Technology Innovation and Digital Skills Review, published December 2021, section 8.2
[52] Ipsos MORI, Institute of Public Care and Skills for Care, NHSX Adult Social Care Technology Innovation and Digital Skills Review, published December 2021, section 8.6.
[53] Sriram, Jenkinson and Peters 'Carers' experiences of assistive technology use in dementia care: a cross sectional survey' (BMC Geriatrics, 2021).

Social care workforce

2.53 The adult social care sector is highly fragmented, with over 18,200 diverse organisations that employ 1.56 million people in providing care in 38,000 locations, ranging from small 3-bed care homes to 100+ bed care facilities. There is strong evidence that technology can improve the quality and safety of care, for example, use of acoustic monitoring can reduce falls in care homes by 20% or more.[54] This can enable care professionals to monitor an individual and provide medical intervention earlier.

2.54 Tools such as Digital Social Care Records, linked with Shared Care Records, can ensure all professionals involved in a person's care have access to the right information, meaning people do not have to tell their story repeatedly. They can also free up time usually spent chasing up GP or hospital discharge information missing from their paper records, meaning carers have more time to provide meaningful care. Evidence shows this can release up to 20 minutes per care worker, per shift.

2.55 NHSX-commissioned research also indicates demand for wider use of technologies, with 80% of the social care workforce agreeing that digital technologies can help them do their job better or more efficiently.[55] Improving the digital skills of the workforce to make the most of digital tools will also contribute to workforce policy proposals to professionalise careers in social care and support closer partnership working with colleagues in the NHS.

Social care providers (including independent and VCSE sector providers)

2.56 During the pandemic, the uptake of technology accelerated. For example, NHSmail, a method of secure communication, is now being used by nearly 3 in 5 social care organisations, compared to under 1 in 5 pre-pandemic. Research commissioned by NHSX found that 90% of care providers said they will continue to use technology as they have during the pandemic, suggesting digital care and support is here to stay[56].

2.57 Despite many providers adopting and retaining some degree of digital working, full digitisation of the sector is a long way off, with about 40% of providers having a digital social care record (growing at about 3% per year). In research conducted by NHSX, providers have cited barriers to adopting technology, including budgetary constraints, lack of digital skills and a lack of awareness of the technologies available to them.[57]

[54]There are case studies across the sector which have indicated that acoustic monitoring technology can reduce falls by ~20% or more. For example Friends of the Elderly use of Ally Care technology has reduced falls by 55%, whilst WCS Drovers House's use of CLB's acoustic monitoring module reduced falls by 50% by alerting staff at an early stage, allowing them to intervene before an incident occurs.
[55] Ipsos MORI, Institute of Public Care and Skills for Care, NHSX Adult Social Care Technology Innovation and Digital Skills Review, published December 2021; section 9.6.4
[56] Ipsos MORI, Institute of Public Care and Skills for Care, NHSX Adult Social Care Technology Innovation and Digital Skills Review, published December 2021; section 9.7.6
[57] Providers surveyed as part of the IPSOS Mori Reviews. 57% cited budget as a concern, 45% cited digital skills and 35% cited a lack of awareness about what digital technology was available. Ipsos MORI, Institute of Public Care and Skills for Care, NHSX Adult Social Care Technology Innovation and Digital Skills Review, published December 2021; section 10.4.2

2.58 Digitisation can support greater efficiency and productivity for providers. Providers should also be able to use data to better demonstrate the quality of care they provide to CQC, LAs and potential customers.

Commissioners – local authorities (LAs) and integrated care systems (ICSs)

2.59 As a result of digitisation, commissioners of care should have access to more accurate and timely information about care provision in their locality, giving them increased oversight and understanding of their local area. This could support a shift to a more proactive and preventative approach to population health management.

2.60 LA providers of social care are likely to enjoy the same benefits as in the independent and voluntary community and social enterprise (VCSE) sectors, with LAs who have adopted technology to support the delivery of care reporting improved outcomes and significant savings[58]. Delivering some programmes of work through ICSs means they have the potential to work more effectively with the care provision in their local communities, using technology to prevent avoidable incidents and admissions into acute care.

The wider health and social care system

2.61 Technology is a key enabler for the wider reform agenda, with digital tools and technology potentially supporting independent living and improving the quality of care. The government's proposals could also support the long-term sustainability of both social care and the NHS through improved efficiencies and drive closer integration between health and care by ensuring the health and social care workforce can share information using digital tools. Both the NHS and social care could benefit from using technology to prevent avoidable incidents and admissions into acute care[59].

2.62 Other drivers of emergency care admissions could also be addressed by technology, such as hydration monitoring to prevent urinary tract infections and electronic medications management to reduce medication errors.

Wider government strategy and arm's length bodies

2.63 The government's plans on wired and wireless connectivity complement DCMS-led plans to improve connectivity across the country. By upgrading the fixed line connections of care homes with slow and outdated connections, this work will support care homes to have a minimum

[58] ADASS' 2019 Budget Survey found that 96% of Directors of Adult Social Care saw the use of assistive and communications technology as 'quite or very important for making financial savings'. In addition, there are case studies across the sector which have indicated the benefits of digitisation for local authorities. For example, in the East of England, all 11 councils with responsibility for adult social care have committed to adopting the same platform to collect and share data and intelligence, with capital savings of £550,000 delivered to date and further estimated ongoing annual savings of over £550,000.. The approach has also seen a 10 percent improvement in measurable provider quality.

[59] There are case studies across the sector which have indicated that acoustic monitoring technology can reduce falls by ~20% or more. For example Friends of the Elderly use of Ally Care technology has reduced falls by 55%, whilst WCS Drovers House's use of CLB's acoustic monitoring module reduced falls by 50% by alerting staff at an early stage, allowing them to intervene before an incident occurs. Falls among older people cost the NHS ~£2bn a year. Falls: applying All Our Health, gov.uk (2020)

bandwidth of 100mbps recommended by the OECD for organisations to succeed in digital transformation.[60] The government and NHSX have existing working relationships with DCMS and UK5G and will be working closely with them as they continue to build their wired and wireless connectivity strategies.

2.64 The government's proposals on connectivity also have the potential to positively impact DLUHC's agenda on levelling up. Data shows broadband levels are lower in rural and coastal areas.[61] These areas have an older population than urban areas and therefore are more likely to benefit from proposals to upgrade connectivity in care settings.[62]

2.65 Supporting the care technology sector to develop innovative technology could help to address the grand challenge of an ageing population and help deliver the ambition of the UK Life Sciences Vision to put the UK caretech sector at the forefront of global care technology innovation.

Description of potential costs

2.66 The government has committed to funding of at least £150m to deliver a programme, which will include:

- Scaling proven care technologies and a tech fund to support the scaling of care tech.
- Increasing the adoption of digital social care records.
- Cyber security support.
- The upgrade to fibre broadband for care homes dependent on poor connections.
- Activity to improve digital skills in the sector.

2.67 Any wider costs to other parties, such as **LAs or providers**, are not imposed, meaning they are only likely to act in a way that incurs costs if they perceive a net-benefit (especially private actors, like individuals and providers).

2.68 For **people and families,** it is expected that increased awareness of the technologies available to support care could mean increased uptake of both consumer and LA-funded technology to support care at home. It is recognised that some costs for families may be outside of funded provision and could mean a modest cost to people drawing on care and support should they choose to purchase technology.

[60] OECD Report on the Digital Transformation of SMEs' (2021) notes that 'high speed broadband is a prerequisite for SME digital transformation'. OECD define high-speed broadband as having download speed of at least 100Mbit/s, i.e. fibre.
[61] Ofcom, Connected Nations 2020 research showed that 84% of rural areas have access to superfast broadband, compared to 98% of urban areas. For further information see section below on 'regional variation'.
[62] ONS Data shows that the rural population has a higher proportion of those aged 65 and over, at 24.8 per cent, compared with the urban population where 16.8 percent are 65 and over.

2.69 For **providers**, there are likely to be moderate short-term costs that will depend on the current digital maturity of the provider and their existing infrastructure. This includes installation and unit costs of technology, costs of upgrading infrastructure like Wi-Fi, cost of training for staff and cost of devices. While some providers are likely to draw on funding and support as part of NHSX's digitisation work, it is anticipated that there could be costs to providers outside of this.

2.70 For **LAs,** there is likely to be increased demand on LA-funded technology services and adaptations. For **ICSs**, it is expected that there could be a modest short-term resource cost associated with applying to the funds set out in this package.

Description of potential benefits

2.71 There are significant potential benefits from these interventions, including:

- **For people, families, and paid and unpaid carers: a potential reduction in falls and improved wellbeing** through the use of acoustic monitoring, resulting from fewer night-time disturbances and improved sleep for residents in care homes. The use of digital tools to keep in touch with family and friends could also positively benefit residents' wellbeing, as well as providing peace of mind for families.

- **For social care providers: potential productivity improvements that save time on administrative tasks.** Digital Social Care records have demonstrated a significant time saving of between 15 and 90 minutes per care worker per shift by reducing time spent doing handovers or chasing up information with the NHS. [63] Consequently, the time released, and potential productivity saving is significant in aggregate, and could enable the provider to support more people (potentially reducing the rate of increase for the cost of care in the sector). Evidence shows that adoption of other digital systems in other sectors achieved productivity gains which can improve service efficiency - the Enterprise Research Centre suggests that use of customer relationship management software raises organisational productivity by 18%; cloud-based computing by 14%; and web-based accounting software adds 12%[64].

- **For the social care workforce: potential reduced digital exclusion.** Evidence indicates social care workers are more likely to be digitally excluded[65] compared to other parts of the population. Data from Skills for Care[66] indicate that the workforce is disproportionately female

[63] Quantified time savings vary across case studies, but are shown to be consistently significant: After a time and motion study Handsale Care Homes report a 90 minutes time saving per carer per day after the adoption of a digital social care record;
Birdie report an average time saved of 2.5 hours per carer per week through the use of a digital social care record; Quinton House estimate that they save 1.5 hours per care assistant per shift after the adoption of a digital social care record;
Person Centered Software reports a care provider will have expected savings of three days per month per care worker after the implementation of a digital social care record.
[64] Enterprise Research Centre, 2018: State of Small Businesses.
[65] Digital skills in adult social care: rapid evidence review, Skills for Care, 2021
[66] The adult social care workforce comprised 82% of workers identifying as female, compared to 47% of the economically active population. 27% were aged 55 and over, compared to 21% of the economically active population. The state of the adult social care sector and workforce in England, Skills for Care, October 2021, p. 17.

and aged over 55, compared to the population overall, and both groups are more likely to be digitally excluded by lacking basic digital skills[67]. Investing in digital skills for this group could bring wider benefits to building digital literacy in the wider population, equipping staff with skills that could benefit both their professional and personal lives.

- **For the wider health and care system: potential reductions in demand on NHS services,** in particular a reduction in hospital admissions and consequently a reduction in beds used.

2.72 By ensuring that fundamental digital capability and infrastructure is in place, the sector could be better placed to realise the benefits of developments in digital technologies in the future.

Impact on small and micro businesses

2.73 Smaller care homes are less likely to have good internet connectivity and are more likely to have no internet at all, when compared to bigger capacity providers. 53% of smaller providers report good connectivity, and 7% report having no internet.This is compared to 65% good connectivity, and 1% with no internet in larger providers[68]. The proposed connectivity programme is designed to support care providers with the worst connectivity and should have a net positive impact on smaller providers.

