Title: Social Care Funding Reform Impact Assessment **IA No:** 9531 **Lead department or agency:** Department of Health **Other departments or agencies:**	**Impact Assessment (IA)** **Date:** 03/02/2015 **Stage:** Consultation **Source of intervention:** Domestic **Type of measure:** Primary legislation **Contact for enquiries:** Funding - James Umpleby (james.umpleby@dh.gsi.gov.uk) Appeals - Jonathan White (jonathan.white@dh.gsi.gov.uk)

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, Two-Out?**	**Measure qualifies as**
£2.29 bn	£ N/A	£ N/A	No	NA

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

Currently individuals face the risk of losing almost everything to pay for their care costs - ten percent of older people face care costs over £100,000. Most people are unable to protect themselves against these risks as affordable financial products are unavailable. The inability of people to protect themselves from these risks and maximise their wellbeing represents a market failure. Government intervention is therefore required to protect people from the risk of unlimited care costs. Separately, the limitations of the existing adult social care system of redress have been set out by the Law Commission.

What are the policy objectives and the intended effects?

The primary objective of the policy is to provide people with financial protection from catastrophic care costs and as a result give them the peace of mind from knowing that they do not risk losing all their assets to pay for their care. The policy should also help encourage people to take responsibility and plan and prepare for their care needs in later life, whilst helping ensure that the system is financially and politically sustainable and that it supports the wider government objectives for the care and support system including encouraging planning and prevention. For the system of redress, the objective is to make the system fairer and more equitable.

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

Extensive policy options were considered by the Commission on Funding Care and Support. The Government accepted the principles of their recommendation of a cap on care costs in July 2012. The analysis included within this impact assessment focuses on the Commission's proposed system of a capped cost model with an extended means test for residential care. For the system of redress, the preferred option is to introduce the right to appeal certain care and support decisions. Doing nothing would leave the existing system of redress unchanged.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** Month/Year

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** 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:** 0	**Non-traded:** 0	

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

Signed by the responsible Minister: _____ Date: 3 February 2015

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 2016	PV Base Year 2016	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low:	**High:**	**Best Estimate:** £2.29 bn

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate				**£12.35 bn**

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

All the costs listed below fall upon the government and will be fully funded
Costs of the cap and extended means test for older people (NPV £8.78 bn)
Costs of reforms for working age people (NPV £2.38 bn)
Costs of additional assessments (NPV £2.30 bn)
Reduction in costs to disability benefits (NPV -£1.32 bn); Appeals costs (NPV £0.103 bn to £0.206 bn)

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

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low				
High				
Best Estimate				**£14.64 bn**

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

Peace of mind to everyone from knowing that they will no face unlimited care costs (NPV £4.80 bn)
Financial benefits to those receiving additional support (older people NPV £7.46 bn, working age NPV £2.38 bn)

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

People planning and preparing for their care and support needs in later life.
Space for financial services products that enable people to plan/prepare and further mitigate their risks.
Wider benefits from supporting other objectives for the care and support system including supporting preventative services and the provision of information and advice. Efficiency / equity gain of value of spending on successful appellants, net of spending that will no longer be made.

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

Demand for formal care follows projections produced by PSSRU
Care costs rise in line with average earnings
80% of self-funders take up the reforms.
Appeal rates (1.4% to 3.4% of assessments) and independent review unit costs (£531 in 2013 prices).

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: N/A	**Benefits:** N/A	**Net:** N/A	No	NA

SUMMARY TABLE

Summary table of costs and monetised benefits

Social Care Funding Reform

£ billions, 16/17 prices undiscounted	*15/16*	*16/17*	*17/18*	*18/19*	*19/20*	*20/21*	*21/22*	*22/23*	*23/24*	*24/25*	*25/26*	*Discounted Total*
Older People												
Cap and means test Assessment, Case Management and Review Costs	0.11	0.32 0.26	0.33 0.21	0.45 0.22	0.73 0.23	1.07 0.24	1.32 0.25	1.47 0.27	1.57 0.28	1.68 0.30	1.79 0.31	8.78 2.30
Working Age												
all costs		0.09	0.13	0.15	0.23	0.26	0.36	0.40	0.41	0.42	0.43	2.38
Total care and support cost	**0.11**	**0.66**	**0.67**	**0.82**	**1.19**	**1.57**	**1.93**	**2.14**	**2.26**	**2.40**	**2.54**	**13.46**
Benefits												
Reduced eligibility		-0.06	-0.07	-0.08	-0.11	-0.16	-0.20	-0.22	-0.23	-0.24	-0.24	-1.32
Potential increased take up											To be quantified in the final IA	
Net cost to benefits		**-0.06**	**-0.07**	**-0.08**	**-0.11**	**-0.16**	**-0.20**	**-0.22**	**-0.23**	**-0.24**	**-0.24**	**-1.32**
Net Cost	**0.11**	**0.59**	**0.60**	**0.74**	**1.07**	**1.41**	**1.74**	**1.92**	**2.04**	**2.17**	**2.30**	**12.14**
Financial transfers to older people		0.25	0.27	0.37	0.62	0.91	1.12	1.26	1.34	1.45	1.55	7.46
Financial transfers to working age adults		0.09	0.13	0.15	0.23	0.26	0.36	0.40	0.41	0.42	0.43	2.38
Additional peace of mind		0.17	0.20	0.26	0.41	0.57	0.72	0.80	0.85	0.91	0.96	4.80
Net Benefits		**0.51**	**0.59**	**0.78**	**1.26**	**1.74**	**2.21**	**2.46**	**2.61**	**2.78**	**2.94**	**14.64**

NPV **2.50**

Note: numbers may not add due to rounding

Social Care Appeals

£ millions, 16/17 prices undiscounted	*16/17*	*17/18*	*18/19*	*19/20*	*20/21*	*21/22*	*22/23*	*23/24*	*24/25*	*25/26*	*Discounted Total*
Assessment, PB and IPB appeals	9.85	8.02	8.15	8.29	8.44	8.59	8.80	8.98	9.16	9.33	**75.28**
Carers appeals	6.32	6.39	6.49	6.60	6.71	6.81	6.96	7.09	7.20	7.30	**58.13**
Review appeals	5.08	5.70	5.81	5.92	6.03	6.14	6.30	6.44	6.56	6.67	**51.84**
Additional LGO reviews	0.46	0.21	0.21	0.21	0.21	0.21	0.22	0.22	0.22	0.23	**2.08**
TOTAL	**21.70**	**20.32**	**20.65**	**21.01**	**21.39**	**21.75**	**22.27**	**22.73**	**23.15**	**23.52**	**187.33**
TOTAL INCLUDING UPLIFT	**23.87**	**22.35**	**22.72**	**23.11**	**23.53**	**23.92**	**24.49**	**25.01**	**25.46**	**25.87**	**206.07**

