

Title: Assessment, eligibility and portability for care users and carers Accompanying IA for the White Paper "Caring for our future: reforming care and support" IA No: 7064 Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA)
	Date: 03/07/2012
	Stage: Consultation
	Source of intervention: Domestic
	Type of measure: Primary legislation
	Contact for enquiries: Caroline Allnutt, Department of Health

Summary: Intervention and Options	RPC Opinion: GREEN
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Cost of Preferred (or more likely) Option			
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Measure qualifies as One-Out?
N/A	£0m	£0m	No
			NA

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

The current system of assessment and eligibility is often confusing and unfair for users and carers, with variable access across the country. Care users find it difficult to move between councils, particularly as their care and support can be interrupted until a new assessment is carried out. Carers do not yet have the same entitlements to assessment and support as care users, which can affect both their own outcomes and those of the people they care for. There is a lack of clarity regarding the responsibility for the assessment and provision of care and support in prisons, which has led to care needs not being assessed or appropriately provided for. Injured veterans must use their compensation payments to pay for social care.

What are the policy objectives and the intended effects?

To bring about greater clarity, consistency and equality of access to care and support for care users and carers; provide freedom of movement and continuity of care and support to individuals with care needs and carers who move from one local authority area to another; create a more nationally consistent system for assessment and eligibility for users and carers which is understandable, transparent and outcome-focused; ensure early and effective assessment and support for carers to help them maintain their own health and wellbeing and support those they care for to stay at home; provide better access to assessment and provision of care for people with care needs in prison; and recognise the contribution of injured veterans.

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

As set out in the White Paper "Caring for our future", take forward the following policy proposals: Implement a minimum national threshold for eligibility; introduce a duty for local authorities to provide an equivalent package of care and support for users and carers who move into their area until they are able to carry out a reassessment; develop and then test proposals for a new assessment and eligibility framework working with local government and the sector; simplify the legislation in respect of carers' assessments; introduce a new duty on local authorities to meet eligible needs for carers' support; specify in legislation that there should be a threshold of responsibility between prisons and local authorities for prisoners' care and support; and disregard armed forces compensation payments from the financial assessment for social care.

Will the policy be reviewed? It will be reviewed. If applicable, set review date: Month/Year					
Does implementation go beyond minimum EU requirements?			No		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	Micro No	< 20 No	Small No	Medium No	Large No
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)			Traded:		Non-traded:

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

Signed by the responsible SELECT SIGNATORY:  Date: 3/7/12

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 2010	PV Base Year 2015	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate:

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	13	183	1554

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

There may be ongoing costs to councils from providing services to people with needs which are not currently provided for under their local authority eligibility threshold. There are costs of care for users and carers moving local authority area, additional carer assessments and support, care for prisoners and of disregarding armed forces compensation. There may be transitional costs relating to assessments for people in areas providing services at a different level to the national threshold.

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

*The cost table does not include transitional costs for the development and testing of a new eligibility framework (£0.7m) and the transitional costs of armed forces compensation (£3.9m), both which come into effect prior to 2015.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate		3	23

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

The benefits cannot be monetised, with the exception of the transfer payments to fund user incentives in the development and testing of a new assessment framework, and transfer payments to armed forces veterans.

**The benefits table does not include transitional benefits which occur prior to 2015. These are transfer payments to fund user incentives in the development and testing of a new eligibility framework (<£0.03m) and the initial transfer payments to veterans (£3.9m).

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

The benefits comprise almost entirely welfare gains for users and carers from each of the proposals discussed in this Impact Assessment. The proposals aim to bring greater clarity, consistency and equality of access to care and support and to reduce unmet need for prisoners, carers and in areas with stringent eligibility. There may be some savings to the NHS from increased support for carers and increased social care for people with substantial needs in areas not currently meeting those needs.

Key assumptions/sensitivities/risks

Discount rate (%)

3.5

There is inevitable uncertainty about some important factors, especially the number of extra carer assessments and care and support services that will result from the proposed legal changes in respect of carers. There is also uncertainty about the numbers of prisoners with care needs.

BUSINESS ASSESSMENT (Option 1)

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

Summary of impact

1. This Impact Assessment provides analysis of the relative costs and benefits of proposals set out in the White Paper “Caring for our future: reforming care and support”. In particular it discusses the impact of proposals set out in Chapter 4 of the White Paper relating to the following policy areas:
 - Assessment, eligibility and portability
 - Better support for carers
 - Care and support in prisons
 - Fairer support for veterans
2. This is a consultation stage Impact Assessment. The majority of the proposals discussed below require primary legislation for implementation. The Government has announced its intention to publish a draft Care and Support Bill for pre-legislative scrutiny, after which formal introduction to Parliament will follow as soon as possible. A further final stage Impact Assessment in respect of these legislative proposals will be published at that point.
3. For the purposes of this Impact Assessment, we have assumed that proposals that require legislative enactment will be implemented from 2015/16, although the implementation timetable is subject to the passage of legislation through Parliament. Other proposals that do not require enactment through primary legislation may be implemented earlier.
4. The proposals set out in the White Paper have been developed in the light of publication of two important reports that made recommendations on how to reform care and support. The Law Commission’s report on adult social care was published in May 2011 and recommended bringing together all the different elements of social care law into a single, modern adult social care statute.¹ The Commission on Funding for Care and Support, chaired by Andrew Dilnot, made recommendations for changes to how the cost of care is shared between the individual and the state as a partnership, as well as other important recommendations for the reform of care and support.²
5. In September 2011, the Government launched *Caring for our future: shared ambitions for care and support*, a period of focused engagement with people who use care and support, carers, local councils, care providers, and the voluntary sector. The aim of the engagement was to bring together the recommendations from the Law Commission and the Commission on Funding of Care and Support with the Government’s *Vision for Adult Social Care*³ and to discuss priorities for reform with stakeholders.
6. This extensive engagement has informed development and appraisal of the proposals set out in the White Paper. Engagement took the form of meetings, conferences, workshops and correspondence. Events were led by members of the care and support community and involved the input of users, carers, local councils, care providers and the voluntary sector. In addition, the Department of Health has also used literature reviews and workshops held with academic experts to inform policy development. This process has enabled us to discuss the effectiveness of a range of policy options and associated costs and benefits.
7. The proposals discussed within this Impact Assessment do not fall within the scope of the Government’s “One-In One-Out” (OIOO) rule which states that “no new primary or secondary UK legislation which imposes costs on business or civil society organisations can be brought in without the identification of existing regulation with an equivalent value (in terms of net costs to business) which can be removed.”
8. These proposals do not involve any additional regulatory measures that impose costs on business or civil society. The changes to the law proposed in the White Paper relate to the responsibilities of local authorities and other public sector partners for planning and commissioning of adult social care services and for meeting the needs of their local population. Therefore, as set out below, additional costs arising as a result of these proposals will be incurred by local government.

¹ http://www.justice.gov.uk/lawcommission/docs/lc326_adult_social_care.pdf

² <https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf>

³ Department of Health, *Vision for Adult Social Care*, November 2010.

9. Table 1 below provides a summary of impact for each proposal discussed in this Impact Assessment.

Table 1: Summary of impact

Proposal	Is new legislation required?	Estimated implementation date	Agency costs fall to	Agency benefits accrue to
A. Establish a national minimum threshold for eligibility for care and support	Yes	2015/16	Councils	Care users and carers
B. Place a duty on local authorities to provide an equivalent package of care and support for users and their carers who move into their areas until they undertake a new assessment	Yes	2015/16	Councils	Care users and carers
C. Develop and then test proposals for a new assessment and eligibility framework for both users and carers working with local government and the sector	No	2012 onwards	DH	Care users and carers
D. Simplify the legislation in respect of carers' assessments	Yes	2015/16	Councils	Carers
E. Introduce a new duty on local authorities to meet eligible needs for carers support	Yes	2015/16	Councils	Carers
F. Specify in legislation that there should be a threshold of responsibility between prisons and local authorities for prisoners' care and support	Yes	2015/16	Councils	Prisoners with care needs
G. Amend social care regulations and charging guidance so that armed forces veterans injured in action no longer need to use their compensation payments to fund publicly arranged social care	No (amend existing regulations)	2012	Councils	Veterans using care and support

10. Table 2 below sets out how we estimate costs and benefits will be profiled over a ten year appraisal period. As set out above, Year 1 of implementation is assumed to be 2015/16 although this is subject to the passage of legislation through Parliament. The table does not include transitional costs for the development and testing of a new eligibility framework (£0.7m) and the transitional costs of armed forces compensation (£3.9m), both of which come into effect prior to 2015. It does not include transitional benefits that occur prior to 2015. These are transfer payments to fund user incentives in the development and testing of a new eligibility framework (<£0.03m) and the initial transfer payments to veterans (£3.9m).

Table 2: Summary of costs and benefits of proposals (£m)*
(Price base year: 2010/11)

Proposal	Agent	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total	Average annual
National eligibility minimum threshold – transition costs ¹	Councils	13.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	13.4	
National eligibility minimum threshold – recurring costs ¹	Councils	17.9	17.9	17.9	17.9	17.9	17.9	17.9	17.9	17.9	17.9	178.5	18
Portability – recurring costs	Councils	4.0	9.0	12.2	12.2	12.2	12.2	12.2	12.2	12.2	12.2	110.7	11
Support for carers – recurring costs	Councils	45.0	80.0	115.0	145.0	175.0	175.0	175.0	175.0	175.0	175.0	1435.0	144
Care and support in prisons – recurring costs	Councils	6.0	7.0	8.0	8.6	8.6	8.6	8.6	8.6	8.6	8.6	81.2	8
Armed forces compensation payments – recurring costs	Councils	2.3	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	25.7	3
Armed forces compensation payments – recurring savings	Users	2.3	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	25.7	3
Total													
Recurring Costs	Councils	88.5	116.5	155.7	186.3	216.3	216.3	216.3	216.3	216.3	216.3	1845	183
Costs (Discounted)	Councils	88.5	112.5	145.3	168.0	188.5	182.1	175.9	170.0	164.2	158.7	1554	
Recurring Savings	Users	2.3	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6	26	3
Savings (Discounted)	Users	2.3	2.5	2.4	2.3	2.3	2.2	2.1	2.0	2.0	1.9	22	
Net Cost (NPV)												1532	

* Not all benefits associated with these proposals are monetised; only direct cash savings are therefore included within this table. The table shows averages based on unrounded estimates of the costs and benefits of proposals.

¹ Costs shown for Proposal A to establish a national eligibility threshold are indicative, based on what the transition and recurring costs would be if the national minimum threshold was set at “substantial”.