Risks and assumptions

2.74 To enable these technology improvements, care staff and provider organisations must first have the right skills and connectivity to use these tools, as well as the underpinning cyber security to ensure information is handled safely. Given the challenging starting position, the government has developed a package of interventions that address both the 'enabling' elements (i.e., connectivity, skills, cyber) while simultaneously driving adoption of care technology and digital social care records across the sector.

2.75 The key risks of these digital and technology proposals are:

- Research has shown digital transformation is welcomed in the sector but there remains a risk that some care providers may be resistant to digital transformation, either because they lack access to finance due to small profit margins, are struggling with capacity or have a lack of knowledge about the benefits of technology. To mitigate this risk, the programme could focus on developing the evidence of where care tech has the biggest impact on specific health challenges and scaling solutions where the evidence base already exists.

- A related risk is of an increase in upfront capital costs or ongoing service charges, which could affect the affordability and attractiveness of investing in digital technologies. As part of programme delivery, mitigations can be in place to ensure plans both meet the needs of providers and to demonstrate the benefits to their business and service users.

[67] UK Consumer Digital Index 2018, Lloyds
[68] NHSX iPads Baseline Survey, 2020

2.76 The main assumptions are:

- Whilst research has shown digital transformation is welcomed in the sector, there is an inherent assumption that most social care providers want to digitise, and all their staff will be open to learning digital skills.
- The government is assuming that working through ICSs will have the desired impact on people drawing on care and support and they should benefit from improved outcomes. There is also an assumption that ICS leaders will understand the wider system benefits of technology and be willing to invest time, resource, and funding into driving digitisation of social care services to achieve these benefits.
- The government is assuming that the upfront capital costs should remain low/manageable for providers, and that any ongoing service charges will ultimately offer value for money based on the benefits described.

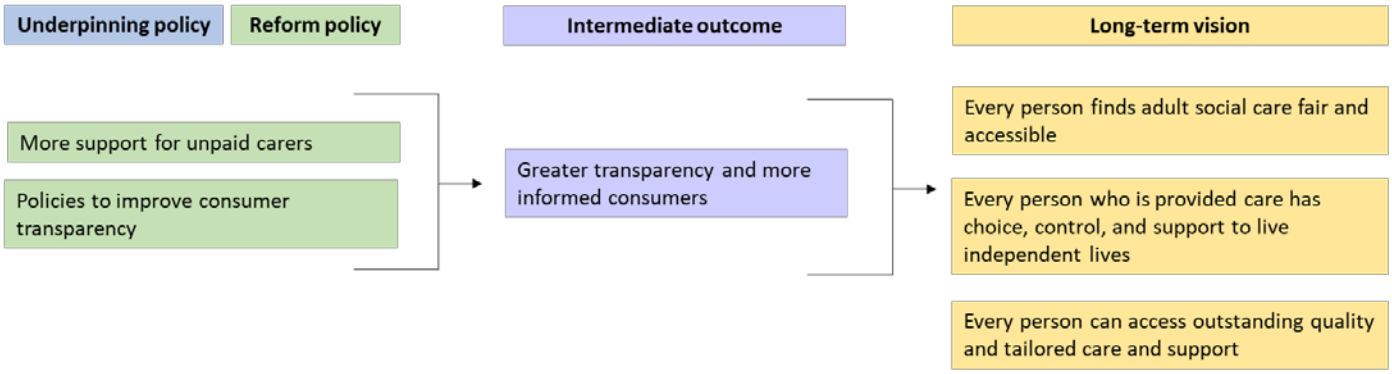
3. Empowering those who draw on care, unpaid carers, and families

Opportunities for Improvement[69]

- People find it hard to navigate the social care system and understand what they are entitled to, which can put pressure on unpaid carers.
- Unpaid carers can find it difficult to balance paid employment and/or socialising with care.
- People with certain disabilities face barriers in the labour market, which means they have lower employment rates.

3.1 The white paper groups together policies focused on support for unpaid carers, and people who draw on care and support. The logic map for how these measures are intended to work together is outlined in Figure 4 below.

Figure 4: How policies link to long-term vision



3.1 Unpaid carers

Summary of reform proposal

Unpaid carers and the challenges they face

3.2 Unpaid carers play a vital role in communities. For most people, care begins at home. Many people wish to play a role in caring for their friends and family, and the government recognises that for some this can be a significant commitment.

3.3 The 2011 Census recorded an estimated 5.4 million people of all ages providing unpaid care. Using more recent data, DHSC estimates that in 2021 there were 7.7m unpaid carers aged 16+ in

[69] DHSC, 2021. Evidence review for adult social care reform

England[70, 71, 72]. Of these, 19% provide care for 20 or more hours per week, equal to nearly 1.5 million people. For context, in 2020/21 there were an estimated 1.67 million jobs in the adult social care sector, with 1.56 million of these within LAs, independent sector employers and jobs working for direct payment recipients[73].

3.4 In the 65+ age group alone, 2.1m people are in receipt of informal care[74], while 0.9m people are in receipt of formal support[75]. DHSC does not have data on the number of people under the age of 65 who receive unpaid care.

3.5 Currently the adult social care system benefits from an estimated £57- £132 billion of unpaid care annually[76, 77]. This is the estimated economic value of the provision of unpaid care across the UK; for England the annual value is estimated to be £108 billion[7879]. Whilst not directly comparable, for context, this contribution is greater than expenditure on state-funded formal care. Rising demand for care, alongside any potential increases in adult social care system costs, is likely to result in overall rising demand for informal and unpaid care. It is therefore important to support carers.

3.6 Caring can be rewarding, but it can also have negative impacts on the carer, such as making it difficult to balance paid employment with care or preventing people from socialising or undertaking other activities as much as they would like. Unpaid carers can experience negative impacts on their mental and physical health, on their quality of life, and on their outcomes.[80] Unpaid carers are significantly more likely to have poorer mental and physical health, have lower earnings, and to leave employment than non-carers.[81] Poorer health and wellbeing outcomes are increasingly associated with caring as the intensity of the caring role increases. Since 2013, more carers are caring more intensely, with a 13% and 30% rise in the proportion caring for 20+ and 50+ hours a week respectively.[82]

3.7 There is a wide variety of caring circumstances, experiences and needs. The government recognises that people who provide care are diverse and varied; meaning different services and interventions are likely to be effective for supporting different groups. Table 2 below sets out some examples.

[70] CPEC, 2020. Projections of Adult Social Care Demand and Expenditure 2018 to 2038.
[71] ONS, 2018. 2018-based National Population Projections
[72] NHS Digital, 2019. Health Survey for England.
[73] Skills for Care. The State of the Adult Social Care Sector and Workforce 2021
[74] CPEC, 2020. Projections of Adult Social Care Demand and Expenditure 2018 to 2038.
[75] NHS Digital 2021. Activity and Finance Report 2020/21.
[76] ONS, Household Satellite Accounts, chapter 3, published 2016
[77] Carers UK, 2015. Valuing Carers 2015 – The rising value of carers' support
[78] Carers UK, 2015. Valuing Carers 2015 – The rising value of carers' support
[79] These estimates do not capture the benefits created in the health and social care system as a result of the care provided, for example in any potential delayed entries to formal care, or in the possible avoidance of hospital admissions. Data limitations mean that it is difficult to quantify these impacts.
[80] Brimblecombe et al., 2018. Review of the international evidence on support for unpaid carers. Journal of Long-Term Care, pp.25–40
[81] NHS Digital. The Health Survey for England.
[82] NHS Digital. The Health Survey for England.

Table 2 - Examples of different sub-groups of the unpaid carer population

Sub-group	Characteristics
Carers of people living with dementia	It is estimated that there are 260,000 older people with dementia in receipt of unpaid care[83], with 40% of the people providing this care experiencing symptoms of depression or anxiety[84]. These carers face increased social isolation as a result of the care that they provide[85]. In addition, the experience of someone caring for a person with dementia can intensify over time.
Older people providing unpaid (i.e., aged 85+)	Older adults who provide unpaid care are also more likely to be living with multiple long-term conditions and may have complex health needs of their own. This group may have a greater need to protect their own physical health, for reasons including to enable them to continue to provide care. In addition, caring may lead to worse health and delays in meeting their own needs[86].
Young people providing care (i.e., aged 16-25)	Younger carers are likely to experience high 'carer burden' (defined as emotional, physical, and social hardships associated with caregiving). In addition, evidence suggests that younger carers are more likely to be in full time employment, which can lead to greater associated burden[87].

3.8 The Care Act 2014 requires LAs to promote a diverse and high-quality market of care and support services for people in their local area. LAs are required to undertake a Carer's Assessment for any carer who appears to have a need for support. LA level data shows that the number of carers assessed, reviewed and/or supported has declined since 2014/15, falling from approximately 437,000 in 2014/15 to just under 390,000 in 2020/21.[88]

3.9 Information and advice is the most common type of support provided to unpaid carers; its use has increased since 2014/15 and in 2020/21 59% of all carers assessed, reviewed and/or supported were being supported in this way.

3.10 Since 2014/15, LAs have reduced real gross expenditure on support to unpaid carers by 35% whilst increasing overall real gross expenditure on adult social care by 7%.[89] The Care Policy Evaluation Centre (CPEC) found a large variation across LAs in terms of the support available to unpaid carers, and a statistically significant reduction in carer satisfaction with this support.[90] These points suggest that the system needs reform and stimulation.

The proposal

3.11 The proposal is for a new fund through which the government will work with the sector to stimulate a change in the services provided to support unpaid carers [measure 9]. The government expects

[83] Wittenburg et al., 2019. The costs of dementia in England
[84] Livingston, G. et al., 2013. Clinical effectiveness of a manual based coping strategy programme (START, STrAtegies for RelaTives) in promoting the mental health of carers of family members with dementia: pragmatic randomised controlled trial
[85] Charlesworth et al., 2008. Befriending carers of people with dementia: randomised controlled trial
[86] PHE, 2020. Caring as a social determinant of health: review of evidence
[87] PHE, 2020. Caring as a social determinant of health: review of evidence
[88] NHS Digital, 2021. Adult Social Care Activity and Finance Report 2020-21
[89] NHS Digital, Adult Social Care Activity and Finance Report. https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report
[90] CPEC, 2020. The Carers in Adult Social Care (CASC) study. https://www.lse.ac.uk/cpec/assets/documents/cascfinalreport.pdf

that this funding will identify and test a range of new and existing interventions that support unpaid carers, which could include respite and breaks, peer group and wellbeing support, and new ways to combine these to maximise their impact. The projects initiated through this funding are intended to build commissioner and service provider understanding of what support works best for those with different caring circumstances, acknowledging the wide variety in caring experience and need amongst carers.

3.12 As this fund is about identifying and testing interventions, the proposal includes extensive impact and process evaluation to generate evidence on efficient and effective ways to support unpaid carers. By continuing to build and share the evidence, the aim is to drive the development of a strong investment case for commissioners and therefore stimulate the growth, development and roll out of services across the country.

Summary of affected groups

- **Central government:** it is possible that the interventions tested through the fund might lead to a better targeting of resources to meet demand and prevention for state-funded services such as the NHS.

- **Public Sector, local government, and other commissioning bodies:** the objective of the fund is to generate evidence on how to support unpaid carers. This evidence could inform the decision-making of commissioners and increase the choice and effectiveness of support for unpaid carers. Over the long-run, increased uptake of interventions which are found to be cost-effective may lead to savings and efficiency gains – for example, in delayed demand for formal state-funded adult social care.

- **Private business (including charity/voluntary):** It is possible that there could be increased demand for some types of support offered by charity/voluntary sector, particularly for any intervention which has been tested through the fund. It is also true that this fund might raise the profile of unpaid carers which might create some additional demand for support.