Note: numbers may not add due to rounding

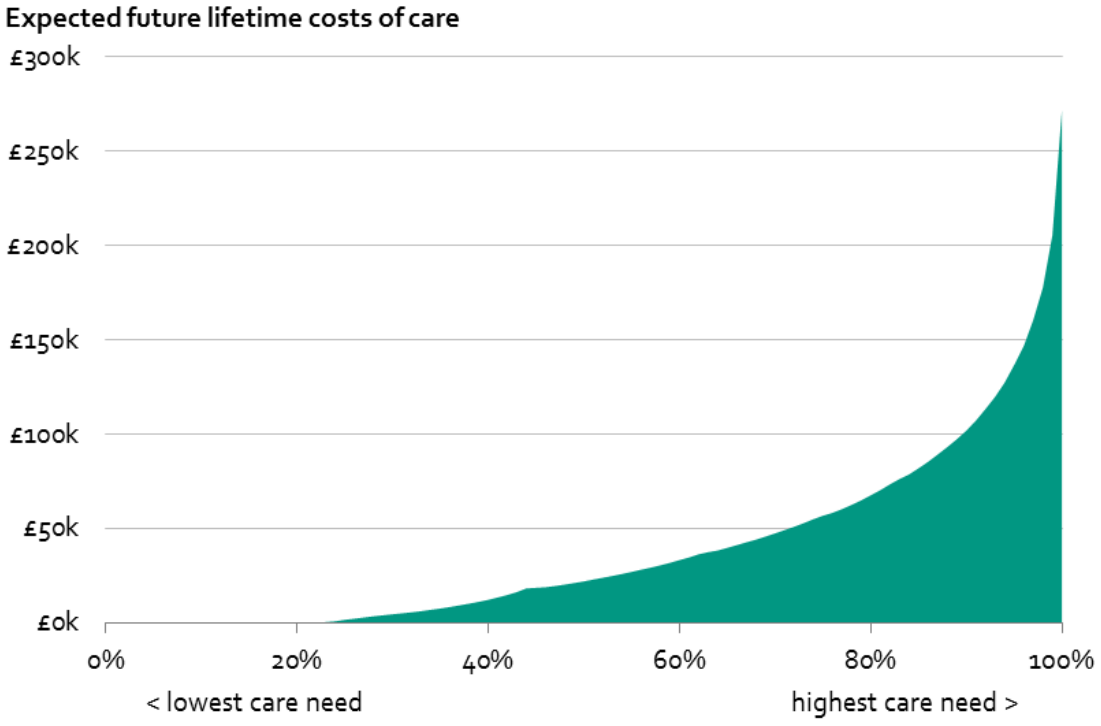
PART I – FUNDING REFORM

Background

The case for change

1. The current system has changed very little since it was first designed in 1948 and as a result, no longer reflects the realities of today's society, particularly in terms of the ageing population or definitions of wealth. Under the current system people face the risk of very high and unpredictable care costs and have limited options available to them to protect themselves. The report by the Commission on the Funding of Care and Support[1] and "Caring for our Future: progress report on funding reform"[2], set out in detail how catastrophic care costs create practical difficulties and distress for people receiving care and support.
2. People who need care and support for a long period, such as those with long-term chronic disabilities such as dementia, face these high care costs whilst others do not ever develop significant care needs and therefore spend very little, if anything, on care. People are unable to predict what their future needs might be and therefore what level of costs they may face. This means they can have no degree of certainty in order to plan and prepare.
3. Figure 2 shows the estimated distribution of future lifetime care costs that people aged 65 currently face. Around 10% of people aged 65 can expected to experience lifetime case costs exceeding £100,000.

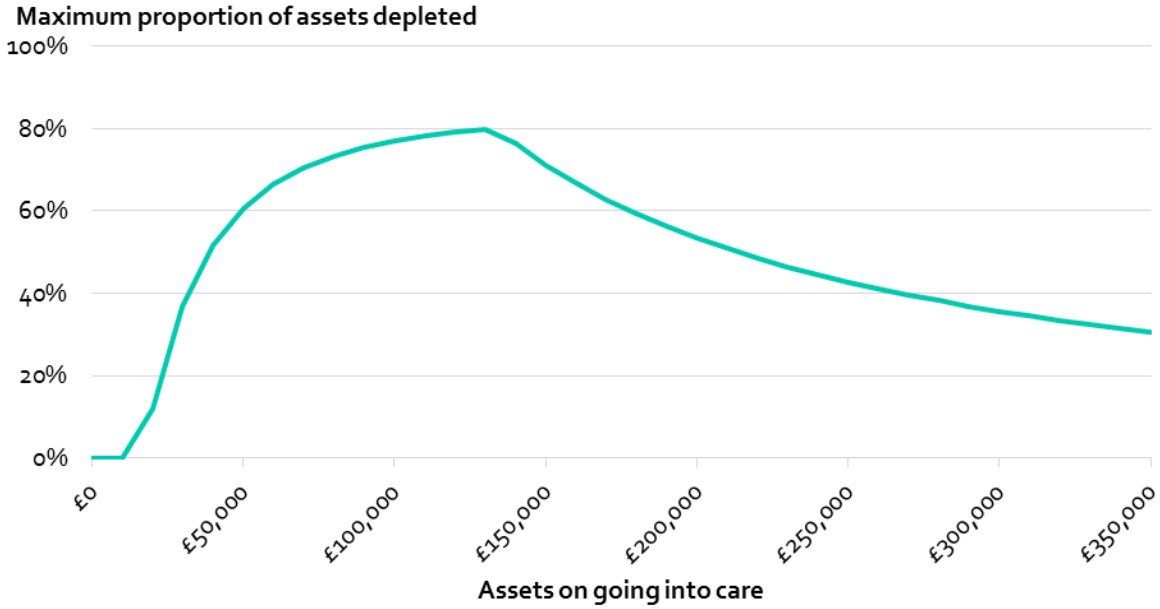
Figure 1: Expected future lifetime costs of care for people aged 65 in 2009/10, by percentile (2009/10) – PSSRU modelling published in the Dilnot Commission's Report



[1] http://www.dilnotcommission.dh.gov.uk/
[2] https://www.gov.uk/government/publications/government-publishes-progress-report-on-social-care-funding-reform

4. There is state support available for those who would have difficulty in paying for the costs of their care but only if their assets fall below £23,250. This means that anyone who has worked to buy their own home is usually excluded from support. Even those who do receive state support are required to contribute almost all their income in user charges if they live in a care home or all their income above an amount allowed for costs of living in their own home (subject to some exemptions) if they are receiving care there. This means that people with even moderate levels of assets are at risk of having to spend down their assets to £23,250 paying for care, and even then are still required to make a contribution. People feel that it is unfair that if they have budgeted carefully through their working life and that they are penalised for doing so because they receive little or no help.
5. Figure 2 illustrates how much someone might deplete if they stay in a care home for 8 years. Around 1 in 25 people who enter a care home have lengths of stay in excess of 8 years[3].
6. Those who are most at risk in this scenario have assets between £100,000 and £150,000, below the median housing wealth (for homeowners). They face the possibility of spending around 80% of their assets paying for their care. These are the people who are least able to manage high costs in the current system, so are most in need of protection.