Evidence Base (for summary sheets)

This section includes:

- I. Consideration of the problem
- II. Rationale for intervention
- III. Policy objectives and proposals
 - *Assessment, eligibility for care and support for users and carers and portability of care and support arrangements*
 - *Reforming legislation to provide better support to carers*
 - *Care and support in prisons*
- IV. Impact of policy proposals
- V. Risks
- VI. Specific impact tests

I. CONSIDERATION OF THE PROBLEM

Overview

11. The current system of assessment and eligibility can be confusing, unfair and unpopular with many carers and users. Local authorities currently assess users and carers and set their eligibility criteria using guidance issued by the Department of Health.⁴ Access to care and support varies across the country, with different authorities setting different thresholds for eligibility and broad variations in how these thresholds are interpreted. Individuals who have the same needs can be eligible for care and support in one part of the country but not eligible in another part.
12. This lack of consistency is one of the factors that act to prevent people moving between local authority areas (portability), potentially to take up or remain in work, or be closer to their family. Users and carers primarily find it difficult to move around the country because their care and support is often interrupted until the new local authority carries out an assessment and arranges access to new personal budgets.
13. The Carers Strategy highlighted the crucial role of carers and the importance of a fair and transparent offer to both users and carers.⁵ However, carers do not yet have the same entitlements to assessment and support as the people they care for.
14. Carers' legislation has been introduced as Private Members Bills on an ad hoc basis, reflecting the changing attitudes towards carers over the last 25 years. Under current law, local authorities only have a duty to undertake carers' assessments if certain conditions are satisfied. Moreover, local authorities currently have a power rather than an express duty to provide support to meet carers' needs identified through assessment. When exercising this power, local authorities can, but are not required to, apply an eligibility framework and criteria. There is a lack of consistency and transparency in relation to how local authorities decide whether and how carers receive support.
15. There is also a lack of clarity around the legislation regarding the responsibility for the assessment and provision of care and support in prisons. There is evidence that this has led to care needs not being assessed or identified, which increases the risk of litigation, and places pressure on both prison and healthcare resources. Poor planning and assessment of care needs can lead to individuals leaving prison and returning home with inadequate support, which can therefore increase the risk of re-offending.

⁴ Department of Health, *Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care*, 2010.

⁵ Department of Health, *Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own*, June 2008 and *Recognised, valued and supported: next steps for the Carers Strategy*, November 2010.

16. Members of the armed forces who are injured on active service receive compensation under the Armed Forces Compensation Scheme. There are two types of payments: Personal Injury Compensation (PIC) and Guaranteed Income Payments (GIPs). GIPs are intended to make up for loss of earnings. In the financial assessment for charging for state supported social care, the PIC is disregarded, provided it is placed in a PIC trust. However, only the first £10 per week of a GIP is disregarded, the rest is taken into account. The Government does not believe it is fair that armed forces veterans receiving publicly supported social care therefore have to use all but the first £10 per week of the Guaranteed Income Payments they receive, under the Armed Forces Compensation Scheme, to pay for their care.
17. The proposals discussed in this Impact Assessment are intended to support greater equality and consistency in access to assessment and provision of care and support. Other proposals set out in the White Paper also support this objective – for example the need to reduce variation in the quality of care and support, the availability of information and advice to users and carers and the extent to which support is personalised and integrated across health, social care and housing.⁶

Variation in people’s ability to access care and support

18. Currently, individuals and families who develop a care and support need approach their local authority to have an assessment of their needs. If their need is severe enough to meet the local authority’s eligibility threshold for access to care and support, and their means are determined as not sufficient to provide it for themselves (as defined by the financial means test), the local authority will provide them with care and support.
19. Although assessment and eligibility operate within a broad national framework, local authorities are able to set their own eligibility thresholds in response to local needs and circumstances, resulting in variation in the access to care and support across the country. The system can seem opaque and inconsistent – users and carers do not know from local authority to local authority whether they will be eligible for care and support. There is a lack of clarity around the interdependencies of the carers and community care legislation.
20. The Fair Access to Care Services (FACS) framework sets out eligibility criteria against which local authorities assess an individual’s need.⁷ Local authorities are able to choose where they set their eligibility threshold and therefore the level of need at which they will offer support. This results in variation in the levels of access to care and support offered, as demonstrated in Table 3 below:⁸

Table 3

FACS threshold for access to care and support	Number of local authorities setting their threshold at that criterion
Critical	3
Upper substantial	3
Substantial	120
Moderate (including upper moderate)	24
Low	2

21. Differences in thresholds applied by local authorities are compounded by considerable variation in the way that they interpret the eligibility criteria set out in the FACS guidance. A recent survey of care managers at different local authorities showed significant differences in their assessment of the eligibility of individual case studies. The study showed for example that a user deemed to have critical needs by a care manager in one local authority was thought to have no needs by a care manager in another local authority.⁹

⁶ The impact of such proposals is discussed in the corresponding Impact Assessments “Independence, choice and control” and “Quality, care providers and the workforce”.

⁷ The current assessment framework is commonly known as *Fair Access to Care Services*. It is formally published as *Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care* (Department of Health, 2010).

⁸ Based on a review of local authority published eligibility criteria in autumn 2011.

⁹ PSSRU, *Survey of Fair Access to Care Services (FACS) assessment criteria among local authorities in England*, 2012.

22. A 2008 review of eligibility criteria by the Commission for Social Care Inspection (now part of the Care Quality Commission) flagged as two of its top findings:¹⁰

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

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

23. In addition, it is difficult to know what a particular threshold means in practice – meaning therefore that a comparison of thresholds across the country is not useful. The Commission on Funding of Care and Support found that:¹¹

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

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

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

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

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

27. The 1998 Modernising Social Services White Paper set out as its aim for the new FACS guidance that “Eligibility criteria should inform users about what sorts of people with what kinds of need qualify for what types of service... There has to be a greater level of consistency and fairness in social care.”¹² The evidence cited above suggests that this aim has not been fully achieved.

28. In 2010, Government took the decision to prioritise funding for social care, making available an additional £7.2 billion over the four years of the Spending Review. However, despite the fact that this is estimated to provide enough funding for local authorities to maintain access to care and support at current levels, taking into account a program of efficiency, there is evidence to suggest that some local authorities are restricting eligibility for care and support. For example, a recent budget survey carried out by the Association of Directors of Adult Social Services (ADASS) suggested that 23% of the £1bn reduction in social care funding in 2011/12 was brought about by service reductions rather than efficiencies.¹³

Underlying causes of the problem

29. The lack of clarity and consistency in access to care and support is largely due to local areas having significant flexibility over eligibility and assessment. The FACS statutory guidance on setting eligibility

¹⁰ Commission for Social Care Inspection, *Cutting the cake fairly*, 2008.

¹¹ *Fairer Care Funding, The Report of the Commission on Funding of Care and Support*, 2011.

¹² Department of Health, *Modernising Social Services White Paper*, 1998.

¹³ Association of Directors of Adult Social Services, *ADASS Budget Survey*, 2011.

criteria and interpreting each threshold does not impose mandatory duties – this therefore results in local variation in the care and support people receive. Indeed, current legislation does not allow for mandatory duties.

30. Government is clear that some local variation is appropriate within a system that promotes local determination and personalised public services.
31. Individual and family circumstances should be taken into account by a local authority in determining the size of a care and support package. For instance, factors such as the care that may be provided by a carer, the accommodation an individual or family lives in, their specific needs and the outcomes they want to achieve, could contribute to variation in the size of a care and support package provided to individuals and families with similar needs.
32. Local discretion on other variables such as overall local authority funding, resource allocation and the configuration of local authority markets and services, as well as variation in local needs will also result in variations in care and support packages.
33. Finally, it needs to be recognised that within any framework for assessment and eligibility there will always be some differences in outcome given the element of subjectivity or professional judgement that is involved.
34. However, users and carers should be able to know whether they will be eligible for care and support and have a sense of the way in which their care and support needs will be assessed no matter where they live in the country. There is a clear distinction to be made between access to care and support where we believe there should be more national consistency in provision, and the size and type of care and support package received which is determined by local decisions and individual circumstance.
35. What has emerged is not the locally led system within a nationally consistent framework which was Government's intention, but rather a system with broad variation that can be opaque to users and carers. The view that Government needs to take action to address this was supported during the *Caring for our future* engagement.

Barriers to portability of care and support

36. The Government set out its intended policy with regard to portability in its *Vision for Adult Social Care* published in November 2010.¹⁴ It set out that:

“The system should support rather than hinder people’s goals. People who want to pursue educational or employment opportunities, for example, should be able to move from one part of the country to another without having to go through unnecessary multiple assessments and uncertainty. We want to see greater portability of assessments, and will consider how to pursue this in the light of the work of the Law Commission and the Commission on Funding of Care and Support.”
37. There are several barriers to portability in the current system. At present users and carers may face discontinuity of care and support when moving from one local authority area to another until they receive an assessment. Although we do not have a clear view on the numbers of people who do not move local authority area as a result of these barriers, stakeholders, in particular younger disabled adults, carers and their representative organisations, have been heavily critical of the current approach.
38. The lack of consistency of eligibility thresholds and the interpretations of those thresholds, the variance in care and support packages and charging arrangements also act as barriers to portability. Some of these differences are legitimate as part of a local system, such as the size of care and support package and will vary from local authority to local authority depending on local decision-making.

¹⁴ Department of Health, *A Vision for Adult Social Care*, 2010.

39. However, others, such as eligibility thresholds and in particular the current discontinuity of care and support, affect access and can therefore present significant barriers to freedom of movement that need to be addressed. Individuals and families should have greater certainty over their ability to access care and support across the country, to enable them to move more freely between areas.
40. There was very strong support for removing the discontinuity of care and support during the *Caring for our future* engagement. This supports the response to consultation by the Law Commission which found that:¹⁵

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

41. At present, the level of portability in the system depends on voluntary information exchanges and agreements between local authorities and so is variable across the country.

42. Radar summarise the problems well, setting out that:¹⁶

“Currently, disabled people face very severe and unnecessary barriers when moving from one local authority to another. That is because they cannot be certain that they will receive equivalent levels of care and support in a new locality.

Even where people are already getting care and support in one authority they will often be unable to start the process of sorting out arrangements in a new location until they have moved, and they then have to negotiate a new care package from scratch. For many disabled people effective and timely social care is the difference between independence and entrapment.”

Support for carers

43. Piecemeal legislation and guidance about carers' assessments has created a process that is confusing, prolonged and overly bureaucratic, both from the perspective of carers and those administering the process. The current processes tend to focus on supporting carers in their caring role and do not necessarily result in the provision of support to improve the health and wellbeing of carers and their quality of life.
44. Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes. These in turn can affect a carer's effectiveness and lead to the admission of the cared for person to hospital or residential care.
45. For example, the Carers, Employment and Services (CES) report by Carers UK and the University of Leeds 2007 found that only a minority (about a quarter) of carers believed they had adequate support from formal services – even though 42% were paying privately for these.¹⁷ Very few were getting carers' breaks or respite services and a large minority felt poorly informed about available support. Among 'new' carers in the CES study, 46% of full-time employees, and 62% of part-time employees felt they did not have adequate support to enable them to work.¹⁸
46. H. Arksey et al found that carers' opinions on the quality and adequacy of support provided by local authorities varied widely, even within the same local authority.¹⁹ Many carers (or care users) were unwilling to accept assistance from their local authority, and there was no evidence of a direct link between the number of hours that carers worked and the level of support received. They found that local authority support was generally not seen as essential to the ability of carers to undertake paid work, partly because it did not easily accommodate work patterns. Whilst local authorities could provide reasonably effective short-term solutions to help carers combine work and care, it was much harder to sustain this support in the longer-term. Services that carers felt would make it easier for

¹⁵ The Law Commission, *Adult Social Care Consultation Analysis*, 2011.