- **Individuals providing and receiving unpaid care:** people who are supported through these interventions may experience positive outcomes including improvements to physical and mental health. In addition, it might be that people who receive unpaid care also experience benefits if the health and wellbeing of unpaid carers improves.

Description of potential costs

3.13 Government will invest up to £25 million working with the sector to kick start a change in the support provided to unpaid carers. The annual profile of this expenditure has not yet been confirmed and it is not yet possible to break down specific costs of the fund as much of the development and design is ongoing. However, expected costs may include:

- Identification and development of interventions to test through the fund. Development stages might include ensuring that interventions are culturally appropriate for use with target

population groups. In addition, the process by which interventions are delivered and any guidance and training products will all likely need to be developed.

- Funding of interventions and associated delivery costs including the actual cost of delivering any support to unpaid carers who participate in the programme, and costs associated with identification and referral onto any support.
- Programme management costs relating to the day-to-day management of the programme.
- Evaluation and data collection costs which will cover a multi-disciplinary evaluation including quantitative and qualitative analytical strands.
- Dissemination of evidence and engagement with the sector is intended to form a substantial part of the programme.

3.14 Depending on the design of the final scheme, implementing and expanding these interventions may lead to additional costs to LAs and commissioners from potential co-funding, any additional time spent identifying unpaid carers, referring/signposting, reporting and administration burden. These costs are not imposed and would be incurred voluntarily by those participating in the scheme. They would though represent an opportunity cost, in terms of the value of the next best alternative use of the funds / resources.

3.15 In the long run, it is anticipated that LAs and other commissioning bodies would choose to adopt and fund interventions identified and tested through this programme as part of their routine budgeting and policy approach to meeting their duties. The unit costs (in terms of cost per intervention) borne by LAs and other commissioning bodies who decide to adopt any intervention tested through the fund are intended to be smaller than those realised by the government in the short term, as the associated research and development activity needed for the identification, development and testing of interventions should have already taken place.

3.16 Additional costs might occur to LAs and other commissioning bodies due to the need to continue to fund and provide existing provision alongside newly adopted interventions stemming from this fund over the short-term. This might arise as LAs may require a period of ‘double-running’ new interventions while also ensuring continuity and availability of support for unpaid carers.

3.17 There will likely be opportunity costs arising from LAs and commissioners using their resource to adopt and fund interventions identified and tested in the programme. These costs have not been formally assessed.

Description of potential benefits

3.18 There is a significant evidence gap surrounding the impact of support for unpaid carers. As such, there is very little evidence on the cost-effectiveness of different interventions on which estimates of the benefits of this fund could be based. One of the primary objectives of this proposal is to generate evidence to develop understanding of the cost-effectiveness and impacts of different types of interventions.

3.19 There are several potential benefits and/or savings that the funding could generate:

- **Individual to the unpaid carer:** improved physical and mental health; improved quality of life and wellbeing; better labour market and economic outcomes; longer lasting, more sustainable caring relationships; and improved choice over care decisions.
- **Societal:** reduced demand for the NHS; reduced demand for adult social care; and increased tax-revenue (as a result of better labour market and economic outcomes).
- **Systemic:** new evidence on supporting unpaid carers (filling a crucial evidence gap); identification of value for money, scalable interventions for specific groups of unpaid carers; greater choice in supporting unpaid carers; and long-run savings and efficiency gains for LAs' support for unpaid carers.

3.20 The table below presents examples of possible interventions which the government might consider testing and evaluating and describes the evidence to illustrate the types of outcomes / benefits that could be expected. As outlined above, a primary intention of this programme is to generate evidence and develop a better understanding of what works.

3.21 The NHS commissioned the New Economics Foundation (NEF) to develop a framework to better understand the value and costs of adults providing unpaid care. This project reviewed available evidence for different types of intervention to support unpaid carers, some of which is detailed below[91].

Table 3: examples of interventions to support unpaid carers

Type of intervention	Evidence
Unpaid carer peer support groups	The NEF describe the likely benefits to include a significant improvement in carers' level of depression[92] and improved social connectedness. Subsequently the improvement in mental health and wellbeing that are demonstrated here may lead to a potential reduction in NHS mental health service demand, as well as potentially longer lasting care relationships through improved carer sustainability.
Respite Care	This is care provided to the cared-for person that gives the carer a break, which varies in terms of length and frequency. It has been found to reduce carer social isolation, improve the likelihood of employment[93] and reduce caregiver burden[94]. However, there is lack of high-quality evidence on different types of respite services.

[91] NEF Consulting, 2019. NHS England: The Socioeconomics of unpaid care
[92] Chu et al., 2010 The Effects of a Support Group on Dementia Caregivers' Burden and Depression
[93] Pickard et al., 2015. The Effectiveness of Paid Services in Supporting Unpaid Carers' Employment in England
[94] Mossello et al., 2008. Day Care for older dementia patients: favourable effects on behavioural and psychological symptoms and caregiver stress

Type of intervention	Evidence
START Programme[95]	The START (STrAtegies for RelaTives) programme is a tailored approach developed to provide information on managing difficult behaviours, coping techniques for stress, how to access support and learning about dementia. Carers receive an 8-week programme of individual psychological therapy sessions. The programme led to an improvement in carer mental health compared to carers who did not participate in the programme in the short and long term. The programme was also cost-effective in the short and long-run due to the reduced use of other services.

3.22 Research suggests that a combination of interventions, such as multi-dimensional support, may be more effective in supporting the diverse needs of carers.[96] Possible combinations might include skills training, assistive technology, wellbeing training and support, coupled with respite care. These combinations might also be used in conjunction with interventions with other adult social care services either for the unpaid carer themselves or the person they care for, such as the Disabled Facilities Grant or Information and Advice.

3.23 In the long run, it is anticipated that LAs and other commissioning bodies could transform the way that they support unpaid carers and deliver these interventions alongside or in place of existing support. The intention is that this more efficient approach to support could create savings at a local and national level, mitigate costs elsewhere in the system, and lead to improved outcomes for unpaid carers and the people they support. Long-run benefits will depend on factors such as level of adoption of new approaches to supporting carers.

3.24 A secondary benefit might be more unpaid carers with the ability to stay in employment and for longer, bringing financial security and financial equality to carers and improved outcomes to employers, the exchequer and wider economy. It is difficult to quantify these long-run benefits, and there is considerable uncertainty to the extent to which they might be realised.

Small and micro businesses

3.25 No significant negative impacts on small or micro businesses are anticipated. It may be that this fund has a small effect on competition in the market of commissioned support for unpaid carers if tested interventions are delivered by firms which newly enter the market, or it might be that existing firms could provide the interventions, or a combination of both. This fund might provide a platform for small or micro businesses including academic and/or social enterprise ventures to grow or emerge.

Risks and assumptions

- **Difficulty in identifying effective interventions**: as outlined above, current evidence is inconclusive on which intervention or set of interventions is best for which group of carers,

[95] Knapp et al., 2013. Cost effectiveness of a manual based coping strategy programme in promoting the mental health of family carers of people with dementia (the START (STrAtegies for RelaTives) study): a pragmatic randomised controlled trial.
[96] PSSRU, 2019. Support for Unpaid Carers: Economic Evidence.

hence the need for this work to test real world solutions for LAs. This poses a challenge in identifying the most effective interventions to develop and test.

- **Difficulty in identifying LAs to trial interventions, and/or lack of take or engagement from LAs following trials**: LAs currently have multiple priorities, including post-pandemic recovery, which could affect LAs ability to take part in the scheme. Similarly, following trials and evaluation, there is a possibility of lack of uptake and engagement in LAs.

- **Risk that any sector transformation is not sustainable** and occurs only in the short-term. This is mitigated by seeking early understanding of barriers to uptake by LAs.

- **Challenges in demonstrating improvements in unpaid carers health and wellbeing as a result of interventions**: a number of factors can impact the health and wellbeing of an unpaid carer and there may be other changes in systems at the same time as interventions are tested (such as wider Social Care Reform changes).

- **Trials do not find successful or effective interventions, or evidence is inconclusive:** As new initiatives are being tested there is always a risk these will not turn out to be effective – though evidence on what does *not* work is also valuable. Additionally, the evaluation may not be able to generate conclusive findings. To mitigate this risk, evaluation processes will be designed utilising best practice and through closely working with stakeholders.

Wider government support for unpaid carers

3.26 The white paper references support for unpaid care being launched across government:

- DWP will launch Local Supported Employment to identify effective ways LAs can support autistic people and people with learning difficulties into employment [measure 11]. The impact of the Local Supported Employment scheme is not considered in this impact statement.

- BEIS will introduce a Carer's Leave entitlement of 5 days of unpaid leave per year for eligible employees [measure 12]. A published consultation IA is available at Carer's leave consultation: Impact Assessment (publishing.service.gov.uk).

3.2. Information and advice

Summary of reform proposal (including rationale)

Current challenges

3.27 Navigating the adult social care system when care and support is required can be challenging. Among those surveyed who receive LA-funded support, a third (33%)[97] who have tried to find

[97] NHS Digital, 2020. Personal Social Services Adult Social Care Survey in England, 2019-20.

information and advice about support found it difficult, and 38%[98] of carers surveyed who tried to find information and advice found it difficult. This figure is expected to be higher among those who do not qualify for LA care and support and so have to navigate the adult social care system with less professional support. There is also a link between finding it easy to access information and overall satisfaction with care received. Among those who were satisfied with their care, 72% found it easy to find information and advice about care and support. Among those who were dissatisfied, only 21% found it easy to find information and advice.[99]

3.28 Currently, people draw from a wide pool of information and advice sources when they need care and support. This could include information from family and friends, community groups, the voluntary sector, health and social care professionals as well as online resources. These sources do not always provide consistent information. LAs have duties under the Care Act 2014 to ensure that information and advice services are available to their local populations, but stakeholders have advised that some people do not know, or want, to go directly to their LA in the first instance.

3.29 In addition to information, many people need advice specific to their personal circumstances, to understand the complex adult social care system, including what they are entitled to and what they could access. There are advice services that exist both nationally and locally, though access to these depends on where a person lives and their specific needs. Currently, there is a lack of evidence of the effectiveness of different advice initiatives and, despite there being some provision, there is evidence that people still struggle to navigate and understand the adult social care system.

The proposal and options considered

Piloting innovating approaches to providing personalised advice

3.30 The government is providing funding of at least £5 million to pilot and evaluate new ways to help people navigate their local adult social care systems [measure 7]. The plan is that pilots will be focused on the provision of personalised advice. The government will start with an analysis exercise to understand the current provision of personalised advice, including how effective it is and whether there are gaps in existing provision. Funding is likely to then be offered to pilot new approaches to personalised advice, which need to be robustly evaluated to understand (among other things) what approaches are effective, why they are so, and the value for money they offer.

3.31 When considering policy options to improve information and advice, the government spoke to several sector stakeholders who agreed that personalised advice is a current gap which should be an important initial priority for DHSC to address.

3.32 The government is adopting a ‘trial and evaluate’ approach for two main reasons. Firstly, LAs have discretion over how they deliver information and advice services, and as such, there is variation in the nature of service provision between local areas. Differences between local areas such as

[98] NHS Digital, 2019. Personal Social Services Survey of Adult Carers in England, 2018-19.
[99] NHS Digital, 2020. Personal Social Services Adult Social Care Survey in England, 2019-20.

population needs and geography (for example, urban/rural) means there isn't a 'one size fits all' solution to this policy problem.