Figure 2: Maximum asset depletion under the current system for an individual entering residential care



Source: Based on DH modelling of at the average local authority rate of around £570 per week and 8 years in residential care, by initial level of housing wealth (2016/17 prices)

7. Given the lack of certainty, a risk-averse person might want to plan for the worst case. The Commission on Funding Care and Support suggested that this leads to asset hoarding, where people are unwilling to release the value from their assets to invest in preventative services, for fear of facing catastrophic costs in later life. This may have a detrimental impact on their health and wellbeing and, perversely, means that those people are likely to have to pay more should they develop care and support needs. Those who cannot easily afford to cover what they perceive to be the worst case from their wealth will want, and will benefit from, protection from unlimited care costs.
8. In other areas of our life, when faced with the risk of high costs, people are protected through insurance – either provided by the state (e.g. the NHS) or purchased privately (e.g. house insurance). Pooling risks is welfare enhancing because it provides peace of mind (for risk averse people) and means that people do not have to sacrifice too much consumption to save enough to protect themselves against the worst case scenario.

[3] PSSRU, Lengths of stay in care homes http://eprints.lse.ac.uk/33895/1/dp2769.pdf

The Missing Market for Care Insurance

9. Faced with these high and unpredictable costs, people might usually be expected to protect themselves. However in England, it is not currently possible to buy products which fully pool the risk of long-term care costs. A small market for pre-funded long-term care insurance grew up in the 1990s but products were withdrawn in the 2000s, with insurers citing both supply side and demand side difficulties.
10. Comas-Herra et al.[4] provide an evaluation of the barriers to a fully private insurance system for social care costs. The supply side barriers identified include both adverse selection and uncertainty about future care needs and costs. While the demand side include the high cost and poor affordability of care insurance.
11. The only risk-pooling products currently available are immediate needs annuities (INAs). These products are typically sold to people entering a care home, who make a one-off payment in return for which they usually have their l care home costs covered until they die. They allow people going into a care home to pool their longevity risk, but not the risk of going into a care home in the first place.
12. People going into a care home are already likely to be in the top quarter of the population by lifetime cost, so this makes the products expensive – a typical INA costs around £85,000[5], although they are priced depending on the individual's risk profile.
13. These products are much easier for the industry to price than pre-funded insurance, as the timescales from premium to payout are much shorter, but they are an incomplete insurance solution for a number of reasons.
    - INAs only allow partial risk-pooling. There is an incomplete market for pooling the remainder of the risk.
    - Partial risk-pooling is inadequate for many people with lower wealth. INAs will only ever be a solution for relatively wealthy people.
14. The absence of a pre-insurance market is a market failure which leads to unfairness and inefficiency. Many people, faced with the prospect of high care costs and being unable to do anything about them, worry about how they will manage when they develop care needs in later life.
15. People who are not able to save sufficient money to cover a worst case scenario will not be able to do anything to prepare for care costs. This will either cause significant worry, or disengagement with the issue. It will also mean that when these people come to needing care they may have less flexibility to make good choices about their care, so will not contribute to driving improvements and innovations in the care market.

Commission on Funding of Care and Support

16. The Commission on Funding Care and Support (the "Dilnot Commission") looked at a variety of funding models, drawing on expert advice during the significant time they had to investigate options and concluded that a capped cost model was the best option for funding reform.
17. The rational for this decision is available in the report and its supporting documents. We do not intend to reproduce this work here.

Scope of this impact assessment

18. This impact assessment is concerned with the government's proposals for funding reform as set out in the Care Act 2014 and the draft regulations and guidance published alongside this document.

[4] Barriers to and opportunities for private Long term care insurance in England: what can we learn from other countries. Adelina Comas-Herrera, Rebecca Butterfield, Jose-Luis Fernandez, Raphaiel Wittenberg and Joshua M. Wiener, Printed in the LSE Companion to Health Policy, Edward Elgar, 2012.
[5] http://www.partnership.co.uk/Documents/Corporate/PR/Immediate%20Needs%20Annuities%20.pdf

Policy Objectives

19. The primary objective of the policy is to address the risk individuals face due to unlimited care costs. The reforms should provide people with financial protection from catastrophic care costs and give them with the peace of mind from knowing that they have this protection.

20. There are also secondary objectives, namely:

- the system encourages people to take responsibility and to plan and prepare for their care needs in later life;
- any reforms should be financially and politically sustainable, this is important since the benefits depend to a large degree on providing people with predictability about much they may need to contribute towards their care;
- the system should support the wider objectives for the care and support system including supporting preventative services and the provision of information and advice to enable people to make effective choices about their care and support.

Summary of options

Option 1: A capped cost model with an extended means test implemented in April 2106

21. A capped cost model announced by the Government based upon the principles set-out by the Dilnot Commission to be implemented in April 2016.

Older people

- a cap of £72,000 (around £60,000 compared to the £25k to £50k range published by the Dilnot Commission) on the costs to meet their eligible care and support needs for adults resident in England;
- an "extended means test" - upper capital threshold of £118,000 (comparable to the £100,000 proposed by the Dilnot Commission) for those in a care home not benefiting from a property disregard;
- upper capital limit in other circumstances and in community care of £27,000;
- lower capital limit of £17,000;
- a tariff income (£1 per week for every £250) continues to be applied to those with assets between the lower and upper capital limits;
- after reaching the cap individuals in a care home will remain responsible for a contribution towards daily living costs of £230 per week with means tested support available on the same basis as for care costs;
- people will meter towards the cap at the rate set out in their Personal (PB) or Independent Personal Budget (IPB);
- the level of the cap will be uprated in line with a measure of average earnings. Other parameters in the financial system will continue to uprated annually.