¹⁶ RADAR, *The Social Care and Portability Bill Information Briefing*, 2011.

¹⁷ Yeandle, S., Bennett, C., Buckner L., Fry, G. and Price, C., *Managing caring and employment*, University of Leeds for Carers UK, 2007.

¹⁸ Yeandle, S., Bennett, C., Buckner L., Fry, G. and Price, C., *Stages and transitions in the experience of caring*, University of Leeds for Carers UK, 2007.

¹⁹ Arksey, H. et al, *Carers' aspirations and decisions around work and retirement*, Department for Work and Pensions, Research Report 290, 2005.

them to work and care included childcare for disabled children, longer day centre hours, and practical help with domestic chores.

47. It is therefore important that care and support legislation supports families and carers to access timely information and advice and early interventions to enable them to care for as long as they wish and are able to and to have a life of their own alongside caring. The White Paper proposals for better access to quality information and advice (discussed in the corresponding Impact Assessment “Independence, choice and control”) will support carers as well as users in this objective.
48. However, as set out above, there are still legislative barriers that can prevent carers from accessing assessment and support, which need to be addressed. Under current legislation, local authorities only have a duty to undertake carers’ assessments if certain conditions are satisfied and only have a power not a duty to provide support to meet carers’ needs identified through assessment. Carers therefore do not yet have the same entitlements to assessment and support as the people they care for. This Impact Assessment therefore considers the impact of proposals within the White Paper *Caring for our future* to address these legislative barriers.

Care and support in prisons

49. At present, a lack of clarity in legislation means that the majority of local authorities do not consider they have a responsibility for the provision of care and support to people in prison. Evidence suggests that uncertainty about responsibilities for assessment and provision with regards to prisoners means that care needs are often not assessed, identified or provided for, both in prison and possibly on return to the community.^{20 21 22} If care needs are identified by the prison, they are unlikely to be met by a local authority.
50. A Prison Governors Association survey, for example, found that 40% of respondents said prisoners themselves provided social care in their prison. Half of prison governors said care was provided by prison staff who were not part of healthcare services, while just 4% said local authorities provided staff to provide social care.
51. Some prisoners may have had care needs before they entered prison. Provision can sometimes be discontinued once an individual enters a prison setting, which may impair rehabilitation and consequently increase the risk of re-offending upon release.
52. Some prisoners may develop needs after they enter prison. As for individuals within the community, local authority specialist expertise should be available to undertake assessment and facilitate the provision of care in order to minimise disability, support rehabilitation and ensure satisfactory supported return to the community or transfer, if appropriate, to a residential or nursing home.
53. There has been recent criticism of the quality of social care provision in prisons from such bodies as Her Majesty’s Chief Inspector of Prisons²³, the Prison Probation Ombudsman prison Independent Monitoring Boards in their annual report to the Secretary of State for Justice, coroners and prisoner advocacy organisations such as the Prison Reform Trust.²⁴
54. There are considerable risks resulting from the current lack of legal clarity regarding social care provision in prisons:
- Care needs may not be assessed, identified or provided for, which can have negative effects on health and wellbeing outcomes for individuals.

²⁰ The Law Commission, *Adult Social Care*, May 2011.

²¹ Her Majesty’s Chief Inspectorate of Prisons, *Old and Quiet*, 2004.

²² Her Majesty’s Chief Inspectorate of Prisons, *Older prisoners in England and Wales: a follow-up to the 2004 thematic review by HM Chief Inspector of Prisons*, 2008.

²³ Her Majesty’s Chief Inspectorate of Prisons, *Old and Quiet*, 2004 and *Older prisoners in England and Wales: a follow-up to the 2004 thematic review by HM Chief Inspector of Prisons*, 2008.

²⁴ Prison Reform Trust Press briefings, December 2010.

- If prisoners' needs are unmet or inadequately catered for, there is a risk of litigation. Prisoners who have not had their needs appropriately assessed, or been provided with the appropriate aids and adaptations, and or for whom the prison failed to make reasonable physical and regime adjustments have successfully sued the Ministry of Justice for lack of care and there are currently several ongoing cases (see Annex A for examples)
 - Similarly, there is a risk that litigation may be initiated by prison officers or other prisoners who undertake care and support activities for which they are inadequately trained.²⁵
 - In the absence of social care provision in prison, some prison *healthcare* providers give personal care.^{26 27} As this should not ordinarily be a healthcare responsibility, this can be a source of local conflict. Moreover, it represents an inappropriate use of healthcare resource.
 - Lack of portability for care within the prison system can hamper a prisoner's rehabilitation. A prisoner's journey throughout the prison system is guided in part by their sentence plan, which addresses their offending behaviour. The lack of clarity regarding responsibilities for social care can be a barrier when attempting to transfer a prisoner to another prison. The receiving prison may claim it is unable to meet this prisoner's needs because the local authority in whose area the prison is situated does not perceive the prisoner's care to be their responsibility. Consequently, some prisoners do not progress satisfactorily through the prison estate as required by their sentence plan. This can increase the length of time spent in prison, increase the risk of re-offending and place an additional burden on criminal justice system resources.
 - In some instances, unmet care and support needs may be manifested by poor or disruptive behaviour that can affect other prisoners and compromise control and order in the prison.
55. In contrast, responsibilities for healthcare are clearly defined. In 2000, the Department of Health became responsible for prison healthcare, initially on a shared basis with HM Prison Service. Financial responsibility transferred to the Department of Health in 2003. Responsibility for prison healthcare now lies with the NHS and operates on the principle of equivalence. This means that prisoners are entitled to the same standard of healthcare in prison as they would expect in the community. Similarly clarifying the position regarding social care would enable this principle of equivalence to be extended, would promote consistency and equality and enable health and social care to be aligned, as they are in the wider community.

Care and support for armed forces veterans

56. Members of the armed forces are called upon to make a unique contribution to the safety of the nation, in some cases involving the ultimate sacrifice. The Government believes that this should be reflected in the support they receive from the state.
57. Armed forces veterans receiving publicly supported care and support have to use all but the first £10 per week of the Guaranteed Income Payments they receive, under the Armed Forces Compensation Scheme, to pay for their care. The Government believes these payments should be disregarded in recognition of the exceptional contribution they make. This requires an amendment to the regulations and guidance setting out how local authorities should assess a person's ability to pay for their care.

II. RATIONALE FOR INTERVENTION

58. Local authorities are responsible for the assessment of need, determination of eligibility and provision of care and support to meet eligible needs. It is the Government's view that local authorities should be able to exercise flexibility in the way in which they meet the needs of their local populations, according to local circumstance. However, evidence suggests that there is currently an unacceptable

²⁵ Her Majesty's Chief Inspectorate of Prisons, *Old and Quiet*, 2004

²⁶ Her Majesty's Chief Inspectorate of Prisons, *Older prisoners in England and Wales: a follow-up to the 2004 thematic review by HM Chief Inspector of Prisons*, 2008.

²⁷ Mottram, P.G., *HMP Liverpool, Styal and Hindley Study Report*, University of Liverpool, 2007.

level of variation in access to care and support affecting care users, those with caring responsibilities and offenders with care needs. This is largely a result of variability in local interpretation of national legislation and guidance. Repeated attempts to bring more national consistency to the system have not had the desired effect.

59. Government intervention is therefore required to support greater equality and consistency of access to assessment and provision of support. Without reform through primary legislation, the level of variation will not be reduced and these aims will not be met.
60. A recent report on assessment and eligibility by the Social Care Institute of Excellence (SCIE) set out that:²⁸

“It is clear that despite the best intentions of revised guidance and continuing attempts to improve practice, the experience and consequences of assessment and eligibility determination are often unsatisfactory.”

61. The Commission on Funding of Care and Support recommended that Government take action in this area and that in the longer term the future system should have a new, more objective assessment scale, with a simplified and clearer process. Until this is designed and implemented, the Commission recommended that the current eligibility threshold should, as a minimum, be set at substantial. The Commission felt that such changes would benefit both people with care needs and carers.
62. Reforming the law to create a clear single statute around assessment and eligibility (as recommended by the Law Commission) also provides an opportunity to look again at how these policies interact with the rest of the system, and to ensure that going forward they are designed in such a way to support greater personalisation and self-directed support for care users, families and carers.
63. There are currently few incentives to ensure that a local authority provides continuity of care and support if an individual or family moves into their area, or even that they re-assess them promptly to ensure that any discontinuation of care and support is short. In practice, the cost of providing services to new users and carers moving into their local area may act as a disincentive to promptly putting in place a care and support package and there is anecdotal evidence from stakeholders that this may be the case.
64. The Government believes that only through national action to give local authorities a legal duty to ensure continuity of care will the barriers to portability be broken down. Such national action was recommended by both the Law Commission and the Commission on Funding of Care and Support. A duty and additional funding for local authorities to ensure continuity of care will incentivise prompt re-assessment. This is because a local authority would be responsible for providing an equivalent package of care and support based on the previous local authority’s assessment until it carried out its own assessment of the needs of the user, and if appropriate the carer, who had moved into their area.
65. To bring about better outcomes for people with caring responsibilities, Government intervention is required to overcome current organisational and cultural barriers that prevent carers from accessing assessments, advice and support. A change to the law is required to remove current legislative barriers that can prevent carers from accessing assessment and support they need. Intervention to improve the legal framework for assessment and support for carers would also help reduce variation and put carers on a level footing with care users. This will support equality and improve health and quality of outcomes for carers, including support to remain in employment, remain involved in their communities and have a life outside of caring.
66. A lack of clarity in the legal framework means that the majority of people in prison with significant care needs do not receive an assessment and consequently their care needs can go unmet. This poses risks to health and wellbeing, risks of litigation and can lead to inefficient use of resources. The current variation in practice suggests that these barriers will not be overcome at local level unless the

²⁸ SCIE, *Crossing the threshold: the implications of the Dilnot Commission and Law Commission reports for eligibility and assessment in care and support*, 2012.

Government intervenes to provide legal clarity on the responsibilities between prison and local authorities.

67. The Government believes that Guaranteed Income Payments (GIPs) received under the Armed Forces Compensation Scheme should be disregarded in the financial assessment for care costs in recognition of the exceptional contribution they make. Government intervention is required to effect an amendment to the regulations and guidance to local authorities setting out how they should assess a person’s ability to pay for their care.

III. POLICY PROPOSALS AND OBJECTIVES

68. The overarching policy objective is to bring about greater clarity, consistency and equality of access to care and support both for people using care and support and for people with caring responsibilities. To achieve this objective, the Government has set out a number of proposals in the White Paper, some of which will be taken forward in legislation, as listed below. Although these proposals have been listed under relevant objectives, the overall package of proposals should be seen as interdependent and mutually reinforcing in respect of all these objectives.