3.33 Secondly, there is a lack of evidence of what is effective in information and advice provision in social care. By robustly evaluating these pilots, the government can start to build an evidence base which could be used to inform national policies and support organisations delivering advice services. While only a selection of local areas are likely to be involved in the pilots, many more are likely to benefit from the learning and evidence that they provide when designing and delivering personalised advice services in their areas.

Fee transparency

3.34 The white paper commits government to considering if CQC registered providers should be required to publish their fee rates. This would benefit those people who fund their own care by ensuring easy access to comparable information on fee rates, enabling them to make informed decisions about the care providers they wish to access.

3.35 People who fund their own care take various factors into consideration when deciding which care provider to choose. This may include the location, facilities, CQC rating and cost. Currently providers are not required to make their fee rates public. Some providers choose to do this, though when this does occur, they tend to be structured in different ways. This results in a lack of transparency in care provider fees and hinders people's ability to make comparisons between providers on cost.[100]

3.36 The need for easily accessible information on fees is heightened by the reality that many people make decisions about their care at a time of crisis and make decisions quickly. By making it a requirement for CQC registered care providers to publish their fees, and do so in a consistent format, those who fund their own care should be better able to make comparisons between providers based on costs, enabling swifter, more straightforward decision making.

Summary of affected groups

Personalised advice

3.37 The nature and scope of the pilots will be determined by the initial analysis exercise, meaning it is not yet possible to pinpoint exactly who will be impacted. The pilots will be designed to provide advice to help people to navigate adult social care, and as such the beneficiaries should be those who need advice about care and support, their unpaid carers, friends, and family. The pilots are likely to be limited to a small number of locations as evidence is gathered on what is effective, so just those living in the pilot areas will be impacted directly by this policy. Learning from the pilots should have a wider reaching impact on those who need care and support, if this can be used to inform national policy making and provides evidence of 'what works' to information and advice providers.

[100] Competition and Markets Authority, 2017. Care Homes Market Study, Final Report. https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf

3.38 LAs already receive funding from central government to deliver their Care Act responsibilities, including information and advice services, and this funding will remain. The government expects LAs to maintain existing funding arrangements for local information and advice services while the pilots are ongoing.

3.39 Access to high quality advice services may impact on how and when people access care and support. Effective advice should link people into the right level of care and support, including when they have relatively low levels of need. It therefore has the potential to encourage people to access care and support before their needs escalate and prevent avoidable deterioration in people's condition, improving their overall health and wellbeing and preventing or delaying the costs associated with meeting higher level needs.

3.40 Improving information and advice services could potentially increase demand on local adult social care services – both provided by the LA and voluntary sector.

Fee transparency

3.41 CQC-registered providers of care homes and home care are likely to be impacted by any new requirement to publish their fee rates as, for some, this is a change to their current working practices. As of November 2021, there are approximately 6,400 providers running 15,200 care homes and 7,500 providers running 10,900 domiciliary care agencies in England.[101] We do not know at this stage how many of these providers already publish their fee rates and therefore how many might need to take action under this proposal.

Description of potential costs

3.42 The government has committed to spend at least £5 million on improving personalised advice services. This is intended to cover the costs of an initial analysis exercise as well as funding for pilots to trial new ways to provide personalised advice. The budget for the pilots includes funding for the development, set up and early running costs of the pilots. The budget also includes the costs associated with robust evaluation of each pilot. Funding will be in place for the duration of the pilots to pay for the costs associated with setting up and trialling something new; not to cover the ongoing running costs beyond the pilot.

Personalised advice

3.43 Should organisations have to bid for funding, this is likely to require a moderate amount of staff time to prepare and submit a bid. The funding will be provided to enable organisations to trial new approaches, and reduce the financial risk associated with this. The organisations may therefore be expected to contribute to the ongoing running costs, which should primarily be staff time. Other costs will depend on the nature of the pilot but could, for example, include marketing costs associated with promoting a new service.

[101] DHSC, 2021. Analysis of Data, Care Directory with Filters (November 2021)

Fee transparency

3.44 There is likely to be a very small cost for providers associated with familiarisation and publishing their fee rates, primarily in terms of staff time. The cost to providers will depend on factors such as whether they currently publish their fees, and the way in which the fee rates will need to be published to ensure they are comparable.

3.45 A small amount of resource is also likely to be required to ensure providers are notified of the requirement and to monitor and enforce compliance on an ongoing basis – arrangements for this are still to be determined.

3.46 Having comparable information on fee rates easily accessible in the public domain could have an impact on the pricing of services, as providers will be able to see the rates other local providers are charging.

Description of potential benefits

3.47 The nature of running pilots to test new approaches and gather an evidence base of 'what works' means it is not possible to robustly quantify the benefits of this policy at this stage. The evaluation of each pilot should aim to demonstrate its benefits, including value-for-money, and this can then be used to inform national policies on how best to deliver personalised advice services.

Personalised advice:

3.48 There is a lack of evidence about what is effective in the provision of personalised advice and the outcomes this has on those it is designed to help. This means that those who plan, design, and deliver services must do so without access to a sound evidence base of what is effective. Trialling and testing new approaches provides an opportunity to develop new and creative solutions to personalised advice as well as creating an evidence base of 'what works'. That evidence base should then inform national policy and be used by organisations to design and deliver cost-effective advice services.

3.49 Evidence of the benefits of a trial and evaluation approach can be found from previous policy initiatives. The evaluation of *The Libraries: Opportunities for Everyone (LOFE)* innovation fund found that small grants can make a big difference to services by reducing the fear of failure associated with trialling something new. They can also lead to significant improvements in outcomes for those who use services. A DWP innovation fund to reduce the risk to young people of not being in employment, education or training (NEET), found that young people who participated in the pilots had improved social and familial relationships and expanded their employment and career horizons. There were also positive impacts on young people's schooling which included better attitudes towards leadership, attendance and behaviour.

3.50 The intended benefit is that those involved in the piloted interventions who draw on care and support will be more informed about adult social care and local care and support services which meet their specific needs and wishes, and consequently will be better able to make informed

decisions about their care and support. In turn, this could assist people in accessing the right care and support at the right time, improving their overall health and wellbeing.

3.51 The impacts of pilots are likely to be relatively small scale given they will be run within local areas. However, the findings from the pilots could be used to inform national policies and support organisations delivering advice services by advising on value for money interventions. Although challenging to directly attribute, there could be wider societal benefits of high-quality personalised advice which leads to people getting the care and support they need, such as: enabling people to stay independent for longer; fewer A&E or other health related attendances due to adult social care needs; and ensuring needs are met appropriately at the right time, reducing preventable deterioration and higher costs associated with meeting more acute needs.

Fee transparency:

3.52 The benefits of requiring CQC registered providers to publish their fee rates are primarily to those who fund their own care. Affordability is an important consideration when deciding between providers and having easy access to this information should enable swift comparisons on cost to be made. Greater fee transparency, by enabling self-funders to make more informed choices based on fees, may in turn encourage price competition between providers.

Small and micro businesses

3.53 Small providers may face higher costs relative to their size from publishing fee rates. However, this cost, per business and in total, is expected to be small and so is not expected to have a prohibitive impact on small and micro businesses.

Risks and assumptions

3.54 The approach assumes that personalised advice piloted interventions could lead to positive outcomes for users of adult social care. The risk of interventions not being successful is inherent to the ‘trial and evaluate’ nature of the scheme but can be mitigated as far as possible through rigorous assessment of potential pilots and awarding of funding.

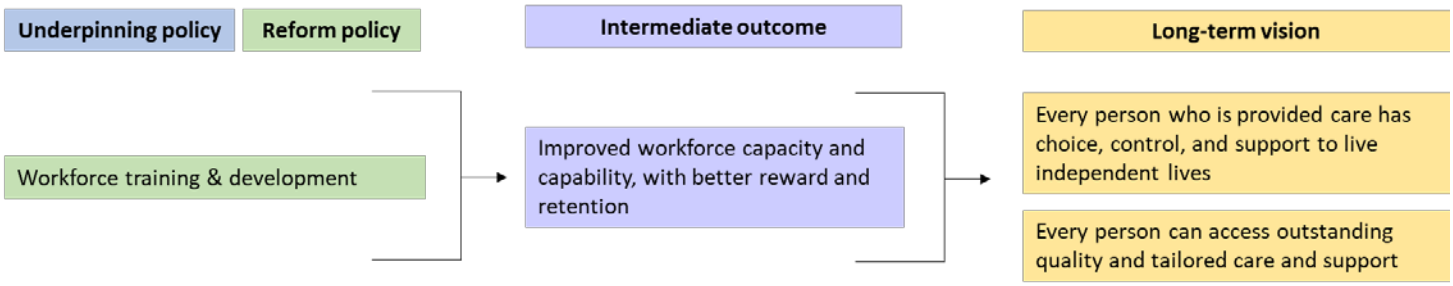
4. Our strategy for the social care workforce

Opportunities for Improvement[102]

1. The social care workforce suffers from high levels of staff turnover and high vacancy rates.
2. The prevalence of poor mental health and burnout is high in the adult social care sector, especially following the pandemic.
3. A significant part of the adult social care workforce is not registered and there is a lack of differentiation between roles and responsibilities within a flat career structure. Currently there are limited opportunities for progression.

4.1 The white paper groups together policies focused on support for the social care workforce. The logic map for how these measures are intended to work together is outlined in Figure 5 below:

Figure 5: How policies link to long-term vision



Summary of reform proposal, including rationale

4.2 There are many barriers to joining and staying in the adult social care workforce, evidenced by high vacancy rates (7.3%), high rates of staff turnover (34% for care workers and 21% for registered managers) and low levels of relevant qualifications.[103] These are likely to have detrimental impacts on the quality of care provided. Challenges in the sector include the low uptake and absence of opportunities to train and progress, duplication of core training and high recruitment costs resulting from the turnover rate, as well as burnout and lack of support. These challenges are long-term but have been exacerbated by the COVID-19 pandemic.

4.3 The government's workforce proposals are intended to address the above challenges. Broadly, these policies aim to intervene now to increase the stock and resilience of skilled workers which should have the knock-on impact of improved retention and increased productivity. This should

[102] Evidence review for adult social care reform (publishing.service.gov.uk)
[103] Skills for Care, 2021. Workforce estimates (skillsforcare.org.uk)

then positively impact on either the quality of care provided or access to care, if not both. This, alongside wider reforms, could generate self-sustaining longer-term improvements, if providers and LAs perceive benefits and make greater local investment. Targeted investment in professionalisation of the adult social care workforce can also help to deliver wider government "levelling up priorities" – as well as "build back better" resulting from more high skilled job opportunities located across the country.

4.4 The government has committed to spend at least £500m to transform the way it supports and develops the workforce. The exact details are subject to further policy development and consultation with the sector, but are likely to include:

- A Knowledge and Skills Framework, careers pathways and linked investment in learning and development to support progression for the social care workforce [measure 13].
- Funding for Care Certificates, alongside significant work to create a delivery standard recognised across the sector [measure 14]. This should improve portability, so that care workers should not need to repeat the Care Certificate when moving roles.
- The expansion of the roll-out of the Social Care Workforce Race Equality Standard (SCWRES). This is intended to support LAs to use data to create plans for ensuring staff from Black Asian and Minority Ethnic backgrounds are treated equally, feel included and valued and their health and wellbeing supported.
- CPD budgets for registered nurses, nursing associates, occupational therapists, and other allied health professionals [measure 15].
- Investment in social worker training routes. This will provide funding to boost the number of qualified social workers to help meet future, long-term demand [measure 16].
- A wellbeing and occupational health (OH) offer intended to provide funding, in order to support COVID recovery, mitigate risk of burnout and provide best-practice guidance for the sector to adopt local policies in the future [measure 17]. The funding will include investment in counselling, mental health first aid training, a coaching offer, a support helpline, pilots for occupational health, and pilots for Freedom to Speak Up Guardians.