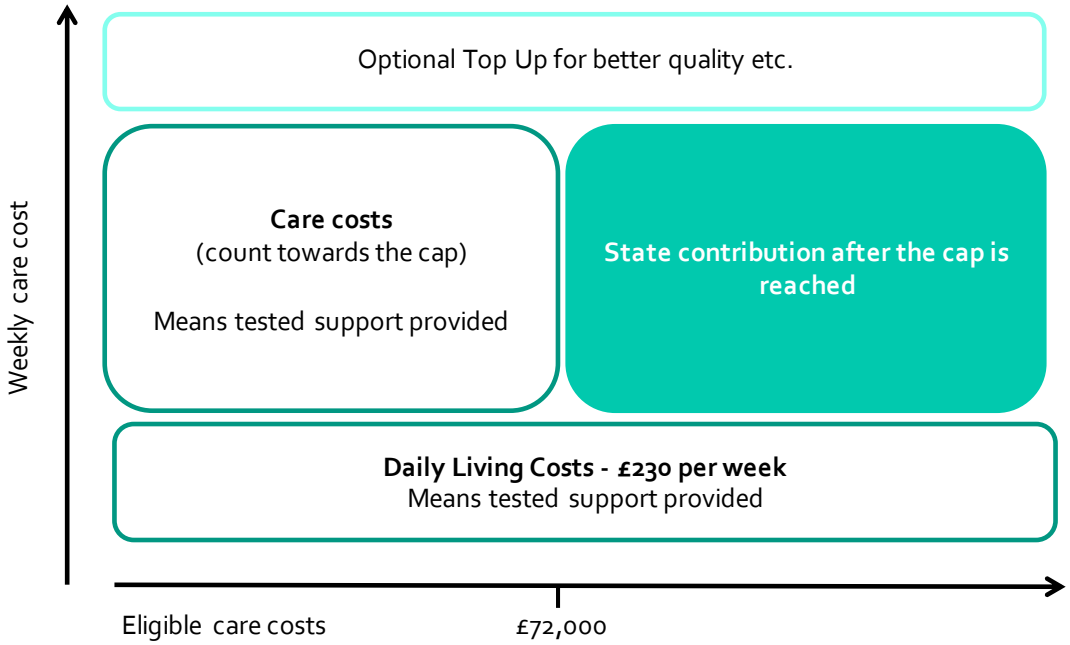
Working age people – the policy set out in the draft regulations and guidance

- A zero cap for people born with care and support needs or developing needs up to the age of 25;
- A cap of £72,000 for people of all other ages; and

- The minimum income guarantee in community care equalised with the older people minimum income guarantee, with an increase to £170.00 (for single people) in 2016/17. The exact trajectory after this point will be determined at the relevant spending review;

22. Figure 3 illustrates how the cap will work in care homes and highlights the additional state contribution to cap people's eligible care costs. The individual remains responsible for daily living costs, with means tested support provided for those who cannot afford them.

Figure 3: How the cap will work in care homes



23. In community care people meter towards the cap at the rate the local authority would pay to meet the individual's needs, and in a care home at the rate the local authority would pay to meet the individual's needs less £230 (the notational contribution for daily living costs). For state supported people this is set out in their Personal Budget and for self-funders set out in their Independent Budget. For example in 2016/17:

Figure 4: Metering rate in care homes and community care

	Rate the Local authority would pay to meet needs	Metering rate
Care home	£570	£340 (= £570 - £230)
Community care	£150	£150

Setting the level of the cap

24. Setting the cap affects both the costs and benefits of the policy. In the current fiscal climate it is necessary to strike a balance between competing government spending pressures.

25. The major considerations in setting the cap were:

- The Commission recommended that an appropriate level of cap in 2010/11 should be £25k to £50k. It also said the cap should inflate over time so that every generation gets a fair deal.
- Cost of the policy. The amount of resources spent on the cap needed to be balanced against potential other uses for those funds and the government's fiscal objectives.
- Sustainability of costs over time. The peace of mind benefits of the reforms rely upon people believing the reforms are sustainable over time and that they will be protected from unlimited care costs if they develop care needs. The lower the cap (and conversely the higher the cost of the reforms) the harder it would be to ensure that individuals believe successive governments will remain committed to this policy.
- The level of protection provided. A lower cap provides greater protection from unlimited care costs but increases the overall costs of the reforms risking potential sustainability issues.

26. The proposal sets the cap at £72,000. In order to ensure that proposals were affordable and sustainable it has been necessary to go slightly above the recommended range of the Commission with a cap equivalent to around £60,000 in 2010/11 prices.
27. Setting the cap at £72,000 provides people with protection from unlimited care costs and ensures that the policy is sustainable in the long term. The government has set out how it will ensure that these reforms are fully funded for the next parliament[6]. This funding commitment is vital to achieving the full benefits of these reforms.
28. This Impact Assessment updates the appraisal of the announced policy set out in the previous version of the Impact Assessment. It compared them to a do nothing option as set out below

Option 2: Do Nothing - The current system

29. This would leave the current system as it is, broadly unchanged since 1948. People in residential care would receive state support only when their assets had fallen to around £23,250. People would still be unable to protect themselves from the risk of unlimited care costs and the system would not reflect the realities of today's society.

Consultation on draft regulations and guidance

30. The consultation document seeks views on areas where challenges have been levelled at the cap that we wish to explore further.
31. During the consultation, Caring for our future, that took place over the summer of 2013, several challenges to the detail of the cap system were identified. In particular the challenges focused upon situations where people may not be fully protected by the cap on care costs.
    a. People who cannot afford daily living costs from their income;
    b. People in domiciliary care who might not be protected by the cap;

32. The benefits of an insurance product depend not only on the amount of money it provides to people in the worst case but the extent to which it offers more or less complete protection. We therefore