Policy Theme	Objectives	Policy Proposals
Assessment, eligibility and portability	<ul style="list-style-type: none"> • Create a more nationally consistent system for assessment and eligibility for users and carers which is understandable, transparent and outcome-focused, supports personalisation and prevention and continues to allow local authorities flexibility to reflect individual, family and local circumstance; • Provide freedom of movement and continuity of care to users and carers who move from one local authority area to another. 	<p>A. Establish a national minimum threshold for eligibility for care and support;</p> <p>B. Place a duty on local authorities to provide an equivalent package of care and support for users and their carers who move into their areas until they undertake a new assessment;</p> <p>C. Develop and then test proposals for a new assessment and eligibility framework for both users and carers working with local government and the sector.</p>
Reforming legislation to provide better support for carers	<ul style="list-style-type: none"> • Ensure carers have the same rights as users with regard to access to assessments and support. 	<p>D. Simplify the legislation in respect of carers’ assessments;</p> <p>E. Introduce a new duty on local authorities to meet eligible needs for support.</p>
Care and support in prisons	<ul style="list-style-type: none"> • Provide better access to assessment and provision of care for people with care needs in prison, improving their health and wellbeing, reducing unmet need and the risk of litigation and supporting better use of public resource in meeting those needs. 	<p>F. Specify in legislation that there should be a threshold of responsibility between prisons and local authorities for prisoners’ care and support.</p>
Care and support for veterans	<ul style="list-style-type: none"> • Recognise the unique contribution of veterans by exempting the compensation payments of those injured in service from social care charging. 	<p>G. Amend regulations and guidance to local authorities on the treatment of GIPs in the assessment of a person’s ability to pay for their care.</p>

IV. IMPACT OF POLICY PROPOSALS

69. The impact of implementing this package of policy proposals is discussed in further detail below. Each group of policy proposals is assessed against the baseline “do nothing” option.
70. A central theme of these proposals is that they extend equality between users and carers living in different areas, between users and carers, and for those who wish to move area or are in prison. There will be a welfare gain for users and carers who gain access to services as a result.

Assessment, Eligibility and Portability Proposals

Objectives:

- Create a more nationally consistent system for assessment and eligibility for users and carers which is understandable, transparent and outcome-focused, supporting personalisation and prevention and continuing to allow local authorities flexibility to reflect individual, family and local circumstance;
- Provide freedom of movement, continuity of care and positive experience of transition to users and carers who move from one local authority area to another.

Option 1: do nothing

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

Option 2: implement the following proposals:

- A. Establish a national minimum threshold for eligibility for care and support;
- B. Place a duty on local authorities to provide an equivalent package of care and support for users and their carers who move into their areas until they undertake new assessments;
- C. Develop and test proposals for a new assessment and eligibility framework for both users and carers working with local government and the sector.

Proposal A: Establish a national threshold for eligibility for care and support

72. Government will take forward the recommendations of the Law Commission to consolidate and simplify the fragmented legislation around assessment and eligibility and issue revised statutory guidance to reflect these changes. (The overall impact of legislative clarification and consolidation is discussed in the corresponding Impact Assessment on reform of the social care legislation.)
73. Under this option, from 2015 Government would also set a national minimum eligibility threshold. This would require new primary legislation with a corresponding impact on local authorities. The Government would take a power in the Care and Support Bill to set mandatory eligibility criteria to which local authorities would have to adhere.
74. This would ensure that local authorities could not restrict their eligibility for care and support beyond the level set nationally and would bring greater consistency in access to care and support. Councils could choose to be more generous than the national threshold if they wished and would retain control over how they interpreted the threshold, overall budget setting, the size of individual care and support packages and the configuration of local services.

Costs

75. Government has not yet set the level of the national threshold. For indicative costing purposes, we have costed a scenario where the threshold is set at substantial under the current framework. Different thresholds will incur different costs. As the White Paper sets out, in setting the level of the

national threshold, Government will need to review the eligibility position of local authorities, and take into account work to develop options for a potential new assessment eligibility framework and the resources available.

76. In estimating these indicative costs we looked at the six local authorities who currently have eligibility thresholds for users above substantial (3 at critical and 3 at upper substantial). We compared data on the six local authorities with thresholds above substantial with data on the rest of the country, but found no pattern in the number of clients supported by local authorities with tighter eligibility or the cost per capita of providing care and support. This highlights the opacity in terms of how eligibility criteria are interpreted and used by different local authorities.
77. Our cost estimates are based on data from a local authority that has recently changed eligibility thresholds. This move, from substantial to critical, released savings of approximately 2% of its annual budget. If we assume that moving the other way from critical or upper substantial to substantial would increase the costs of the six local authorities in question by 2-5%, then the costs from this change would range between £10 million to £25 million per annum. These costs arise from increasing access to care and the costs of the additional care provided.
78. Costs in relation to this proposal also arise from the re-assessment of current care users in those six local authorities to ensure that their needs under the new threshold are being met as well as their previous needs. Provisional RAP data shows that in 2010/11, there were 54,100 users being supported in these councils. Applying demographic pressures, taken from the PSSRU aggregate model, we assume there will be a 1.6% increase in users to 55,000 in 2015/16. We assume that an in-depth re-assessment of users would be similar to a full assessment, and so would cost £250 more than current re-assessment (see paragraph 102 below). We therefore estimate that the one-off cost of introducing a minimum eligibility threshold would be £15 million.
79. However, we would expect that a significant proportion of state-funded users in residential care might not need a re-assessment when the eligibility threshold changes, given their care packages are unlikely to change. If no one in residential care receives an additional re-assessment, the cost to the six local authorities would be £10 million. We therefore put forward a range of £10 -15 million for the cost of re-assessment as a result of moving the eligibility criteria in the six authorities in question.
80. These costs do not include the costs of moving the eligibility threshold for carers because local authorities currently do not have a duty to offer services to carers. The costs of Proposal E to introduce a new duty on local authorities to provide support to carers is analysed in more detail below.
81. There may also be some small costs from re-training staff so that they can consider new aspects of need and create new care and support packages that take account of needs under the new threshold. These are estimated at under £1 million for the six councils involved. To estimate the cost, we assume that the training required would take two days and would cost approximately £600 per person, including the cost of providing cover for staff while they are training. This is based on information provided by local authorities. We also assume that the number of social workers in these councils is around 3% of the England total, as estimated by Skills for Care. This is the same as the proportion of social care recipients in these councils relative to the England total.

Benefits

82. Proposal A would help set out a national minimum offer for access to care and support across the country, which should simplify the system and act to reduce some of the unacceptable variation in access to care and support.
83. Further, it should support portability as users and carers will have greater certainty that they will still receive care and support should they move to a different local authority from their own, as all councils would offer care and support at a national threshold.
84. There would also be benefits in the form of improvements to wellbeing to individuals and their families from the additional expenditure on provision of care and support with potential small savings to the NHS from this new social care expenditure.

85. However, without additional intervention, councils would still be able to interpret the threshold in a subjective way and individuals and families would still face potential discontinuity of care and support when moving to another local authority area. We therefore propose that in addition to Proposal A, we also take forward Proposals B and C, as discussed below.

Proposal B: Place a duty on local authorities to provide an equivalent package of care and support for users and their carers who move into their areas until they undertake a new assessment

86. Taken forward in addition to Proposal A, Proposal B ensures that users and carers do not face discontinuity of access to care and support when they move local authority area and before they are re-assessed by the receiving authority. This proposal requires new legislation with a consequential impact on local authorities.

87. Under the provisions of the draft Care and Support Bill, a duty would be placed on local authorities setting out that they must provide an equivalent package of care and support for users and carers (where they are continuing to care for a user who is also moving) who move into their area until they are able to re-assess them and potentially provide a revised care and support package. This duty would be defined in guidance but in essence would equate to ensuring that a user, and if appropriate the carer, is able to achieve the same outcomes as they had done under their previous local authority, even though the package of care and support they receive from the new local authority may be different. The draft Care and Support Bill also sets out new duties on the local authorities involved to share information to encourage a smoother transition between local authorities.

Costs

88. There would be costs associated with Proposal B both from providing care and support where there may have otherwise been discontinuity and also from additional assessments for users and carers who move local authority area as a result of this proposal.

89. There is very little data available for how many users and carers are prevented from moving local authority area as a result of the barriers to portability. We consequently use ONS migration data as the basis of our estimates, supposing that in the future, users and carers want to and would move with the same propensity as the wider population. We recognise that it may be unlikely that, given their circumstances, they will move as frequently as the rest of the population but it is important that this is catered for and we do not contravene the rights of users and carers to move by not making sufficient funding available for this proposal.

90. We also make assumptions, and vary these, on the split between:

- the proportion of the population that would have moved anyway, regardless of this change; and
- the proportion of the population that would now move as a result of the increased certainty of care and support.

91. We use an assessment cost of £450, which reflects the potential need for a full community care assessment as an individual's circumstances will change when they move local authority area. Assuming that the vast majority of users who move would receive domiciliary rather than residential care, we assume an average weekly domiciliary care cost of £192 a week (12 hours per week at £16 per hour). Finally, we also make assumptions about the current discontinuity of care in the current system, using a higher and lower estimate. We perform a range of calculations using different variants on assumptions to produce an annual cost estimate of between £10 million and £15 million. We assume that this range would cover the costs of removing barriers to continuity of care for both users and carers.

92. However, it may take some time for individuals and families receiving care and support to move towards a level of migration that is similar to that of the general population, given the significant change in policy that is being introduced. Therefore, we assume that not until the third year after implementation will the full costs be potentially incurred, increasing by a third over the intervening years.

Benefits

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

Proposal C: Develop and test proposals for a new assessment and eligibility framework for both users and carers working with local government and the sector

95. As set out above, implementing Proposals A and B would bring considerable benefits, but implemented on their own would still leave potential for variations in access to care and support across the country. Legislative reforms provide an opportunity to review the assessment and eligibility framework in the round, as well as addressing the immediate problems of reductions in access to care and support and people being unable to move between local authority areas.
96. Therefore Proposal C builds on Proposals A and B above by also committing to undertake work to develop and test options for a new objective assessment and eligibility framework, looking at how it affects users, carers and professionals. This would involve working with local government, voluntary organisations, academics and users and carers themselves to develop and test proposals for a new assessment and eligibility framework to understand the costs and benefits of each proposal and enable Government to make a decision about the most effective approach.
97. The proposal to develop and test options for a new assessment and eligibility framework does not in itself require any new statutory measures. However, should this lead to Government taking a decision to implement a new framework, this would require changes to legislation affecting local authorities who would be required to adhere to the new framework.
98. Assessment and eligibility is one part of a complex care and support system that will be undergoing significant change as a result of the measures set out in the White Paper. It will take time to understand the interactions between policies on assessment and eligibility and reform in other areas. Therefore, Government is proposing to undertake development work in the first instance before committing to any specific reform in this area. A recent report for SCIE describes the issue well:²⁹

“The issue of eligibility cannot be considered in isolation. Paying disproportionate attention to the threshold issue can overlook the importance of the wider context within which eligibility operates. Thus in addition to support which is targeted on a particular part of the population (i.e. the eligible population) social care needs to be located within a wider system approach for prevention, reablement and universal services (including information and advice).”

99. Work to redesign the assessment and eligibility framework will also enable an examination, from first principles, of the current spending on these processes in the system, which Personal Social Services Expenditure data shows are around £2 billion per year. The Government’s intention would be for any new framework to be cheaper and more efficient than the current system. The recent SCIE report sets out that:³⁰

“The current assessment process is seen by many to have become unnecessarily complex and to pay little regard to the principles of co-production, or to give scope for self-assessment.”