4.5 The adult social care workforce policies are designed with the aim of meeting key government outcomes, including improving care quality and system reform where workforce is an enabler, as well as safe and stable care provision during winter or other acute capacity pressures. This in turn is linked to promoting provider sustainability and reducing demand on NHS services.

4.6 Since many of these policies are new, the government has placed a strong emphasis on ensuring robust and thorough monitoring and evaluation to help assess the impact of the policies and determine which should be taken forward.

Existing trends:

4.7 In the absence of the additional reforms outlined above, it is assumed that the sector will continue to face the current sector trends.

4.8 In 2020/21 there were an estimated 1.67 million jobs in the adult social care sector, with 1.56 million of these within LAs, independent sector employers and jobs working for direct payment recipients.[104] Though the number of adult social care jobs in England increased by 3% (by 45,000 jobs) between 2019/20 and 2020/21, ASC-WDS data collected between March 2021 and August 2021 shows that the numbers of jobs (filled posts) in adult social care has started to decrease.

4.9 Additionally, based on the Care Policy and Evaluations Centre's (CPEC) projections[105], the total number of publicly funded users (over 65s and adults under 65) is projected to rise from 631,000 in 2018 to 904,000 in 2038 (an increase of 43%)[106], to keep pace with demographic pressures. To meet this demand increase, the workforce will have to grow proportionally in line with this projection. With the current growth rate of jobs, including a reduction in the workforce size over the course of 2021/22[107], this will create a workforce supply gap.

4.10 The sector also faces high rates of turnover; the overall annual staff turnover rate in 2020/21 was 30%, increasing from 22% in 2012/13, with 37% of those leaving the sector.[108] There are also high levels of staff movement between providers, as 63% of recruitment comes from within the adult social care sector.

4.11 In the current workforce, Skills for Care[109] estimates that whilst around 44% of the workforce providing direct care have a relevant social care qualification, the remaining 56% have no relevant qualification recorded. In direct care roles specifically, 43% of staff held a qualification at Level 2 or above in 2021/21. This means that a large proportion of the workforce do not currently hold a relevant qualification and uptake of training to equip them with necessary skills and knowledge for their roles is inconsistent

4.12 The decrease in workforce size over 2021/22, coupled with the forecast growth in care and support needs, presents a potential risk that, in the absence of the proposed reforms, the situation could worsen. If that were to happen, workforce supply pressures could lead to a greater number of people needing to provide unpaid care for friends and relatives as an alternative. This could then reduce their own labour market participation, with consequent impacts on the wider economy. These pressures could potentially be mitigated by the newly reformed system.

[104] Skills for Care. The State of the Adult Social Care Sector and Workforce 2021
[2] CPEC, 2020. Projections of Adult Social Care Demand and Expenditure 2018 to 2038 (lse.ac.uk)
[3] Calculated as the sum of the number of older and younger adults receiving publicly funded care, in 2018 and 2038.
[107] NHS England, 2021. Statistics » COVID-19 Vaccinations (england.nhs.uk)
[108] Skills for Care, 2021. Workforce estimates (skillsforcare.org.uk)
[109] Skills for Care, 2021. The state of the adult social care sector and workforce in England

Process for development and prioritisation of policy options:

4.13 The proposed workforce reform policies have been developed through an iterative process over the course of 2020/21 and have been focused on identifying and tackling key challenges facing the workforce such as gaps in skills development and poor mental health. To identify challenges and effective policy outcomes, each policy went through several different iterations which were closely informed by engagement with the sector, in forums such as the National Wellbeing Forum, the ADASS Workforce Development Forum, the Skills for Care Workforce Development Forum, the Workforce Advisory Group, as well as through consulting other sector experts. For example, policy teams worked closely with Skills for Care in their capacity as the strategic body for workforce development in adult social care in England to understand the current challenges and evidence to support assumptions on learning and development policies. Impacts of the policies were modelled using insights from the Workforce Development Fund and ASC-WDS, which is provided by the sector via Skills for Care.

4.14 This work was carried out in parallel with commissioned research and analysis which mapped out the current literature and evidence on challenges facing the workforce, identified how interventions could achieve key outcomes, and provided insight on the potential benefits of policies to the workforce and the sector. The combination of these areas of work resulted in a suite of proposals specifically tailored to tackling key challenges faced by the workforce. Further development of policies will be taken forward in consultation with the sector.

Summary of affected groups

Impact on individuals who draw on care services

4.15 The adult social care workforce is critical to high quality of care. Analysis from Skills for Care found that establishments with lower turnover rates, lower vacancy rates and higher levels of staff undertaking learning and development were more likely to receive higher CQC ratings of care provided[110]. As such, a well-trained, recognised, and supported workforce, with a clear set of career pathways is more likely to stay in the sector and to deliver better quality and continuity of care, which should in turn lead to more people living well and independently. Skills and knowledge levels in the workforce are increasingly important with the growing complexity of care delivery and recipient need (for example, comorbidity and dementia).

The adult social care workforce

More staff with appropriate care skills/qualifications

4.16 Over the next 12 months, the government plans to work with the adult social care sector, including providers and the workforce, to co-develop a universal knowledge and skills framework (KSF) and career structure for the social care workforce. Building on existing and emerging frameworks for the workforce, and working with the DfE in its development, it is intended that this national

[110] Skills for Care, 2021. The State of the Adult Social Care Sector and Workforce 2021 (skillsforcare.org.uk), Chapter 8

framework will become an accessible articulation of the knowledge and skills required for roles within the sector and set out clear pathways for career progression.

4.17 The Knowledge and Skills Framework will be accompanied by investment in a KSF linked Learning and Development Offer to support individual workers to meet their career goals and the needs of people who draw on care and support. Some of the funding is expected to be directed at key skills gaps, in part informed by the findings of empirical research and engagement with the workforce.

4.18 Workers who receive structured learning and development opportunities are more likely to feel valued and supported and therefore are more likely to remain in their posts.[111]

4.19 Investment in the delivery of high-quality care certificate training should improve the portability of baseline knowledge and skills and provide assurance to employers about social care workers' professional competence. A result of portability should be recognition of skills and a reduction of training repetition for workers who move between roles and services.

4.20 The government anticipates that accredited Level 5 diplomas for both new and existing Registered Managers (RMs) who do not hold relevant formal qualifications, could improve the quality of care, attract new people into the role and reduce turnover.

4.21 Piloting a bespoke support programme for new registered managers in their first year will offer learning and development opportunities, peer support and mentoring, which should help to increase retention and improve the pipeline and supply of high-quality managers in the sector, thereby enabling wider quality improvements and innovation. The government also plans to explore options to develop new pathways into the registered manager role further improving the supply of high-quality managers and leaders.

Continuous professional development (CPD) for regulated professionals

4.22 The proposal should allow regulated health professionals to have three years of additional funding to help support with their CPD, which is compulsory for them to complete to meet revalidation standards. Potential benefits of this fund include improvement in retention, workforce productivity, increase in knowledge within the workforce, which could lead to staff feeling valued and adult social care being an attractive career option for newly qualified health professionals.

Sufficient supply of Social Workers

4.23 Most social workers work within LA social services. As reported by Skills for Care[112], between 2012/13-2020/21 the number of social workers in adult social care increased by around 1000 (5.8%). Social work is a demanding and stressful career, and this is demonstrated in the latest workforce statistics. In 2020/21 there was a turnover rate of 12.8% which is around 2,300 leavers in the previous 12 months. There were 1,500 (8.1%) vacant social worker posts in 2020/21.

[111] State of Adult Social Care, Skills for Care, 2019)
[112] Skills for Care, 2021. Workforce estimates (skillsforcare.org.uk)

4.24 The government plans to invest in new and existing training routes for people who want to become social workers. This is intended to maintain the quality of social work education and training and help to sustain a sufficient supply of social workers with the right skills, knowledge, and values.

Workforce wellbeing and recognition

4.25 The ONS found that care home workers were more likely to suffer from symptoms of depression and anxiety disorder than other professions on average.[113] A range of evidence exists that highlights the impact of occupational health interventions on reducing health-related time away from work.[114] As such, a well-implemented occupational health programme should lead to an improved working environment and a decrease in absenteeism and turnover and so reducing related costs to this for providers.

4.26 The implementation of the Social Care Workforce Race Equality Standard (SCWRES), developed by Skills for Care, is based on the NHS WRES 2015, developed as a tool to measure improvements in the workforce with respect to staff from Black, Asian, and Minority Ethnic backgrounds, with the aim to ensure that staff from Black Asian and Minority Ethnic backgrounds working in local government social care teams are treated equally, feel included and valued, and that their health and wellbeing is supported. Results from the NHS WRES demonstrates some success in this space[115] – they already see an increase in senior representation; an increase in the numbers of staff from minority ethnic backgrounds accessing non-mandatory training and CPD; a better recruitment process; and a reduction in the number of staff from a minority ethnic background being subject to HR processes

Central government (DHSC)

4.27 The government will be responsible for the implementation and delivery of these policies, in coordination with the sector. Where appropriate, DHSC will outline best practice related to these policies and communicate this to the sector. DHSC will also monitor and evaluate the progress of these policies. Towards the end of the three-year investment period, DHSC will look to support the sector to maintain the established best practice. Funding beyond the three-year investment period is subject to future Spending Reviews.

Adult social care providers

4.28 As referenced above, Skills for Care found that establishments with lower turnover rates, lower vacancy rates and higher levels of staff undertaking learning and development were more likely to receive higher CQC ratings of care provided. As such, a well-trained, recognised, and supported workforce, with a clear set of career pathways should deliver better quality of care. Moreover, a reduction in turnover should lead to reduced costs associated with workforce planning and

[113] ONS. Based on data from January to February 2021, Depression and anxiety among adults in selected care occupations: Great Britain - Office for National Statistics
[114] Cullen et al., 2018. Effectiveness of Workplace Interventions in Return-to-Work for Musculoskeletal, Pain-Related and Mental Health Conditions: An Update of the Evidence and Messages for Practitioners (springer.com); Proefschrift Bieb.indd (uva.nl)
[115] NHS Employers, 2021. NHS Workforce Race Equality Standard | NHS Employers

recruitment[116]. In addition, plans for a new Care Certificate delivery standard should improve the portability of the knowledge and skills gained through the Care Certificate, which should in turn reduce repetition of training, avoiding unnecessary costs for providers.

Local authorities

4.29 The Occupational Health (OH) pilot is likely to be delivered through a small group of LAs. DHSC will work to identify suitable candidates, who will need to confirm that they have the capacity and plan to deliver such a programme. DHSC anticipates that it would fund the administrative costs of the LA to bring together small adult social care providers in their region to buy OH as a group.

4.30 As set out in the White Paper, the government's intention is to invest in social work training routes – the exact delivery mechanisms will be determined in consultation with the sector. Managing additional social work training placements may cause pressure on some LAs with small-scale workforce infrastructures that are unable to support the increase in capacity. To minimise the potential risk to delivery, DHSC will work with LAs on ways to manage capacity to support trainee social workers.

NHS

4.31 A more productive workforce, providing increased quality of care, is likely to improve health outcomes for individuals who draw on care services. In turn, this could mean a reduction in risk of injury and illness which could reduce the demand on NHS services compared to its less productive comparator.