[6] Budget 2013 https://www.gov.uk/government/publications/budget-2013-documents

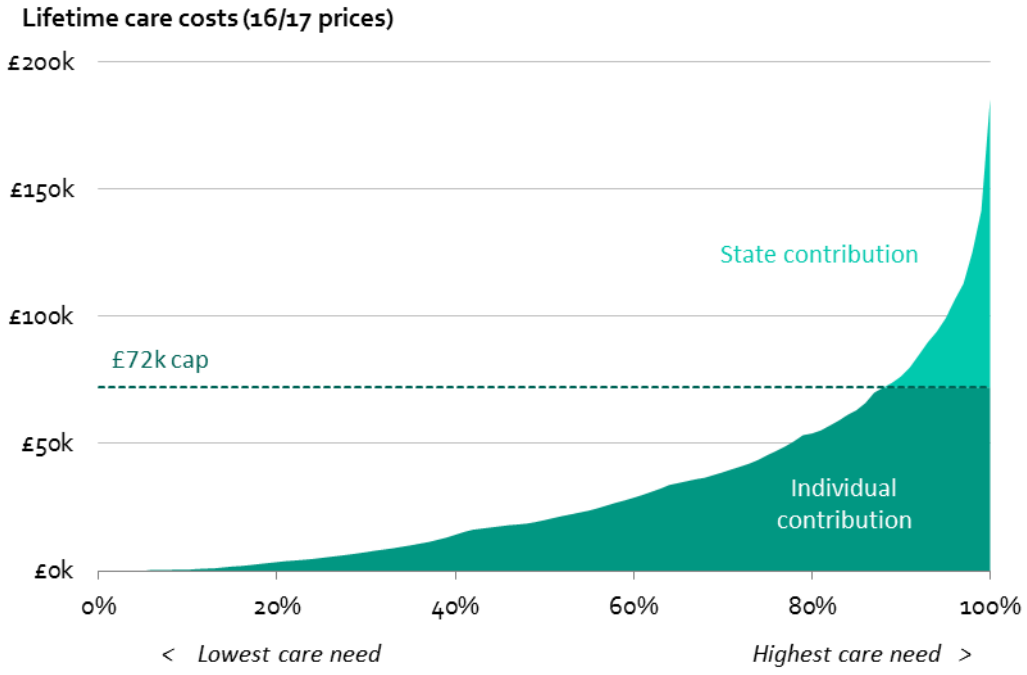
conclude that gaps in the protection provided by the cap would have a larger impact on the benefits, than would be expected if we simply considered the financial value of the insurance provided.

33. For the peace of mind benefits provided by the cap to be effective it is important that there are as few exceptions from the protection as possible. Large and recurring exceptions are likely to significantly undermine the confidence of people in the system. Therefore it is important that the protection provided by the cap is as comprehensive as possible.
34. We provide further information in Annex C.

Impact of preferred option (option 1)

35. The cap and extended means-test, define a clear and fair partnership between individuals and the government, with shared responsibility for care costs. People will still have responsibility for their initial care costs, but if they are unlucky enough to have high care needs, they will not face catastrophic costs.
36. The cap acts to protect people from costs above £72,000. As shown by figure 5 it truncates the distribution of care costs borne by individuals and ensures that they are protected from lifetime costs above this amount.

Figure 5: Lifetime care costs met by the individual and the state under a £72,000 cap, for people entering care, by percentile – PSSRU modelling as published by the Commission uprated to 16/17 prices

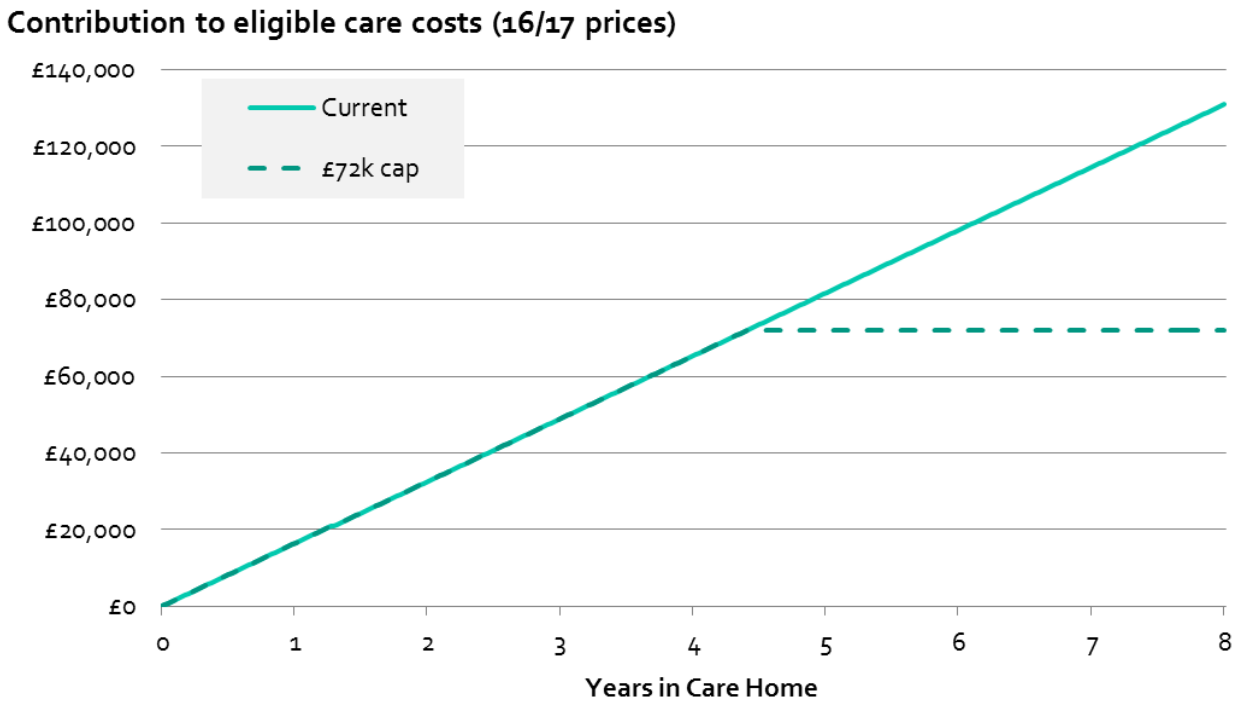


37. Figure 6 shows how with the £72k cap the individual's contribution to eligible care costs is capped once they have reached the cap, whereas in the current system they are at risk of catastrophic care costs.
38. This removes the risk of individuals needing to pay care costs above this amount and makes it feasible for insurance products to be developed to cover the individual contribution. Everyone benefits from the peace of mind from knowing that they will not face unlimited care costs, not just the people who benefit financially from the cap.

39. The total cost to the local authority of meeting a people's eligible needs will count towards the cap, rather than their financial contribution. This means that people meter towards the cap at the same rate irrespective of the state support they are receiving.

40. Meanwhile the extended means test increases the state support for those who would find it most difficult to meet their care costs by reducing the amount they would spend from their assets when they are below the upper capital limit. The metering and the extended means test interact with the protection provided by the cap, so that adults with the least wealth will receive financial support towards their care costs and therefore avoid the risk losing all their assets before they reach the cap

Figure 6: Individuals contribution to eligible care costs (not including the £230 per week as the notational contribution to daily living costs) over 8 years in a care home with care costs of £570 per week



41. This means that people who receive means tested support before reaching the cap spend less on care costs before reaching the cap than people who receive no state support. Figure 5 below shows the amount of the value of their home and savings an individual may have to contribute toward the cost of eligible care needs before reaching the cap – or the effective level of the cap.