²⁹ *Ibid.*

³⁰ *Ibid.*

Costs

100. There is a cost associated with development and testing work of £0.7 million. Costs of developing the framework will be relatively low, with the majority of the work being undertaken in-house using panels of experts to guide the process. There will potentially be some very small travel and subsistence costs for those experts - this will depend on the nature of their association with the work and the policies of their present employer. Given the uncertainty and small amounts involved, these costs are not quantified at this stage.
101. Costs of testing would arise from additional assessments for individuals who will need to be assessed under the current and proposed new system. It may be necessary to incentivise participants to take part in this development work with a small cash voucher. This would represent a small transfer of funding from the Department of Health to individuals.
102. Given these new assessments will be full community care assessments, we use a central estimate of £450 for each assessment. This is a central estimate for the cost of an assessment, and is based on discussions with local authorities about the processes and time involved in carrying out different types of assessments. Testing the framework on 400 participants would therefore cost £180,000, whereas testing it on 1,000 participants would be £450,000. This provides the range for the costs of testing the framework. The figures are based on testing the same proportion of the client population as in previous similar exercises (the lower bound) or testing the same number of people in absolute terms.
103. In addition, previous examples of such work have seen high dropout rates and incentives were used to mitigate this. In previous work, cash vouchers of £30 have been provided to participants and using the range above, this adds to the costs an additional transfer from government to individuals of £12,000 to £30,000.
104. To test a new assessment and eligibility framework, social workers would require training to use the new tool. Skills for Care (2010) estimate that there are approximately 23,000 social workers providing services to adults in England. Referrals, Assessment and Package data suggests that social workers assess and review the care and support needs of almost 2 million users per year.
105. This implies that, on average, one social worker can carry out approximately 85 assessments and reviews each year. Therefore, we estimate that no more than 30 social workers would be required to perform 1,000 assessments under the new framework over a six month period.
106. Based on information from local authorities, we suggest the training required would take two days and would cost approximately £600 per person. Assuming that each session is attended by 10 social workers, we estimate that the training required for the pilot phase would cost around £20,000. This includes the potential cost to local authorities from having to employ temporary cover, as their social workers would not be able to perform their routine tasks whilst being trained, which is based on PSSRU unit costs.
107. Finally, as part of developing a new assessment and eligibility framework, it may be useful to test new IT systems that could be used across local authorities to aid with data capture and sharing. Given the uncertainty of how this may develop, it is difficult to quantify these potential costs – we assume an initial estimate of £200,000.
108. In sum, the total potential costs for developing and testing a new assessment and eligibility framework are estimated at an upper bound of £700,000.
109. We will publish a further Impact Assessment when coming to a decision about whether and how to implement any framework.

Summary of costs of Option 2 (Implement Proposals A, B and C)

110. The total indicative costs associated with Option 2 (Proposals A, B and C) are set out in table 4 below:

Table 4:

Proposal	Cost	One-off/ongoing
A new assessment and eligibility framework – development and testing costs	£0.7m	One-off
Interim measure of a national minimum eligibility threshold – indicative re-training staff and re-assessment costs if the national minimum threshold were set at “substantial”	£11m-£16m	One-off
Interim measure of a national minimum eligibility threshold - indicative costs of moving councils to the new threshold if it were to be set at “substantial”	£10m-£25m	Ongoing
Portability – new assessments and providing equivalent care and support packages in the interim	£10m-£15m	Ongoing

Summary

111. Given the complexities involved and the uncertainty as to what the most appropriate policy solution might be, it is right that Government does not commit to implementing a new system at this stage. The Government is committed to working with the sector and stakeholder groups to look at how a new assessment and eligibility framework, if implemented, could be made to work for everyone. This closely follows the recommendation of the Commission on Funding of Care and Support:³¹

“We believe that [a new assessment scale] should be taken forward quickly. However, it is not obvious to us what this scale should be (and a suitable scale may not yet exist). Given this, we think the Government should urgently review the social care assessment scale, working with local government and third-sector organisations representing users and carers and drawing on academic research and international experience, with a view to moving towards a more objective scale that gives more clarity to users and fairer and more consistent outcomes.”

Summary of Option 2 (Proposals A, B and C)

112. Together these measures will act to clarify the state offer, create a more nationally consistent system for access to care and support and facilitate freedom of movement between local authority areas.

113. Legislation will be required to take the power to set a mandatory national eligibility threshold and to place a duty on local authorities to ensure that there is no discontinuity in care and support for people who move areas. In terms of welfare gain, these proposals will widen access to care and support and reduce the uncertainty facing new users and carers, and those already receiving care and support who wish to move area.

114. Reducing the variation in access to care and support across England will help correct the unfairness in the system that results from where a person lives. Users and carers will benefit directly from these proposals. They will create a clearer system where the processes and outcomes are more transparent for all involved, which in turn will support users and carers and potential users and carers in planning and preparing for their care and support needs.

³¹ Fairer Care Funding, Analysis and evidence supporting the recommendations of the Commission on Funding of Care and Support, 2011.

115. Further, ensuring that people do not face discontinuities of care and support when moving local authority will provide users and carers with the ability to move without being unduly hindered by the care and support system. It supports the basic human right of freedom of movement and may result in people moving to take up or remain in employment, be closer to family and friends or simply to improve their standard of living, all of which have benefits to individual and families as well as potentially to the state.

Reforming the legislation to provide better support for carers

Objective:

Ensure carers have the same rights as users with regard to access to assessments and support.

Option 1: Do nothing

116. Other commitments set out in the Carers Strategy would still be taken forward but the inadequacies of the current legal framework would present barriers to their complete success. Existing legislation would be retained both in terms of carers' assessments and provision of support.

117. Local authorities would continue to have a duty to inform carers of their right to request an assessment, where the local authority believes the carer may be entitled to an assessment under either the Carers (Recognition and Services) Act 1995 or the Carers and Disabled Children Act 2000. Currently only carers providing a substantial amount of care on a regular basis would be entitled to a carer's assessment (2000 Act) and a carer's assessment could only be undertaken if requested by a carer (1995 Act).

118. Assessments would continue to take into consideration the carer's ability to provide and to continue to provide care for the person cared for. They would also continue to take account of whether the carer works or wishes to work or is undertaking or wishes to undertake education, training or any leisure activity. (Carers (Equal Opportunities Act) 2004).

119. Local authorities would continue to have regard to the ability of carers to continue to provide substantial care on a regular basis when assessing whether a disabled person's needs call for the provision of services (Disabled Person (Services, Consultation and Representation) Act 1986). They would also continue to take into account the results of a carer's assessment in making a decision about whether the cared for person's needs call for the provision of services (1995 Act).

120. Anyone providing care by virtue of a contract or as a volunteer with a voluntary organisation would continue to be excluded from the definition of a carer and thus eligibility for a carer's assessment (1995 and 2000 Acts).

121. Local authorities would continue to have a power to provide services to carers. They could, but would not be required to, apply an eligibility framework and criteria.

Option 2: Implement the following proposals

D. Simplify the legislation in respect of carers' assessments;

E. Introduce a new duty on local authorities to meet eligible needs for support.

Proposal D: Simplify the legislation in respect of carers' assessments in line with the Law Commission recommendations

122. This option will entail a number of changes to be effected through legislation with a consequential impact on local government. These changes are firstly listed and then expanded on below:

- Consolidation of the fragmented legal framework that currently exists in relation to carers' assessments;

- Removal of the current restriction that carers' assessments are limited to those carers who provide a substantial amount of care on a regular basis;
 - Assessment to be triggered where a carer appears to have, or will have upon commencing the caring role, needs that could be met either by the provision of carers' support or by the provision of support to the cared-for person;
 - Local authorities to have discretion to assess a carer who receives payment for some of the care they provide or is a volunteer worker, where the local authority believes the relationship is not principally a commercial or ordinary volunteering one;
 - Requirement on local authorities to apply eligibility criteria to carers in a similar way to care users and to meet the eligible needs of carers;
 - Regulations to:
 - prescribe the process for carers' assessments, encouraging a unified approach to care users' assessments and carers' assessments and taking into account carers' wishes in relation to leisure, training and work activities;
 - give local authorities the scope, where appropriate, to carry out an assessment in conjunction with other bodies to be more holistic and cover health and wellbeing;
 - require local authorities to have regard to the family's needs in a holistic way when undertaking a community care assessment or carer's assessment and in determining whether to provide care and support;
 - enable local authorities to tailor assessments so that they are proportionate to the needs of carers.
- i. *Consolidation of the various duties about carer's assessment into a single duty.*
123. This would help to make a carer's entitlements much easier to understand. The overwhelming majority of responses to the Law Commission's consultation agreed that it makes sense to have a single duty.
- ii. *Removal of the 'substantial and regular' test.*
124. This would improve clarity and consistency of approach to assessment, remove the possibility of excluding some carers who care for people with unpredictable and fluctuating needs (for example those with mental health problems) and reduce complexity. This would also enable the assessor to focus on the impact of caring on an individual carer - for example 10 hours caring for someone with challenging behaviour may be far more emotionally and physically demanding than 20 hours caring for someone who is appreciative of all the support they are given. A large majority of Law Commission consultation responses agreed the test should be removed.
- iii. *Removal of the requirement that a carer must request an assessment before the duty to undertake an assessment is triggered. Instead the trigger for an assessment would be where it appears to the local authority that the carer may have, or will have, needs that can be met by the provision of support to the carer or the person they care for. Effectively this represents a direct offer of an assessment based upon the appearance of need.*
125. Again, this would simplify the process for both carers and local authorities, support a proportionate response and help local authorities to offer assessments to people who did not readily identify themselves as carers, despite carrying out significant caring responsibilities. The majority of responses to the Law Commission consultation agreed the request mechanism should be removed.
- iv. *Requirement that a carer's assessment considers the person's ability and willingness to provide and continue to provide care and whether the carer works or wishes to work or is undertaking or wishes to undertake education, training or any leisure activity.*

126. This would consolidate existing requirements from different Acts and guidance. It would help to ensure that due consideration is given to supporting carers to have a life of their own alongside caring as well as how they are coping with the caring role. In particular, it would help to ensure that consideration is given to supporting carers to remain in or return to work.
- v. *Local authority discretion to assess a carer who receives payment for care they provide or who is a volunteer worker.*
127. This would enable local authorities to offer a carer's assessment to a carer who is paid for some of the care they provide or to a volunteer worker, when the authority believes the relationship is not principally commercial or volunteering. This proposal received a mixed response in the Law Commission consultation including concerns that this might erode the distinction between a carer and a paid employee and have resource implications. Making this a power rather than a duty would enable local authorities to decide whether to offer an assessment when the caring relationship appears not to be principally a commercial or volunteering arrangement and to control resource implications. It is not envisaged that this power would be used extensively and resource implications would therefore be minimal.
- vi. *Requirement through regulations that local authorities should take into account the results of the assessment of the person cared for in determining whether to provide support to the carer.*
128. This would support a more unified approach to carers' and users' assessments, which is likely to support better coordination and joint planning, while still enabling carers to be separately assessed from the person they care for if they so wished. The regulations would also allow for the Secretary of State, if he so wished, to require local authorities to have regard to the family's needs as a whole when undertaking either a user's or carer's assessment. Neither of these proposals is likely to have cost implications.