Description of potential costs

4.32 government has committed to funding of at least £500 million over three years. There are also likely to be costs to LAs and providers, both from familiarisation and for any co-investment into workforce reform over this period (which should largely be incurred voluntarily and dependent on take-up of the schemes).

Summary for each of the reforms

4.33 The following section provides a brief qualitative description of the costs from each policy, split by those to government (predominantly the cost of funding reforms) and to other parties, where possible.

1. The Knowledge and Skills Framework

4.34 Over the next 12 months, the government plans to work with the adult social care sector, including providers and the workforce to co-develop a universal knowledge and skills framework (KSF) and career structure for the social care workforce. Building on existing and emerging frameworks for the workforce, and working with the DfE in its development, it is intended that this national framework will become an accessible articulation of the knowledge and skills required for roles

[116] Skills for Care, 2021. https://www.skillsforcare.org.uk/Documents/Standards-legislation/CQC/Safe-staffing/Calculating-the-cost-of-recruitment.pdf

within the sector and set out clear pathways for career progression. Costs will include the opportunity cost of time spent by the sector and providers on developing this framework.

2. KSF linked Learning and Development Offer

4.35 The Knowledge and Skills Framework will be accompanied by investment in a KSF linked Learning and Development Offer to support individual workers to meet their career goals and the needs of people who draw on care and support.

4.36 government funding of the reforms includes the cost of delivering the training and qualifications, set up costs, and monitoring and evaluation costs.

4.37 The costs to LAs/providers could include the cost of additional staff time invested in learning and development. Final costs will depend on the mix of qualifications which providers are willing to co-invest in.

3. Care Certificate funding

4.38 Government funding over the three-year period could include the associated cost of funding the Care Certificates qualification for some parts of the workforce, as well as setup costs and monitoring and evaluation of the reform.

4.39 The estimated costs to LAs/ providers could include the cost of additional staff time invested in learning and development. Again, the final costs will depend on the mix of qualifications which providers are willing to co-invest in.

4. CPD for regulated professionals

4.40 Government funding is likely to include payments to each regulated professional who is eligible for the new CPD fund, with the potential for some additional administrative costs. The job roles included in regulated professionals are Registered Nurses, Nursing Associates, Occupational Therapists and Allied Health Professionals.

4.41 There are unlikely to be costs to LAs within the three-year period, other than where they are employers of eligible regulated professionals and may face the same cost implication for backfill as other employers. There are no expected costs to providers.

5. Wellbeing and Occupational Health Offer

4.42 Government funding covers immediate Covid recovery (with lasting benefits) including mental health services and training; interventions to support long-term best practice and funding for wellbeing promotion. Based on similar existing programmes or services, potential costs include administration, implementation, and evaluation costs.

6. A Social Care Workplace Race Equality Standard (SCWRES)

4.43 The cost of a SCWRES includes the funding provided by government to aid the implementation and monitoring of the programme.

4.44 There may also be resourcing costs as LAs oversee the standard in each LA where it has been adopted. There are no expected costs to providers.

7. Investment in social worker training routes

4.45 The government is committed to ensuring a sufficient supply of social workers with the right skills, knowledge, and values to support adults, children, and families and ensure the continuation of good outcomes for people who rely on services. The exact delivery mechanisms and use of investment in social work will be determined in consultation with the sector.

Other costs

4.46 The paragraphs below cover other potential additional costs to providers or LAs which are uncertain at this stage as policy design is yet to be finalised:

- ***CPD for regulated professionals*:** It is not currently known how much CPD is undertaken by regulated professionals. This policy could increase participation on CPD courses which could result in increased cost of additional staff time invested in learning and development being required.

- ***Investment in social worker training routes*:** The government is engaging with stakeholders to ensure best use of investment in social worker training. This includes exploring solutions on how to absorb growth in hosting practice placements. The contingency for this is working with LAs to support LA long-term resilient workforce planning for the wider adult social care workforce and increase placements for all social work training routes. It is likely that LAs would have to adjust teams to accommodate an increased number of people on training programmes. This could include lost productivity and more time spent by practice educators to support people through the programmes. This may limit the availability of placements. The government is considering how best to support LAs to expand capacity to enable people to access training routes.

Description of potential benefits

4.47 The government's reform proposals have been developed to address key underlying weaknesses in the adult social care workforce. Outputs are likely to include a significant number of new qualifications, digital tools, wellbeing and OH programmes and resources, and more social workers in the system.

4.48 Taken as whole, the package aims to deliver the following potential benefits:

- Improved productivity of the workforce.

- Improved quality of employment.
- Improvement in turnover and vacancy rates.
- Realise wider efficiencies in the adult social care system.
- Improved care quality.

4.49 The following section outlines how these benefits are anticipated to materialise from the proposed activities. As noted above, a necessary platform for these benefits is a resilient workforce at stable capacity, supported by current baseline activity which needs to continue.

Improved productivity of the workforce

- A more skilled workforce should either be able to produce a higher quality of output in the same amount of time (as per improved care quality point below) or the same level of care but for more users. If these efficiencies are realised, then there should be improved access to care and more people benefitting from better care.
- Evidence shows that care workers and registered managers with a qualification(s) can lead to an increase in worker productivity. 92% of employers who accessed training through DHSC's Workforce Development Fund reported an improvement in quality[117]
- Where improved skills and qualifications raise worker productivity, this may increase the efficiency of care provision, which should in turn benefit providers in terms of improved profitability and / or users in terms of service quality, affordability, and improved access to care. There is also evidence to suggest that skills and qualifications could encourage recruitment and reduce turnover in the sector, which would benefit providers. There may be an increase in costs to providers because of progression, and indirectly to LAs if any cost is passed on through higher fee rates but this is difficult to predict. There would be an associated financial benefit to workers, such that the overall impact of this should be a net benefit to society.

Improved quality of employment

- The workforce package seeks to improve recognition, wellbeing, resilience, and reduced burnout. It could also raise staff morale and engagement.
- Investment in training/qualifications allows workers already in the sector to upskill and become qualified.
- The SCWRES should directly impact equality issues and provides support to staff from Black, Asian, and Minority Ethnic backgrounds working in local government social care

[117] Gov.uk, 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/957124/gov-resp-to-hscc-rep-on-asc-funding-and-workforce-web-accessible.pdf

teams. A scoping review for SCWRES found that inequalities and underlying racism drove poor morale.

- Investment in training routes for social workers is likely to result in not just an increase in headcount but more so in increased productivity; a reduction of work-related stress and burnout, increased wellbeing within the existing workforce; all of which should positively impact quality and retention.

Realise wider efficiencies in the adult social care system

- The white paper commits to a Skills Passport, which aims to enhance the portability of skills and reduce duplication of basic training costs for staff moving between employers. The government expects there to be a reduction of duplicate training costs to providers resulting from the Care Certificates funded for those workers who move within the sector once they have acquired it.

- A 2004 study shows investment in workplace health promotion brings up to £10 in cost savings for every £1 spent.[118] Wellbeing and OH interventions should also reduce sickness absence relative to the counterfactual.

- Increasing social worker numbers should reduce the reliance on more expensive agency social workers, which may result in better quality of care and reduced downstream pressures on NHS through lower referrals.

Reduced turnover & fewer vacancies

- Lower turnover and/or fewer vacancies would result in reduced recruitment costs for care providers. Poor staff retention represents a particular challenge and cost to the sector, with the cost of recruiting a care worker estimated to be up to £3,600.[119]

- Clearer training and development routes should also create clear expectations about the role and the skills, standards and behaviour required. This could lead to improved staff satisfaction in role, thereby improved retention.

- Skills for Care research[120] of employers with turnover of less than 10% found that activities including investing in learning and development, celebrating organisational and individual achievements, and involving colleagues in decision making all contributed to staff retention.

- Evidence shows that turnover rates decrease as experience in the role increases[121]. Improved workforce recognition could also attract new entrants which would pass cost benefits on to care providers as well as increase efficiency, productivity, and quality.

[118] WAO. https://www.wao.gov.uk/sites/default/files-old/download_documents/Occupational%20Health%20Good%20Practice%20Guide.pdf
[119] Skills for Care, 2021. Calculating the cost of recruitment (skillsforcare.org.uk)
[120] Skills for Care, 2019, Retaining your staff
[121] Registered managers that had worked in the adult social care sector for 20 years or more (whether as a registered manager or in another role) had a far lower turnover (15.5%) than those new to the sector (46.9% for

- Where the fewer vacancies are realised, this should mean that staff are less stretched, less likely to burnout, and have more time to provide quality care, leading to higher job satisfaction and lower turnover.

- The SCWRES may also increase retention in local government from increased recognition and morale.

- CPD funding provides regulated professionals with further opportunities to participate in learning and development courses that should support them in their career. This provides the opportunity to attract new staff to the workforce, reduce vacancies and ultimately improve continuity and quality of care

Improved care quality

- An improvement in the quality of the employment offer could lead to an improvement (reduction) in the turnover rate amongst the workforce, which should lead to more continuity of care. In addition, the Care Certificate and the Learning and Development Offer, supported by the Knowledge and Skills Framework (KSF), should lead to a more skilled workforce. Both factors are likely to improve of the quality of care received by users.

- Professionalisation should mean better skills, especially specialist skills for high-end needs. CQC (2019) found that specific training in areas such as dementia, medication, and nutrition supported a personalised care approach, leading to better quality outcomes for those receiving care.

- A reduction in worker turnover could mean reduced emotional impact on care recipients and a higher quality of care. Evidence suggests[122] that over 65s receiving home care particularly value continuity as this enables them to get to know their regular carers well. It is assumed that this is also the case for under 65s who receive care.

- Reduced mistakes and therefore better quality of care can lead to reduced downstream pressures on NHS through lower referrals.

Small and micro businesses

4.50 Skills for Care estimates of residential and non-residential adult social care organisation sizes in England[123] can be used to calculate that 85% of adult social care providers have fewer than 50 employees, and so are classified as small or micro businesses. A summary of the number of organisations and the proportion of business in each size band can be seen in the table below.

those with less than one year of experience). The role has become more complex, broader, and professionalised over time, including stronger emphasis on legislative and safeguarding requirements, with responsibilities and pressures, including long working hours.

[122] Social Care Institute for Excellence, 2014, What older people want: Commissioning home care for older people.

[123] The size and structure of the adult social care sector and workforce in England (skillsforcare.org.uk)

Table 3: Estimated number of adult social care organisations in England by size group (number of employees)

Size group	Micro (1-9)	Small (10-49)	50-249	250+	Total
Number of organisations	9,000	6,000	2,350	400	17,750
% of total no. of organisations	51%	34%	13%	2%	100%

4.51 Most care providers are small or micro businesses or civil society organisations, and these proposals will apply to their staff. These businesses should therefore benefit in particular from these proposed reforms.

Risks and assumptions

4.52 The main dependencies include:

- Ensuring a level of need/demand for training.
- Ensuring there is awareness and accessibility of training, wellbeing, and social work programmes across a variety of providers.
- Ensuring there is sufficient accompanying admin funding and resource to enable implementation.

4.53 As set out in the following sections, several mitigations have been built into the proposal including targeting training, co-production, communications campaigns and the role of enhanced regulation.

Demand

4.54 The government is confident there is strong need for training already in the system (based on close stakeholder engagement, plus anecdotal evidence from Skills for Care, who tell us that demand for their current Workforce Development Fund outstrips supply ten to one).

4.55 The government plans to co-produce the Knowledge and Skills Framework and wellbeing support with the sector to ensure it is flexible, delivered in a way that is accessible, and meets the needs of providers and staff whilst being targeted at government priorities. The government will set up targeted conversations with LAs to encourage and support uptake of the workforce package in its entirety.