Figure 7: The effective level of the cap for different levels of starting assets (i.e. value of home and savings) for an individual entering a care home with local authority care home rate of £570 per week.

Initial assets	An older person's contribution to care costs before reaching the cap
£250,000	£72,000
£200,000	£72,000
£150,000	£69,000
£100,000	£47,000
£70,000	£30,000
£50,000	£19,000
£40,000	£13,000
£17,000 or less	£0

DH modelling - assumes the individual has income of £255 per week

42. The time to reach the cap is dependent on the local authority care home rates and any prior community care. For example, an individual who has received 1 year of community care before moving into a care home with rate £550 will reach the cap after 3 years and 10 months.

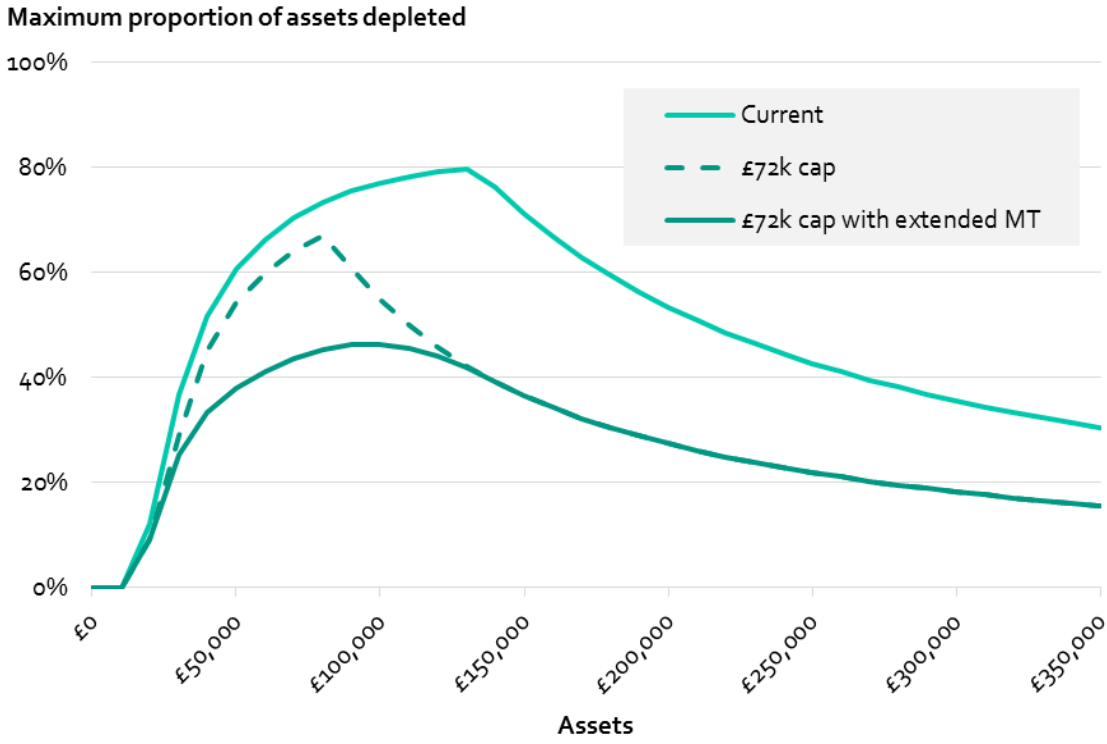
Figure 8: Time to reach the cap in care home at different levels of local authority care home rates and prior years in community care

Years of prior eligible community care	0 years	1 year	2 years
Care home fee	Time in care home to reach the cap		
£450	6 years, 4 months	5 years, 7 months	4 years, 11 months
£500	5 years , 2 months	4 years, 7 months	4 years, 0 months
£550	4 years , 4 months	3 years, 10 months	3 years, 5 months
£600	3 years , 9 months	3 years, 4 months	2 years, 11 months
£650	3 years , 4 months	2 years, 11 months	2 years, 7 months
£700	2 years , 11 months	2 years, 8 months	2 years, 4 months
£750	2 years , 8 months	2 years, 4 months	2 years, 1 months

DH Analysis – assumes community care costs of £150 per week

43. In the current system it is those of moderate wealth who face the risk of spending the highest proportion of their assets to pay to meet their care and support needs. Since someone with wealth of £100,000 we have to self-fund their care until they have depleted their assets to the current upper capital limit, £23,250. It is for these people that the cap and extended means test provides the greatest protection.

Figure 9: Possible asset depletion for people who enter a care home and have 8 years in a care home with local authority care home rate of £570 per week.



Source: DH modelling - assumes the individual has income equal to £255 per week

44. For example, someone with moderate levels of assets of £130,000 could deplete 80% of their assets over 8 years in a care home with care fee £570 per week. Under the reforms this same individual would deplete just over 40% over the same care journey and deplete around £50,000 less from their assets.

Figure 10: Asset depletion for individual with moderate wealth

Assets depleted under the current system and the reforms for an individual with assets of £130,000 when entering a care home and staying in the care home for 8 years.

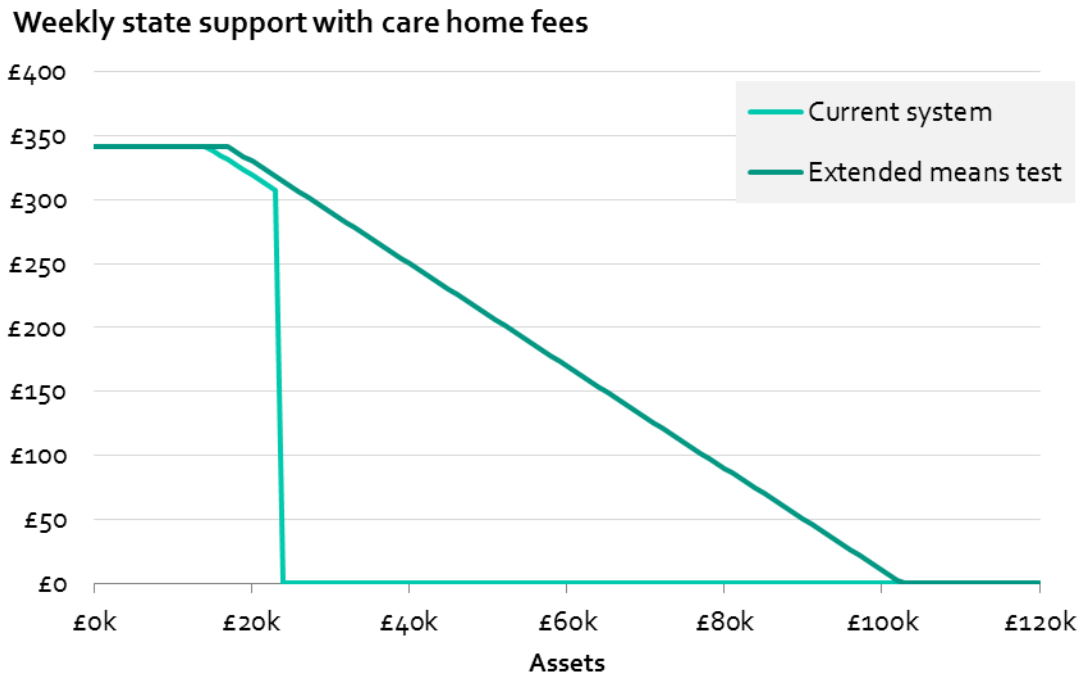
	Current System	Option 1
% of assets depleted	80%	42%
Assets depleted (£)	£104,000	£55,000
Difference (£)		-£49,000