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

129. In addition to the measures outlined under Proposal D, this would entail a new requirement on local authorities to determine whether a carer's needs are eligible needs using eligibility criteria and arrange for support to meet the eligible needs. This would require new legislation – the Care and Support Bill would place a new requirement on local authorities and remove the current ambiguity about how decisions are made regarding the provision of support to carers.
130. Local authorities are already required in law to provide support to some carers under existing community care legislation, for example, when a critical risk to the sustainability of the caring role is identified. Many authorities already use an eligibility framework in determining and providing support to carers. The resource implications of bringing the practice of all authorities up to this standard by the imposition of a new duty are considered below. Eligible needs for the carer could be met through support to the person cared for as well as support to the carer. The need to ensure that eligibility criteria for both users and carers are compatible will be a key feature during the development and testing of a new framework (Proposal C above).

Costs and benefits of Option 2 (Implement Proposals D and E)

Costs of Proposal D (Simplify the legislation in respect of carers' assessments)

131. We have aimed to identify the potential increase in demand for carer assessments following law reform by looking at the current pattern of assessments in local authorities, using two approaches.
132. We consulted ADASS carers leads who provided different views about whether the proposed legal changes would result in increased numbers of carer assessments. We therefore examined the ratio of the number of carers receiving assessments in relation to the overall number of service users (not just carers) in each local authority and estimated the potential additional demand if authorities were to increase the proportion of assessments to the level of, for example, the 90th percentile. We also examined an increase in assessments for carers currently not receiving assessments but "known by association" to local authorities.

133. The unit cost of a carer’s assessment is estimated to be approximately £100, from data gathered by Surrey County Council. (Costs were estimated between £90 and £120 - those at the higher end being conducted by a qualified social worker.)
134. Activity data (RAP) showed that in the 152 upper tier local authorities, the ratio of carers’ assessments to the overall number of service users ranged from a minimum of 6.9% to a maximum of 69.4%. The median was 25.0% and the 90th percentile was 39.3%.³²
135. Our analysis looked at how many additional assessments would be required if those authorities with a proportion lower than the 90th percentile were to increase their proportion of assessments to this level. The analysis showed that the number of assessments would need to rise by 50% to enable all councils to reach the 90th percentile, and the additional cost would be in the region of £23 million.
136. An alternative approach is to use data from the PSSRU survey of adult carers 2009/10. Analysis of the survey data from those councils that included data on carers “known by association”, showed that 35% of carers did not receive an assessment.³³ This equates to approximately 250,000 carers - providing them with an assessment would represent a 54% increase in assessments and cost approximately £25 million.
137. Table 5 below summarises the additional assessment costs estimated using the two approaches:

Table 5:

	Matching the 90th percentile	Carers ‘known by association’
Extra assessments	230,000	250,000
% increase	50%	54%
Assessment cost	£23 million	£25 million

Costs of Proposal E (Introduce a new duty on local authorities to meet eligible needs for support)

138. RAP data shows there were over 400,000 carer assessments conducted in 2010/11. Approximately 380,000 carers received services, of whom 189,000 received ‘carer specific’ services. Our analysis estimates the increase in demand for these support services, arising from the increased demand for assessments discussed above. We also examined the ratio of number of users of services for carers compared to the number of carers’ assessments in each authority and estimated additional demand if authorities were to increase their ratio of users of services for carers to carers’ assessments to the level of the 90th percentile.
139. The average amount spent on ‘carer specific’ support is assumed to be in the region of £1,000 per carer, over the duration of a caring spell, which is assumed to be between 2 to 3 years.^{34 35} This is informed by the findings of a survey by The Princess Royal Trust for Carers.
140. It is anticipated that demand for support for carers would be likely to increase with the adoption of Proposal D due to the rise in assessments, and under Proposal E due to both the rise in assessments and a new duty on local authorities to determine whether a carer’s needs are eligible needs, using eligibility criteria, and provide or arrange support to meet eligible needs of carers.

³² NHS Information Centre, Community Care Statistics: Social Services Activity England 2010/11 (Provisional release), November 2011. <http://www.ic.nhs.uk/pubs/carestats1011ssa>

³³ Survey data limited to the 41 councils that included carers known by association.

³⁴ This would imply a cost per carer of approximately £330 per year; but, as each cohort of carers are assumed to provide care for an average of 3 years, we assume there are 3 carer cohorts receiving support in any one year (once the system reaches an equilibrium).

³⁵ Support for carers may be provided in many ways and at different costs. For example a carer’s needs may be met by the provision of respite care to the user or direct support to the carer through a personal budget. In the absence of hard data we have estimated this value, based on a sample of current charges for a sitting service of 2-3 hours a month or a personal budget averaging between £250-£500 pa based on a recent survey of members of the PRTC network.

141. It is hard to estimate how quickly an increase in assessments and provision of support might occur because it will largely depend on:
- the time it takes local authorities and the voluntary sector to recruit and train additional staff to undertake assessments;
 - other proposals to tackle the challenges associated with identification of carers and access to information and advice set out elsewhere in the White Paper and corresponding Impact Assessments; and
 - the changing attitudes and behaviours of carers themselves.
142. Community Care Statistics show a 34% increase in carers assessments between 2005/06 and 2010/11. Even when there was a Performance Indicator in the National Indicator Set on the number of carers assessments (which arguably should have been a driver for increasing the number), growth was modest. Between 2008/09 and 2009/10:
- the number of carers offered an assessment increased by 4%;
 - those offered a service (including only information and advice) increased by 9%; and
 - those receiving carer specific services remained the same.
143. We therefore do not anticipate that an increase in assessment would rise sharply within a short space of time from implementation of new legislation, rather it would be more likely to grow gradually over 3 or 4 years.
144. The analysis described above found that the number of assessments would increase by 50%, if local authorities were to match the proportion of assessments to the 90th percentile, or by 54% if all carers 'known by association' were assessed. If the current ratio of assessments to services were applied to the additional assessments, these increases would result in an extra 105,000 to 110,000 carer specific services, costing between £104 million and £112 million. It should be noted that this is likely to be a maximum estimate, as it seems probable that, as a wider group of carers receive assessments, the ratio of assessments to recipients of carer support would be lower for the additional group of carers.
145. The analysis examines the ratio of recipients of carer specific support to the number of carer assessments. It looks at how many additional services would be required if those local authorities with a proportion lower than the 90th percentile were to increase their current ratio of support to assessments to this level. Matching the 90th percentile for the ratio of carer specific support to assessments would add 130,000 support services, a 63% increase, and cost approximately £131 million. This estimate is illustrative and may be generous since the new duty may not in practice require that all councils reach the 90th percentile for the ratio of recipients of carer support to carer assessments.
146. Table 6 below shows the costs of additional services and associated costs:

Table 6:

	<i>Arising from a 50-54% increase in assessments</i>	<i>Matching the 90th percentile</i>
Carer specific services	105,000-110,00	130,000
Cost	£104 - £112 million	£131 million

147. These two estimates are not mutually exclusive. There could be an increase in recipients of carer support due to more carers receiving assessments and, as a result of the new duty to provide support, an increase due to councils offering support to a higher proportion of carers already assessed. As discussed above, both estimates are generous and we consider that it would be plausible to assume an overall estimate for additional carer support in the range of £125 million to £150 million.

Summary of costs of Option 2 (Implement Proposals D and E)

148. We estimate that implementing these proposals would generate additional assessments at a cost of some £25 million. In addition, demand for support for carers would also increase, both as a consequence of there being more assessments and additionally (independently of the increase of assessments) through a new duty to provide support for carers. Costs arising from these changes are estimated to be in the region of £125 to £150 million.

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

Table 7:

£m at constant 2010/11 prices					
	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Assessment	15	20	25	25	25
Support	30	60	90	120	150

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

151. Following a carer assessment, care and support to meet eligible needs (such as respite care) could be subject to means testing as it is now and we estimate this could potentially reduce the costs of support by some 5%. Local authorities would also retain the power to charge carers for support directly provided to them, although we anticipate that, as now, they would use this power sparingly in recognition of the significant contribution that carers make both in terms of the value of the care they provide and because that care can avoid or delay a user's need for long-term nursing or residential care.³⁶

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

153. We might also expect that proposals relating to assessment and support for carers, in conjunction with proposals for improved information and advice discussed in the corresponding Impact Assessment "Independence, choice and control", could increase awareness of and have a consequential effect on the number of people applying for Carer's Allowance and any linked benefits or services. An increase in the number of assessments over the current level could lead to an increase in the number of people claiming Carer's Allowance. The size of this impact will depend upon the characteristics of the people who claim – for example, an individual's age, whether they are in paid employment and the extent of their caring role will all affect whether they are eligible to receive Carer's Allowance.

³⁶ Wanless, D., *Securing Good Care for Older People: Taking a Long Term View*, King's Fund 2006.

Benefits of Option 2 (Implement Proposals D and E)

154. The Impact Assessment that accompanied publication of the updated Carers Strategy in November 2010 identified a number of benefits to be gained from strengthening support for carers, particularly in terms of preventing carer burn-out, early interventions that maintain or improve carers' health and greater choice and control for individual carers.³⁷
155. The PSSRU Survey of Adult Carers 2009/10 was based on 35,000 responses from carers over 18 years of age who were in touch with social services either through having been assessed or reviewed themselves, or named on the file of a care user assessed or reviewed in the previous 12 months.³⁸ This indicates that most of those receiving carer support, including breaks, were very satisfied:
- 54% of carers reported they were extremely or very satisfied with support or services - of those 54%, 45% said they had as much control over their daily lives as they wanted;
 - 61% of carers accessing breaks of more than 24 hours were either extremely or very satisfied.
156. The Survey of Carers in Households 2009/10, based on just over 2,000 responses, gives an indication of the low proportion of carers in the population who are currently assessed and the potential unmet need for support (though it does not go into the level of support that might be needed):³⁹
- 6% of carers were offered assessment and 4% had been assessed. 67% of those assessed had received some sort of service;
 - 66% said someone else would need to look after the person they cared for if they wanted a break from caring for a couple of days. 16% said there was no one they could rely on to provide care.
157. The Survey of Carers in Households also shows the adverse effects of caring that we expect to alleviate through reform of the law:
- Among working age carers, 26% felt caring had affected their ability to stay in employment, and of these, 39% had left work altogether, 32% had reduced their employment hours and 18% had agreed flexible employment arrangements;
 - Around half (52%) of carers said that their health had been affected because of the care they provide (39% of those caring for less than 20 hours and 66% of those caring for 20 or more hours);
 - Around two in five carers (42%) said their personal relationships, social life or leisure time had been affected because of the assistance they provided.
158. The independent evaluation of the Carers Strategy Demonstrator Sites published in November 2011 reports potential benefits from improving both assessment and support for carers including:⁴⁰
- Preventing or delaying hospital or residential care admissions for care users;
 - Sustaining the caring role;
 - Improved health and wellbeing of carers;
 - Assisting carers to remain in or return to work;
 - Access to peer support networks.
159. Particular points to note from the evaluation of the demonstrator sites are:
- Carers valued different ways of accessing support including self-assessment. Assessments focusing on carers identifying their own support needs rather than a range of services offered by the local authority often resulted in low cost solutions and/or support from family and friends.
 - Breaks from caring and practical support have the potential to prevent carer burnout and health deterioration and to sustain the caring role. A large minority of carers reported that taking a break

³⁷ Impact Assessment for *Recognised, valued and supported: next steps for the Carers Strategy*, Department of Health, 2010.