Accessibility and awareness

4.56 Given the provider market is highly varied, made up of small, large, independent, and LA-funded providers, the government will work to ensure awareness and accessibility of the workforce package. This is why, for example, the Care Workforce Hub (accounted for in baseline spend) will be vital as it will enable DHSC to communicate directly with the workforce to advertise training, initiatives and support that will be available, and we have factored in spend for a coordinated communications campaign.

Regulation

4.57 Funding available now for a workforce package creates a risk for sector dependency on government investment in the long-term. However, the proposed investment has been designed to ‘pump-prime’ the market designed to create an increased baseline level of skills and qualifications, which should allow government to reduce its investment and allow the market to take over.

4.58 The government is working with CQC to explore strengthening existing regulations to place requirements on care providers to have an appropriate skill set in their workforce and appropriately supporting workforce wellbeing, including ensuring the market continues to respond after initial government investment to increase the skill base and offer of wellbeing and OH support.

5. Supporting local authorities to deliver social care reform and our vision

Opportunities for Improvement[124]
1. Variability in the culture and strategic leadership across different LAs, which affects the quality and choice of services available. 2. Government currently holds insufficient levers for oversight and improvement.

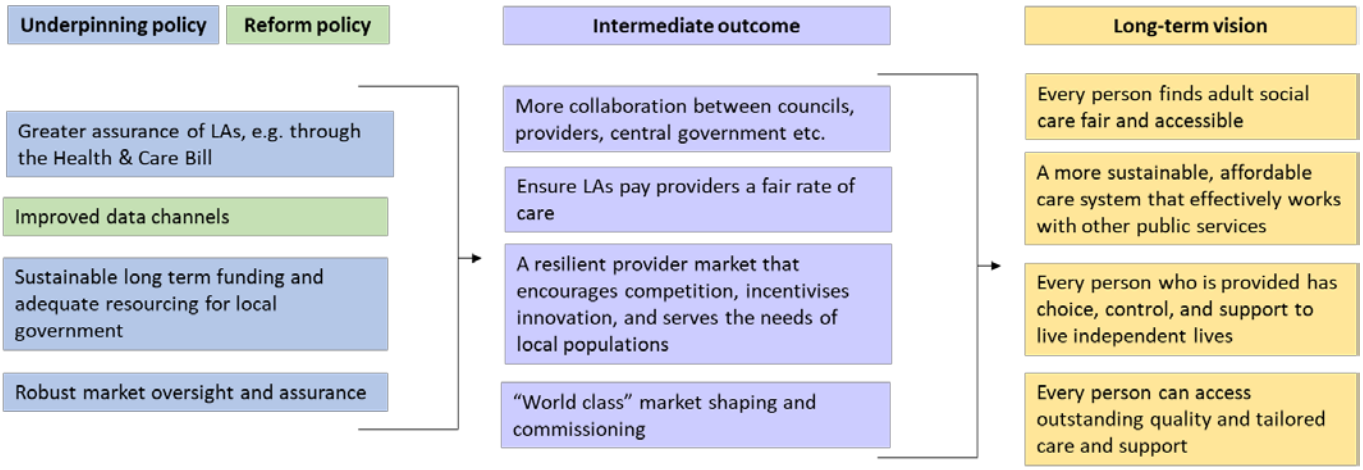
5.1 The white paper groups together policies aimed at supporting LAs to deliver social care reform. The proposals can be grouped into 3 categories:

- **Assurance:** Assessments of LA performance by CQC and LA intervention measures where there is serious and persistent risk to people's safety
- **Data:** Better quality and use of data at personal, local, regional, and national levels
- **Improvement:** An enhanced improvement support offer to the adult social care sector

5.2 Note that the white paper also announces funding for LAs to move towards paying a fair rate for care. This measure is assessed in the impact assessment for Social Care Charging Reform[125].

5.3 The logic map for how these measures are intended to work together and underpin system reform is outlined below:

Figure 6: How policies link to long-term vision



[124] Evidence review for adult social care reform (publishing.service.gov.uk)
[125] Impact Assessment template (publishing.service.gov.uk)

Background and rationale

5.4 The Care Act 2014 provides a strong foundation for the social care system and sets out the duties of LAs in the provision of adult social care. However, the ambition of the Care Act has not been achieved consistently. As outlined in Table 1, there is variation in the quality and safety of care across LAs, unhealthy social care markets and information failures in navigating the system:

- As of November 2021, 14.3% of providers had a 'requires improvement' rating and a further 1.4% are rated as inadequate.[126] There is stark geographic variation, with evidence of poorer quality care in less prosperous areas where LAs often pay lower rates for care and self-funders are less affluent.

- In many LAs, there is evidence of low fee rates and cross-subsidy between care home residents paying for themselves, and those who are funded by their LA.[127] Uncertainty over future funding can stifle provider investment and, along with low fee rates, can result in poor workforce conditions, inadequate quality care, market fragility and pose a threat to continuity of care.

- Most people think the NHS provides social care services, whilst just under half (47%) wrongly think social care is free at the point of need[128]. A recent Social Care Institute for Excellence (SCIE) survey found greater awareness of some social care settings than others, with 98% of over 65s aware of care homes compared with 66% aware of extra care housing, 40% of shared lives housing and 56% of supported living[129].

5.5 Going forward, the Care Quality Commission (CQC) will assess LA performance to identify and address the variations outlined above. The white paper proposals seek to create the right system infrastructure to:

- identify and share how well LAs are meeting their adult social care duties (as set out in Part 1 of the Care Act)

- enable better sharing of data and information on quality, continuity of care and outcomes

- put in place mechanisms to drive forward improvement activity

5.6 The Health and Social Care Bill (2021) sets out a new duty for CQC to assess LAs' performance of their adult social care functions in Part 1 of the Care Act 2014 ('Assurance'); establishes new powers of intervention where the Secretary of State for Health and Social Care considers a LA is failing to discharge its Care Act duties to an acceptable standard ('Improvement'); and includes powers to require data from regulated adult social care providers ('Data').

[126] DHSC analysis of Care Quality Commission, Care Directory with Filters, published November 2021.
[127] CMA, 'Care homes market study: Final report', published November 2017.
[128] Ipsos MORI, 'State of the State 2017-2018', published October 2017.
[129] Social Care Institute for Excellence (SCIE), 'A place we can call home: A vision and a roadmap for providing more options for housing with care and support for older people', published November 2021.

5.7 Whilst the detail of the approach (scope, frequency, intensity etc.) is yet to be determined, the likely impacts of the measures included in the Bill are fully assessed in separate impact assessments:

- The impact of assurance proposals: Health and Care Bill 2021: Impact Assessments for Adult Social Care Provisions. A summary of findings is provided in 'Summary of reform proposals' below for information.

- The impact of the underpinning legislation required for data proposals: Health and Care Bill core measures Impact Assessment (publishing.service.gov.uk). Note that the white paper proposals relating to data go beyond what is detailed in legislation, so the wider impacts of these white paper proposals are outlined below.

5.8 Reforms relating to improvement are not addressed in the published IA, so are also covered below.

Summary of reform proposals

Assurance

5.9 The proposals are for enhanced assurance of LA delivery of adult social care statutory duties under the Part 1 of the Care Act 2014, using CQC to assess LAs' delivery and putting in place an intervention regime focused specifically on adult social care [measure 22]. This offers increased understanding of what is occurring across social care provision through an established, independent regulator; contributes to capacity to share good practice and to target support where problems are identified, including in the most worrying cases where the Secretary of State may wish to intervene to drive improvements.

5.10 The published IA estimates undiscounted costs to government of £11 million over the three-year period (£49 million over 10 years), arising from administrative costs and intervention and/or support activities, to DHSC, CQC and LAs, along with familiarisation. Expected benefits relate to improved quality of care to people who draw on care and support, improved offer to the adult social care workforce, NHS savings, and improved equity in outcomes. Although it is difficult to quantify these benefits of the policy, a break-even analysis conducted in the IA focussing only on the improved quality of life outcomes for users (in QALYs) indicates that the benefits of the intervention are likely to outweigh the costs.

5.11 For more information on this proposal and the detailed assessment of costs and benefits, please see the published IA.

Data

5.12 The programme of work to improve data in adult social care, that impact the system, at a local, regional, and national level, includes commitments to:

- Introduce powers for the Secretary of State (SoS) to require information from all regulated adult social care providers about themselves, their activities connected with the services they provide in England and the individuals to whom those services are provided (in England or

outside England where the services are commissioned by English LAs) [measure 23]. Note that the impacts of this specific reform are detailed in Health and Care Bill core measures Impact Assessment (publishing.service.gov.uk).

- Better link social care data with health, through client-level data, which should drive integrated care between the health and care system.
- Improve the sharing of information across the sector through an adult social care data portal which builds on the current adult social care COVID-19 Dashboard.
- Build up detailed evidence on the effectiveness of social care provision and reform interventions to inform government policy.

5.13 The Office for Statistics Regulation's 2020 report, A*dult Social Care Statistics in England*[130], highlighted significant data gaps, noting that the social care system would be assisted by more comprehensive and better data. Access to good quality, timely data is vital for underpinning a robust system of assurance. The data proposals build on the government's commitment to using data to improve the health and care of the population in a safe, trusted, and transparent way. This was recently outlined in *Data Saves Lives*, the data strategy for health and social care, published in June 2021. The data projects also support the delivery of the government's mission to transform the use of data to drive efficiency and improve public services as set out in the National Data Strategy.[131]

5.14 The proposals outlined are considered to target the key gaps in understanding of the system, without unduly impacting the sector in terms of burden. The proposals align well with the other proposals outlined in the White Paper that support digitisation and aim to provide the underpinning data architecture to support the government's vision for the sector over the long-term.

5.15 Work to improve adult social care data and build the evidence base has been underway since the COVID-19 pandemic. The pandemic has demonstrated the importance of good quality, timely data in responding to health emergencies. Improved data matters in solving problems, supporting efficiency, and maximising outcomes. It is also important to inform decisions made by individuals about the care they receive or provide for themselves and their families.

Improvement:

5.16 Through the introduction of CQC assessment of LAs and better data, the government will have more insight into what is, and is not, working well. In response, the government wants to expand the scale and reach of the support offer to the sector.

5.17 Improvement funding will be increased to more than £70m between 22/23 and 24/25, including an expanded support offer for LAs facing specific problems in their delivery of social care services and support to implement reform [measure 21]. As part of this, the government plans to become more

[130] OSR, 2020. Report on Adult Social Care statistics in England – Office for Statistics Regulation (statisticsauthority.gov.uk)
[131] National Data Strategy - GOV.UK (www.gov.uk)

proactive in making sure support is targeted where it is needed most, informed by data, intelligence and the views and experience of people who draw on care and support and their carers. The government will also invest in a commissioning capability offer to deliver a step-change in market shaping and commissioning capability in LAs. High-quality LA market shaping and commissioning is critical to achieving several of the reform ambitions outlined in the white paper, and evidence has highlighted current variability in practice. To shape the capability offer, the government will first undertake a review, in partnership with the sector, to understand what's working and where the gaps are to ensure that the offer targets the areas that could deliver the greatest improvement.

5.18 The government is designing the improvement offer in partnership with the sector. The offer will be shaped to align with the assurance, data, Integrated Care Systems, and intervention proposals as they become law. The government expects to be able to provide greater detail as operational policy is developed alongside the timeframes for implementation of legislative proposals.