DH analysis - We assume the care home fee £570 per week and the individual has income of £255 per week and is eligible for high level Attendance Allowance. [Analysis in 16/17 prices]

45. The combination of the cap and the extended means test protects people with all levels of assets from unlimited care costs and defines a new partnership between the individual and the state. People will no longer face the risk of losing everything they own to pay for care and the greatest additional protection is provided to those who risk losing the most in the current system.

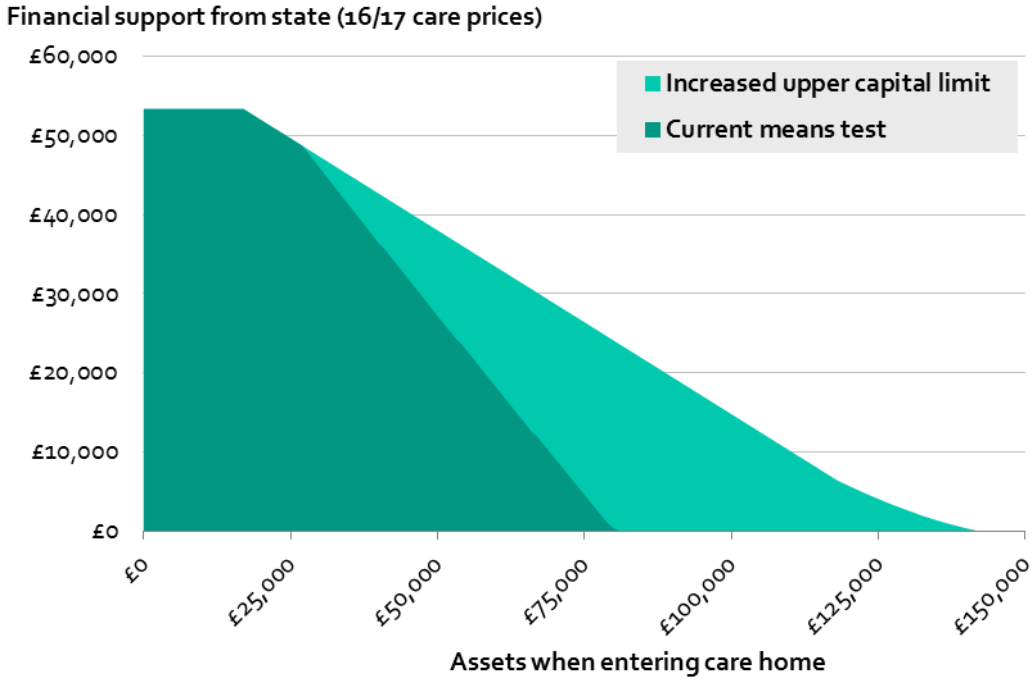
46. The extended means test also provides immediate additional state support to those with low and moderate wealth. It removes the cliff-edge in the current means test, where people with assets above £23,250 receive no state support and those with £23,250 significant levels of state support, and results in a means test that gradually increases the state financial support as people spend down their assets.

Figure 11: Weekly state support with the extended means test compared to the current system for an individual in a care home with fee £570 per week and £255 per week income



47. Over a 3 year stay in a care home the extended means test means that people with assets (when they enter the care home) of up to around £140,000 benefit from additional state support with their care home fees.

Figure 12: State support from the means test under the current and extended means test for individuals receiving three years of care in a care home at a projected typical local authority rate in 2016/17 (£570 per week)



DH analysis - assumes the individual has income of £255 per week

48. For example for an individual with £80,000 of assets when they enter a care home will receive nearly £39,000 of state support through the extended means test compared to not receiving any local authority support in the current system. In the current system they would likely have received around £13,000 from disability benefits over the same 3 years which is no longer payable because they are receiving support through the extended means test. They therefore receive £25,000 extra in overall state support.

Figure 13: State support from local authorities and disability benefits for an individual with £80,000 of assets and £160 per week income over a 3 year stay in a care home (care fee £570 per week)

16/17 prices	Cumulative state support		Cumulative receipt of disability benefit	
	Current	Extended means test	Current	Extended means test
End of year 1	£0	£10,872	£4,356	£0
End of year 2	£0	£23,973	£8,711	£0
End of year 3	£0	£38,885	£13,067	£0

Working Age Adults

49. The fundamental principle behind the cap on care costs is that people have had an opportunity to build up a degree of wealth over the course of their working lives and have the opportunity to plan and prepare for the possibility of care and support needs in the future. However, for people who are born with care and support needs or who develop them in early life this is often not the case as there is simply no way for a child or young adult to protect themselves against this risk. Alongside this, the need for care and support can create barriers to education, employment and training that mean that they cannot plan and prepare in the same way as people who develop care and support needs in later life.
50. The Dilnot Commission recognised this challenge and as a result developed proposals that were based on the assumption that whilst it is reasonable to expect someone who develops care needs in later life to have planned for this possibility and build assets, this cannot be said to the same degree for younger people who were either born with, or who develop a care and support need in early life. The Dilnot Commission therefore recommended that people who develop a care and support need during their working life should be assessed in broadly the same way as an older person under an overarching cap on care costs system but that people who develop care needs before retirement age should benefit from a lower cap which recognises their likely lesser ability to accumulate assets.
51. However, engagement through the 2013 consultation on funding reform highlighted challenges to this approach. Whilst people broadly welcomed the principles there were questions raised, particularly with regards to different levels of the cap as to whether the age at which a person develops eligible care needs is a reliable or fair way of differentiating their ability to plan, prepare and build up assets and whether it was right that working age adults with significant wealth should not have to contribute towards their care costs in the same way as older people. The need to create a system that is simple to understand and easy to communicate was also highlighted.
52. As a result, we have engaged with stakeholders to determine priorities and set out the following option in the draft regulations and guidance.