³⁸ NHS Information Centre, *Personal Social Services Survey of Adult Carers in England 2009-10*, 2011.

³⁹ NHS Information Centre, *Survey of Carers in Households 2009-10*, 2011

⁴⁰ CIRCLE, *New Approaches to Supporting carers' Health and Well-being: Evidence from the National Carers Strategy Demonstrator Sites*, University of Leeds, 2011.

from caring or practical support had improved how they cared for themselves, their ability to cope and deal with stress and how they felt about life.

- Carers who did not receive a break were more likely to show deterioration in wellbeing scores.
- In three sites, alternative care for the user was offered as well as a personal budget to enable carers to undertake an activity to give them a break from caring. However, few carers took up the offer of paid alternative care because having the flexibility to tailor a break to their choice and time enabled them to arrange replacement care informally with friends and family - and many understandably said they preferred this.
- Positive health and wellbeing outcomes for a substantial numbers of carers can be maintained when carers are facing particular challenges including when the caring role begins, when carers experience strain and when they have intense or long-term caring roles.

160. There is a lack of quantitative evidence about the impact on carers' welfare of carer assessments and support. We would expect care support to have an impact on carer stress, anxiety and morale. If carer support improved carers' state on the EQ5D anxiety/depression dimension from moderate anxiety/depression to no anxiety/depression this would constitute a gain of 0.071 quality-adjusted life years (QALYs) per year.

161. If a QALY is valued at £60,000, an improvement of 0.071 QALYs per year over 3 years would be worth almost £12,800 over 3 years. If a QALY is valued at £25,000, the same improvement would be worth over £5,300. These illustrative estimates of the value of the gain from carer support are well in excess of the assumed cost of £1,100 over 3 three years (£100 for an assessment and £1,000 for support). Even if, as seems more likely, care support had a lower impact, so long as the impact was over 20% of a move from moderate to no anxiety/depression, it would still be cost-effective. This suggests that, although there can be no certainty without robust evidence, the proposed expansion of carer assessments and support is likely to be cost-effective. Robust quantitative research on the impact of carer support on carer welfare would be valuable.

Summary of proposals in respect of carers

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

Proposals regarding care and support in prisons

Objective:

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

Option 1: Do nothing

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

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

Option 2: Implement Proposal F to specify in legislation that there should be a threshold of responsibility between prisons and local authorities for the assessment and provision of prisoners' care and support.

Assessment

164. Under this option, legislation would clarify that responsibility for the assessment of prisoners' care and support needs lies with local authorities. It would also place a duty on prisons to cooperate with local authorities in the undertaking of assessment.
165. In order to identify a prisoner's care and support needs, an assessment will be required. As for people in the community, this will be the responsibility of the local authority of the area in which the prison is situated. However, as prisons will provide some level of care and support there will need to be a duty on prisons to co-operate with assessments. Department of Health will work with the National Offender Management Service (NOMS) to identify the level of assessment that appropriately trained prison officers could complete, and the threshold above which a more specialised assessment is required.

Provision of care and support to prisoners

166. Under the provisions of the Care and Support Bill, responsibility for providing prisoners' care and support would rest with prisons up to a specified threshold. Above this threshold, the responsibility for provision of care would rest with the local authority. Where exactly this threshold should lie could then be set out in regulations.
167. Currently, prisons already provide a certain level of social care in fulfilling their duty of care towards prisoners. However, there are some social care activities which prison officers are not appropriately trained to deliver. To determine where the threshold of responsibility for provision of care between prisons and local authorities should lie, the Department of Health will work with the National Offender Management Service (NOMS), local authorities and other stakeholders. This will enable clarification of the threshold below which a prison should be responsible for providing care and support, and above which care should be delivered by specialist carers provided for by the local authority.
168. These proposals will be supported by clarification of arrangements regarding ordinary residence, to be taken forward in the Care and Support Bill as part of the Government's plans to reform the social care statute. Such clarification will make explicit where the responsibility for assessment and provision of care and support lies between different localities.

Costs and benefits of Option 2

Costs

169. We estimate that once fully implemented, the additional costs to local authorities as a result of Option 2 will be £8.6 million per year. This comprises the costs of assessment and the costs of providing care. This is based on estimates of the number of people in prison with physical disabilities. Those in the Criminal Justice System with learning difficulties and mental illness may have severe enough problems to meet the eligibility criteria for local authority care when in the community. However, while in prison the majority of social care needs for these people are likely to be met by the prison, such as day care, food preparation and assistance with activities of daily living.
170. In the absence of studies on the prevalence of physical disabilities in this prison population, estimates have been made based on needs in the general community. The cost of a social care assessment is based on community care costs. The degree of care and support in prison may be different to that in the community for a person of similar disability. Costs borne by the local authority are likely to be primarily personal care, whilst the prison is likely to provide the majority of domestic care, purposeful activity and social support.
171. The costs of older prisoners needing social care are calculated using estimates of the prevalence of disabled older people, the prevalence of people unable to perform at least one activity of daily

living and the costs of social care. The costs would include providing all people in prison over 50 with a social care assessment. It is unlikely that all prisoners over a certain age threshold would need an annual assessment. However, this figure is a worst-case scenario until we establish what proportion of prisoners will need repeat assessments and the frequency of these.

Table 8: Prevalence of need and potential costs of social care for people in prison over 50 yrs

Prevalence of need and potential costs of social care for people over 50 yrs in prison-	
Assessment	
No of people over 50 in English prisons May 2011	8874
Cost of one assessment ¹	£300
Cost of one assessment per year for all over 50s	£2.7m
Provision of care and support	
% of older people in the community (over 65s) estimated to have a disability ²	27.6%
% of those with a disability unable to perform at least one ADL	24.1%
Number of prisoners over 50 who may have a disability (note prevalence data used - general population over 65s)	2449
Number of prisoners over 50 who may be unable to perform at least one ADL	590
Average annual cost of social care per prisoner (based on 2009 costs) ³	£6110
Estimated cost of providing social care	£3.7m
TOTAL Social care costs for people over 50 yrs in prison	£ 6.4m

¹ We expect assessments of prisoners to be less costly than assessments of people in the community since some relevant information, eg about informal care, will not be relevant or will already be available.

² Based on PSSRU estimate of 2.7m disabled older (65+) people in UK

³ Based on analysis undertaken in the preparation of Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system

Table 9: Prevalence of need and social care costs for people in prison aged less than 50 yrs

People in prison less than 50 years with Physical Disability (PD)	
Assessment	
Total population under 50 in English prisons May 2011	76,263
No of people with PD who received care in the community in England	25,700
No of people aged 16-49 in England	30,373,000
Prevalence of PD in England	0.085
Possible number of people in prison aged 18-49 year olds requiring assessment	65
Cost of one assessment	£300
Cost of one assessment per year for 18-49 year olds with PD	£19,500
Provision of care and support	
Average weekly cost of social care per prisoner	£644
Average annual cost of care provision per person ¹	£33,488
Estimated cost of providing social care	£2,176,720
TOTAL cost of provision and assessment of people in prison aged less 50 years	£2.2m

¹ Based on community costs - average cost of residential and nursing care adults 18-64 with PD, <http://www.ic.nhs.uk/webfiles/publications/009>. The costs were reduced by 24% to take account of the board and lodging component that is part of custodial provision.

Table 10: Total Costs

TOTAL cost of assessment and social care provision for people in prison aged over 50 years	£ 6.4m
TOTAL cost of assessment and social care provision for people in prison aged less than 50 years	£2.2m
TOTAL cost of assessment and social care provision for older people and adults with physical disability	£8.6m

172. Once the threshold below which prisons are responsible for care and support is agreed, further work will be needed to estimate the burden for NOMS and the gaps in current provision.
173. We anticipate that it may take some time before all necessary additional assessments are carried out, therefore we assume that costs are staggered for the first few years of implementation - £6 million in Year 1, £7 million in Year 2, £8 million in Year 3 and then £8.6 million thereafter.
174. Clarifying where responsibility lies for the care of people in prison will result in the identification of previously unmet need. Local authorities are currently responsible for meeting the care and support needs of their residents, including recently released prisoners. As a result of these proposals, it may be that an individual’s need is identified during their time in custody and that the individual will therefore be eligible for ongoing support following their return to the community. This could involve an additional cost for the individual’s home local authority. It is estimated that 25% of prisoners are released each year; therefore as an indicative cost, we estimate that the care and support costs of recently released prisoners may be in the region of £1.5 million per year.

Benefits

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

Proposals regarding armed service veterans

Objective:
Recognise the unique contribution of veterans by exempting the compensation payments of those injured in service from social care charging.

Option 1: Do nothing

178. Doing nothing would mean that armed forces veterans receiving publicly supported care and support would continue to have to use all but the first £10 per week of the Guaranteed Income Payments (GIPs) they receive, under the Armed Forces Compensation Scheme (AFCS), to pay for their care.

Option 2: Implement Proposal G to amend the regulations and guidance to local authorities on the treatment of GIPs in the assessment of a person’s ability to pay for their care.

179. In recognition of the exceptional contribution made by armed forces veterans injured on active service, veterans will no longer need to use their GIPs to pay for state-funded care and support. To achieve this, the following social care charging regulations and guidance will be amended:

- The National Assistance (Assessment of Resources) Regulations 1992;
- The Charging for Residential Accommodation Guide;
- The Fairer Charging Policies for Home Care and other non-residential Social Services – Guidance for Councils with Social Services Responsibilities.

180. The intention is to introduce the disregard from October 2012.

Costs

181. The disregard will be a transfer from local authorities to injured veterans. It will represent an additional cost for local authorities, who will have a reduced ability to raise income from user fees.

182. In estimating the additional costs to local authorities, we have used information supplied by the Ministry of Defence (MOD) on the characteristics of GIP recipients most likely to receive care and support, the average value of their GIP and the current number of GIPs. Finally, we have looked at the interaction of these awards with social care charging.

183. GIP payments are classified into four bands - A-D, with band A being the highest. The value of the GIP a veteran receives depends on a number of factors, including the length of service and the severity of their injury. We assume that people with a Band A or B GIP are the most likely to be in receipt of care and support. A GIP is paid following discharge from the armed forces.

184. As of May 2012, there are currently 328 service personnel entitled to an AFCS GIP (Band A or Band B) of which 95 are currently in payment. Their GIP related income is distributed as follows:

Table 11:

Per annum income from GIP	Number of personnel at Band A	Number of personnel at Band B
£0 -10,000	0	2
£11,000 - £20,000	3	37
£21,000 - £30,000	19	19
£31,000 - £40,000	6	6
£41,000 - £50,000	0	2
£51,000 - £60,000	0	1

185. To calculate the aggregate cost of the disregard, we need to first calculate the amount that veterans with Band A or B GIPs would pay, on average, towards their care from the GIP in either residential or non-residential care.