Description of potential costs

Data

5.19 There will be a cost to care providers if they are required to collect new data (on top of the data already collected). There could also be a cost to LAs from any new client-level data collection, including staff time to collect the data; costs to introduce and maintain Information Technology (IT) to store data securely, including security software; familiarisation and training costs in terms of proper handling of data and use of new software for staff, and staff time to collate and send the data in the required format. However, feedback from stakeholders, particularly care providers, has indicated that there is currently duplication of data collection[132]. Therefore, there may be opportunities to at least partly offset costs of any new data collection through streamlining or cessation of existing collections.

5.20 Specifically, for client-level data collection, a New Burdens Assessment[133] will be completed in early 2022 with 30 LA early-adopters, to determine the overall cost of implementing the collection across England.

Improvement

5.21 Increased improvement funding has the potential to deliver a broad range of improvement activity and support to the sector, including universal support (guidance, toolkits, and resources, training, and collaborations opportunities), bespoke support (additional expert support to develop and apply universal tools), and additional work on market shaping and commissioning.

5.22 Any monetised costs to other actors in the system would be indirect. For example, through engaging with the improvement offer, a LA may find that they need to increase spend on specific

[132] DHSC, 2021. Data Saves Lives: reshaping health and social care with data: Data saves lives: reshaping health and social care with data (draft) - GOV.UK (www.gov.uk)

[133] A new burden is defined as any policy or initiative that increases the cost of providing local authority services. The New Burdens Doctrine requires that the net additional costs of all new burdens placed on local authorities by central Government is assessed and fully and properly funded: New burdens doctrine: guidance for government departments - GOV.UK (www.gov.uk)

aspects of their delivery of their adult social care duties, or find the need to fund improvement beyond the national improvement offer. However, the national improvement offer is likely to be free at point of access. LAs will therefore remain in control of their own spending and can choose whether to engage with the support offer in line with their own improvement priorities.

5.23 Any impact on business (private providers of care services) should be indirect and is not an intended outcome of the proposal.

Description of potential benefits

Data

5.24 Data is anticipated to drive collaboration, leadership and joint decision-making among local systems and national organisations. NHS Digital could, in future, aim to link social care data with person-level health. This could be instrumental in understanding a person's journey through the health and care system, as well as the intensity of their care needs and the total cost to the system, which could also drive better integration between the health and care systems. It could also improve system efficiency, for example, through better hospital discharge planning, which is likely to reduce the numbers of delayed discharges and related costs.

5.25 Measures such as improved data collections from care providers could also provide a stronger understanding of the characteristics of people who draw on care and support and the care that they are receiving. This can be used to ensure the current social care market is shaped to meet their needs, allow providers to identify and determine how funding should be used most effectively, and to evaluate spend.

5.26 Benefits of improved data sharing are indirect and will depend on the purposes for which the data are used. However, improved data collection and dissemination is a key enabler that has the potential to drive improvements to quality of care (through enabling research into care outcomes and ensuring that care providers and local government have access to business intelligence to support them in identifying improvements), and to strengthen the Secretary of State's oversight of social care provision, ensuring that the right level of capacity and support is available to ensure service continuity.

5.27 Monitoring of practice nationally and at regional and local levels should mean better understanding of gaps in provision and easier identifying of poor and good practice. Better use of data and a strong evidence base should also help to target support and respond quickly to emerging risks and issues that are identified through data analysis. Data could also be used to support evaluation of the impact of outcomes, and identify and share good practice in social care that could ultimately contribute to driving forward improvement.

Improvement

5.28 The potential benefits of the increased improvement offer are expected to be:

- **Greater understanding of how the system is working and performing** – particularly at a local level where data and intelligence is currently lacking.

- **Improved quality of care** – an increased improvement offer is anticipated to lead to improved LA performance in delivering their adult social care functions under the Care Act 2014, and thus to an improvement in adult social care outcomes and in quality of care. This should help to ensure people are able to draw on care and support at the right time and to a high quality.

- **Improved equity outcomes in care provided** – the increased support provided to underperforming areas could help alleviate geographical difference and promote greater equity in the quality of care provided across the country.

- **Improved integration of health and care services** – programmes to support LA senior leaders could help them to lead more integrated services.

- **Strengthened collaborative working between commissioners (including health and care)** – strengthened ability for LAs and providers to work together to better shape local care and support health and care markets, leading to an improvement in the number of high-quality, personalised care and support options available locally.

- **NHS savings as a result of adult social care spend** - given the close integration of the health and care systems in England, any additional funding for the adult social care system (that leads to increased spending in adult social care) could have beneficial impacts on the NHS. Adult social care support from LAs 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 adult social care market can ensure there is the right level of capacity, limiting the number of delayed bed days in hospital, thus resulting in NHS savings.

5.29 The government's proposals expand the existing sector-led support and improvement offer to support the ambitions outlined in the white paper. It will do this by providing universal and bespoke support to ensure policy and improvement priorities are implemented; it aims to facilitate sharing and embedding of innovation and best practice; and it directly targets areas for additional challenge, drawing on greater visibility of data and performance that should make the improvement needs of the sector more transparent. Where sector-led improvement is shaped around transparent need and shared priorities, this should enable support needs to be robustly identified and met, which should in turn facilitate a self-improvement journey for LAs, leading to improved quality of adult social care delivery and associated better outcomes for people who draw on care.

5.30 LAs will remain responsible and accountable for their own continuous improvement and should actively work on identifying their challenges and taking actions to improve them. However, the improvement offer, with its increased scaled and reach, should better support this, broadening the tools that LAs have at their disposal to enable them to carry out that responsibility most effectively. Additional support for commissioning, alongside a broader self-improvement journey, could lead to

LA commissioning that supports better outcomes for people. This in turn could positively impact people accessing care support, allowing them to get the care they want and need.

Small and micro businesses

Data

5.31 It is plausible that small providers with little IT infrastructure or few staff may face a disproportionately high cost to collecting and storing additional data. However, the intention is to minimise additional cost burden so data collection would aim at being minimal and efficient. The white paper also outlines measures that will support digitisation of the sector, through improving infrastructure and providing support to build digital and data capability (see Section 2.2 of this impact statement).

Improvement

5.32 There is the potential for a small positive impact on small and micro business providing adult social care services as they may benefit from the increased scale and reach of improvement and support activity. One of the anticipated outcomes from strengthening LA market shaping and commissioning is to increase both the diversity of the models of care and provider models for delivering this provision. For example, increasing the number of micro and community owned enterprising deliver care and support.

Risks and assumptions

Data

5.33 The government plans to take steps to reduce the likelihood of actors in the system needing support to prepare for the changes by conducting extensive stakeholder engagement as these proposals develop and continuing to work with providers, CQC, LGA and ADASS, and other sector actors, to develop and/or implement these proposals, produce guidance, and learn from our work during the pandemic response. Previous engagement with providers and LAs provides confidence that there is a strong appetite for improving data and transparency in adult social care.

5.34 For this proposal, the government will be seeking to reduce collection burden on providers and LAs by rationalising collections where duplication or undue burden is found.

Improvement

5.35 Assumptions for the proposal for increased scale and reach of improvement activity include that:

- there is a need for improvement activity in the sector
- CQC assessment and better data will go live, highlighting what is working well and what isn't
- LAs will want to engage in an improvement offer, and the sector will want to continue leading on its own improvement, via Sector Led Improvement.

5.36 There is a risk that the benefits of increased scale and reach of the improvement offer are not maximised due to low participation or an offer that is not properly tailored to the challenges LAs are facing. To mitigate this, this government intends to continue working with stakeholders in the coming months, including LAs and providers, to develop the improvement offer.

6. Overarching risks and assumptions

Overarching risks

6.1 The key overarching risk is related to delivery of what is an ambitious package of measures over the next three years. Given the ongoing fluctuating impact of Covid and associated NHS pressures on the health and social care systems, the system may struggle with capacity to implement the immediate reforms proposed in the white paper.

6.2 Whilst system reform funding and measures are separate to charging reform, there is a risk that the expectation for many complex reforms at once is too much for the system to handle. As outlined above, the reforms will continue to be designed working with the sector, which should help the government to identify delivery risks early and work with the sector to mitigate against these. As outlined in the white paper, social care reform is considered a shared endeavour. To deliver the bold measures, the government must involve people and organisations across the sector. To this end, the government has committed to:

- Work in partnership with stakeholders and people who draw on care and support to develop and design the implementation of the measures set out in this white paper.
- Explore with LAs and other key stakeholders how best to deliver the numerous investments outlined in this document, which are funded by the new Health and Care Levy. The government wants to ensure the investments meet their intended objectives whilst also making it as simple as possible for LAs and others to access the new funding.
- Engage with a diverse range of voices across the sector, including those who draw on care and support, to identify measures of success for the delivery of our reforms.
- Collaborate with TLAP and members of the Health and Wellbeing Alliance to set up co-productive forums to ensure that the voices of those who draw upon care and support are involved in the ongoing design and implementation of social care reform.

6.3 The logic map on Figure 2 (page 12) identified those policies that are ‘underpinning’ to the reforms. If the government fails to get these underpinning measures right, there is a risk that the benefits of other measures, particularly quality related benefits, do not materialise.

6.4 To be successful, several of the measures rely on a stable and sustainable social care market. Without this, there is a risk that the benefits of other measures will not be achieved.

Assumptions

6.5 Most data sources used are based on pre-COVID-19 data collections and therefore this analysis does not take into account any impacts from COVID-19. The latest data on demand for social care – which include the higher mortality observed in 2020 during the COVID-19 pandemic – suggest a decrease in life expectancy for the period 2018-2020, but it is too early to say what the impact of

this will be on long-term trends in life expectancy. It is too early to understand what, if any, impact COVID-19 will have on long-term demand.

7. Monitoring and Evaluation

7.1 To ensure the reforms have reached their intended aims and are making progress towards the vision set out, it is important to devise a robust monitoring and evaluation process. This is especially important given the complexity of the reforms being implemented and the scale of anticipated costs.

7.2 These reforms present a significant opportunity to learn lessons about what works – several of the proposals have been established explicitly to test new and innovative ways of delivering support, with monitoring and evaluation fundamental to these plans. For example, the unpaid carer proposals include extensive impact and process evaluation to generate evidence on effective ways to support unpaid carers in future.

7.3 DHSC is developing an overarching evaluation framework covering both process and impact, which will seek to:

- Monitor and appraise the delivery of individual policies – where appropriate, to facilitate learning to inform future phases of delivery
- Provide evidence of specific outputs and emerging outcomes linked to individual policies. Due to the heterogeneity of the policies implemented, it is likely that a variety of methodological approaches will be adopted
- Go beyond individual policy-level evaluation to monitor the success of the overall programme of reform. The specific contribution of individual policies to overall reform will be difficult to isolate, but the government will seek to outline the causal mechanisms through which policies are expected to lead to reform outcomes.

Logic map

7.4 To inform monitoring and evaluation plans, DHSC have developed a logic map (see Figure 2, page 12) that shows how a combination of the underpinning policies and the reform policies complement each other and deliver a range of intermediate outcomes.

7.5 For example, the underpinning policy of sustainable long-term funding and adequate resourcing for local government combined with reform policies for improved data channels and technology, new models of care and housing funding is expected to result in a resilient provider market that encourages partnership, incentivises innovation, and serves the needs of local populations.

7.6 DHSC will develop the evaluation framework to ensure it meets the above objectives and will build in flexibility so that it aligns with policy implementation. As part of this planning process, DHSC will consider whether – and to what extent – it would be appropriate to involve external organisations in delivering the monitoring and evaluation. DHSC will engage with stakeholders to refine monitoring and evaluation plans, and more detail on the approach will be communicated in due course.

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