Costs per recipient

186. **Residential care:** We assume that a 2% (lower estimate) to 3% (higher estimate) of all GIP recipients in Bands A and B are in residential care (that is two or three GIP recipients in residential care in May 2012). We expect that all of them receive GIP Band A.

187. For residential care, the first £10 per week of a GIP is disregarded and the rest is taken into account. In addition, in 2010/11, every person in residential care had a personal expenses allowance of £22.30 per week.⁴¹ Thus, a total of £32.30 per week (out of their GIP) is disregarded.
188. We assume that the average cost of residential care for this group is £872 per week at 2010/11 prices.⁴² Assuming, as an upper bound, that each recipient receives the maximum level of payment in their income bracket, this would suggest the following contributions currently made by GIP recipients who are in residential care (for 2012/13 in 2010/11 prices):

Table 12:

<i>Per annum income from GIP</i>	<i>Maximum weekly GIP payment</i>	<i>Weekly user charge payable in residential care</i>
£0 -10,000	£192	£160
£11,000 - £20,000	£385	£352
£21,000 - £30,000	£577	£545
£31,000 - £40,000	£769	£734
£41,000 - £50,000	£962	£872

189. We do not know what level of GIP those in residential care receive. To calculate how much they pay towards their residential care costs, we use the weighted average for Band A recipients: £565.53 per week in 2010/11 prices.
190. **Home care:** We assume that 40% (lower estimate) to 60% (higher estimate) of all GIP recipients in Bands A and B need social care and that, other than the small numbers receiving residential care, they receive a package of home-based care.
191. Charges for non-residential care are more complex. Local authorities have flexibility to set their own charging regime. For non-residential services, the income taken into account in charging can include disability related benefits (including GIP) but should exclude disability-related expenditure. Local authorities should also ensure that charges do not reduce the care user's net basic income below the level of Income Support, plus 25% or result in the care user being left without the means to pay for any other necessary care and support or other costs arising from their disability.
192. Using Income Support (IS) plus 25%, the minimum income a person must be left with is (for 2011/2):
- Single person : £67.50 + 25% = £84.37 per week income
 - Couple: : £105.95 + 25% = £132.44 per week income
193. Table 13 below shows the resulting maximum user charge a single person could be asked to pay towards their home care (before curtailing the user charge at the cost of the care package):

Table 13:

<i>Per annum income from GIP</i>	<i>Maximum weekly GIP payment</i>	<i>Maximum weekly fee payable for home care</i>
£0 -10,000	£192	£108
£11,000 - £20,000	£385	£300
£21,000 - £30,000	£577	£493
£31,000 - £40,000	£769	£685
£41,000 - £50,000	£962	£877

⁴¹ The rate of PEA increased to £22.60 from April 2011 and £23.50 from April 2012. This Impact Assessment uses 2010/11 as the price baseline.

⁴² 2010/11 unit cost for residential care for adults with a physical disability.

194. The PSS EX1 for 2010/11 tells us that the average home care package for an adult with a disability costs £203 per week. We assume that these costs will be higher for those in Band A (£275) and slightly lower for those in Band B (£200). Therefore, except for those in the lowest income bracket, the home care users all meet their full care costs out of their GIP.
195. In Band A, we expect all recipients of home care to pay the full cost of £275. Thus, the average weekly care costs borne by recipients of GIP Band A is £318.53 and £319.70 (low and high estimate) per week including the small numbers in residential care. In Band B, we assume that those in the lowest income from GIP bracket will pay the maximum changeable level given their income (=£108.94). Thus, the average weekly cost of care borne by recipients of GIP Band B is £197.25 per week. Under the proposed changes, the above costs would fall to local authorities.
196. We assume that these costs per person stay constant in 2010/11 prices, on the basis that GIP payments will rise in line with general inflation.

Number of recipients

197. There are currently 95 service personnel in receipt of an AFCS GIP (Band A or Band B). A further 230 service personnel have an underlying entitlement to an AFCS GIP (97 Band A, 133 Band B), but have not been discharged yet. We assume that by March 2015 all of these service personnel will have left the services and become eligible for GIP payments. We assume that discharges will occur evenly over time.
198. Further, we assume, for illustrative purposes only, that a further 100 service personnel may in due course be discharged with a GIP (Band A or B) entitlement due to ongoing military engagement. We assume that these GIP recipients are not discharged before March 2015, but before March 2017, and estimate that there will be a total of 425 GIP recipients by March 2017. Table 14 below shows our estimates for the average number of GIP (Band A or B) recipients for the mid-points of the years until 2016/17.

Table 14:

	Q3/4 2012/13	2013/14	2014/15	2015/16	2016/17
Band A	48	74	108	125	135
Band B	94	130	177	200	216

199. We use these caseload estimates and the average cost per recipient calculated above to derive the total costs to local authorities of the proposed disregard. The tables below summarise our low and high cost estimates (assuming 2% and 3% in residential care and 40% to 60% in domiciliary care respectively) as well as our best estimate, which is the mid-point between the two (figures may not add up due to rounding).

Table 15: Lower bound estimate

	2012/13	2013/14	2014/15	2015/16	2016/17
Band A	£180,000	£570,000	£830,000	£1,050,000	£1,200,000
Band B	£190,000	£530,000	£730,000	£880,000	£1,020,000
Total cost	£380,000	£1,100,000	£1,560,000	£1,930,000	£2,210,000

Table 16: Upper bound estimate

	2012/13	2013/14	2014/15	2015/16	2016/17
Band A	£280,000	£860,000	£1,280,000	£1,470,000	£1,590,000
Band B	£290,000	£800,000	£1,090,000	£1,230,000	£1,320,000
Total cost	£570,000	£1,660,000	£2,360,000	£2,710,000	£2,910,000

Table 17: Best estimate (mid-point)

	2012/13	2013/14	2014/15	2015/16	2016/17
Band A	£230,000	£710,000	£1,050,000	£1,260,000	£1,390,000
Band B	£240,000	£670,000	£910,000	£1,060,000	£1,170,000
Total cost	£470,000	£1,380,000	£1,960,000	£2,320,000	£2,560,000

Benefits

200. Veterans will be able to keep their GIP compensation. This represents a transfer from local authorities to veterans, so the benefit to veterans will be equal to the cost to local authorities.

V. RISKS

201. There are risks that the significant changes to the system proposed could impose another layer of bureaucracy and process on the system and therefore that they do not address the issue of needing more clarity and consistency of interpretation. To mitigate this risk, the Government will ensure that appropriate scrutiny of the proposals is undertaken, first through the pre-legislative scrutiny process for the draft Care and Support Bill, then during the passage of the Bill through Parliament and then through consultation on new guidance on our proposals on a national minimum eligibility threshold and portability. This process of scrutiny and engagement should ensure that all implications are properly considered.

202. The work to develop and test options for a new assessment framework will be conducted in close conjunction with local authorities, stakeholders, carers, professionals and users to ensure that options both provide the maximum benefit to users and carers whilst being easy to work through and implement for professionals and local authorities.

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

204. As set out above in paragraph 175, clarifying the responsibility for the social care of people in prison is likely to lead to the identification of previously unmet need. There may be financial implications for local authorities to address these needs once an individual leaves prison and returns to the community.

VI. SPECIFIC IMPACT TESTS

Impact on business and civil society organisations

205. The proposals discussed within this Impact Assessment do not fall within the scope of the Government's "One-In One-Out" (OIOO) rule which states that "no new primary or secondary UK legislation which imposes costs on business or civil society organisations can be brought in without the identification of existing regulation with an equivalent value (in terms of net costs to business) which can be removed."

206. These proposals do not involve any additional regulatory measures that impose costs on business or civil society. The changes to the law proposed in the draft Care and Support Bill relate to the responsibilities of local authorities and other public sector partners for planning and commissioning of adult social care services and for meeting the needs of their local population.

207. For this reason, we do not anticipate that these proposals will result in any negative impact on small businesses. The primary objective of the proposals set out in the White Paper is to support people who use care and support and their carers to maintain their health, wellbeing and independence for as long as possible. However, as part of the overall objective of improving quality of care and experience, proposals are also intended to strengthen and enhance the social care market. In particular, we might anticipate that increased support for carers will provide new business opportunities for providers to enter the market or to diversify their offer of services where they perceive the benefits to outweigh the costs.

Human rights

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

209. Proposal F will benefit some of the most vulnerable prisoners, enabling them to take part in prison life, and reducing the risk of litigation to the Government, under the provisions of the European Human Rights Act.

Justice system impacts

210. Given the current increase in legal challenge to council decisions regarding eligibility, establishing a more nationally consistent and transparent system should help reduce the number of challenges, and therefore burden on the courts. As discussed above, clarifying the threshold of responsibility between local authorities and prisons for assessment and provision of care and support should reduce the risk of litigation brought about by prisoners with care needs, other prisoners or prison staff.

211. The financial costs identified are maximum costs to the local authority. Some of these costs may be born by NOMS, depending on where the threshold for responsibility for care provision falls. We will do further work to understand the costs to the prison service, once we have identified this threshold, and have identified where the gaps are in current provision.

Other impacts

212. The impact of these proposals on equalities is discussed in the White Paper Equality Analysis.

ANNEX A: Examples of lawsuits brought against Government by prisoners with care needs

Price v. the United Kingdom 33394/96

AP, a four-limb deficient thalidomide victim who also suffers from kidney problems, was committed to prison for contempt of court in the course of civil proceedings. She was kept one night in a police cell, where she had to sleep in her wheelchair, as the bed was not specially adapted for a disabled person, and where she complained of the cold. She subsequently spent two days in a normal prison, where she was dependent on the assistance of male prison guards in order to use the toilet. The Court found that to detain a severely disabled person in conditions where she was dangerously cold, risked developing sores because her bed was too hard or unreachable, moreover, was unable to go to the toilet or keep clean without the greatest of difficulty, constituted degrading treatment contrary to Article 3.

Roger Zoppola v Home Office CL 300681

A civil claim under the Disability Discrimination Act 1995 and Human Rights Act 1998, on behalf of a wheelchair using prisoner paralysed from the chest down, alleged discrimination amounting to degrading treatment, citing the use of restraints for attending a funeral and failing to provide adapted toilets and other fundamental equipment.

Michael Ford v Home Office CL 308151

A civil claim further to judicial review proceedings, on behalf of a severely disabled wheelchair using prisoner, alleged discrimination within the prison system in relation to access to adapted toilets, cells, exercise and other aspects of the regime.

Colin Jacklin v Home Office CL 308150

A civil claim on behalf of a prisoner who became disabled whilst in prison, alleged a failure to properly assess and to provide appropriate adapted facilities.

Paul Anderson v Home Office 6CL03274

A civil claim under the Disability Discrimination Act 1995 and Human Rights Act 1998, on behalf of a wheelchair using double amputee prisoner, alleged failures to make reasonable adjustments, to provide access to courses and other facilities within the prison, and in relation to prison officers abusing their power.