Figure 14: Policy option for working age adults set out in the draft regulations and guidance

Element	Age Group			
	18-25	41-50	51-60	60-65
Cap	Zero cap*	£72,000		
Minimum Income Guarantee	Rising to reach parity with those above pension credit age			

* For the rest of their life

53. This balances the priorities highlighted by stakeholders (including equalising the income allowances for working age people with older people) and maintains the principles set out by the Dilnot Commission.
54. It protects those born with a care and support need or who develop one in early life, an essential priority expressed by both the Dilnot Commission and stakeholders, and it eliminates the current inequality in the income people of working age are left with after charges compared with those of pension credit age. In 2015/16 the minimum income guarantee for older people is over £50 higher than for those under 25, assuming that those under 25 are receiving both the disability and enhanced disability premium.

Figure 15: Minimum income guarantee for different age groups in 2015/16

	2015/16
under 25	£132.45
over 25	£151.45
Above pension credit age	£189.00

55. The draft regulations set out provisions to increase the minimum income guarantee for all people below pension credit age receiving care and support to £170.00 in 2016/17. The exact trajectory after this point will be determined at the relevant spending review
56. As well as creating equity between the different age groups, the increased minimum income guarantee for working age people will increase the income they have to spend or save.
57. However, this means that the idea of a tiered cap would necessarily become less of a priority in order to meet the constraints of the funding envelope. Whilst this is a shift from the position set out by the Dilnot Commission it does reduce the number of points at which a person's age is an issue in the level of cap they receive.
58. Any distinction based on age would need to be assessed against the duty to have due regard to the need to eliminate discrimination and advance equality of opportunity and foster good relations between those who do and do not share a protected characteristic in order to satisfy the requirements of the Equality Act 2010. The age of 25 has been chosen as it aligns with the age limits for Special Educational Needs and Disabilities (SEND) and the apprenticeship scheme 'AGE 16-24'. The principal reason for the approach set out above is to meet the essential priority to protect those born with a care and support need or who develop one in early life. This is simply an uninsurable risk that leaves families in fear of catastrophic costs and can prevent people from fully living their lives. Providing this peace of mind will help support people to stay in education and training and enter employment along with the charging framework that disregards all earnings. For those over 25, they

will still benefit from the peace of mind of being protected from catastrophic costs and will receive the added support of being left with more income after charges.

Costs of Option 1

59. There are different costs that result from the implementation of the reforms:

Cost of the cap and extended means test for older people

60. This is the amount of money transferred from the state to older people to protect them from unlimited care costs - through the extension to the means test and the introduction of the cap.

Overview of the modelling

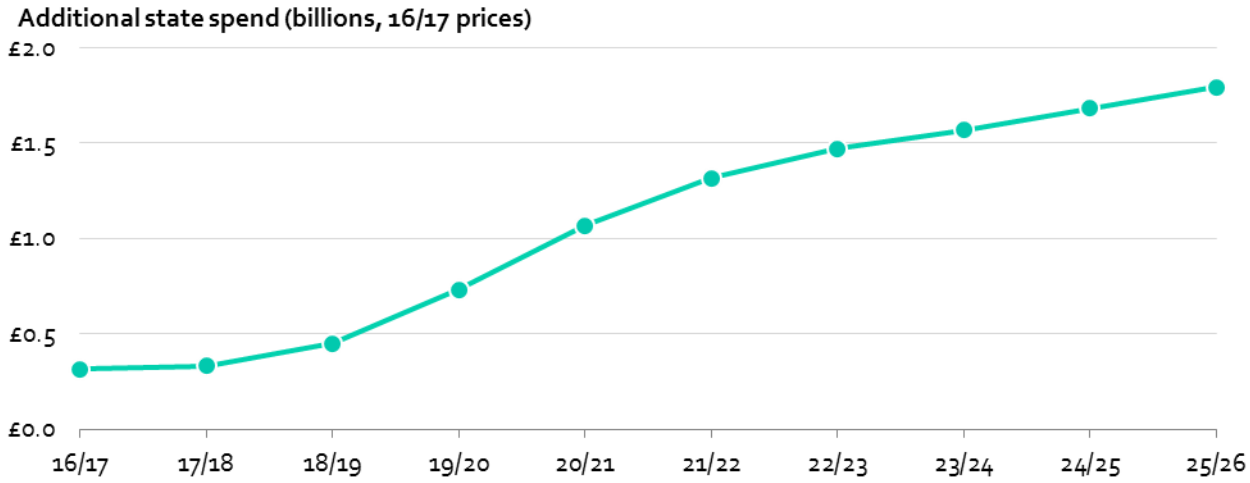
61. The cost projections are estimated using the DH social care funding model (v2014). It is an Excel based model which runs using VBA code. It is designed to estimate the impact of different funding reform options, in particular to estimate the public spend on older adult social care and the distributional impact of the different reforms.
62. The model is a cross-sectional model that retro-speculatively simulates the uncompleted care journeys of a representative cross section of care users in the cross-sectional month being considered. It independently models each quarter of the years 2015/16 to 2025/26. For each financial quarter it models the week in the middle of each quarter.
63. The model uses a base sample of the ADL (activity of daily living) disabled 65+ population from wave 5 of the English Longitudinal Study of Ageing (ELSA)[7]. It models 6 care settings separately; nursing homes, residential homes and 4 levels of home care (low, medium, high and very high intensity). The base sample provides the individual wealth characteristics used in the model.
64. The base sample is statically aged using weightings derived from projections from the PSSRU (Personal Social Services Research Unit[8]) aggregate model of the number and characteristics of care users in each year in question.
65. For each care setting the model runs a representative sample (through weighting the base sample) through an individual care pathway model.
66. Each individual in the sample is assigned a random care pathway from a derived distribution of all uncompleted care pathways using PSSRU survey data. The individual care pathway model computes the state and private spend for each month of the care pathway, this is dependent on the individuals characteristics (income, wealth, household type, housing tenure) and the funding system being modelled. The quantities of the cross-sectional point are aggregated using the weights to produce population level estimates.
67. The quarterly estimates are aggregated to produce estimates for each financial year. The model is run multiple times to average out the statistical randomness in the results.
68. The results produced are not projections of the future but projections under the set of assumptions used, the results are therefore sensitive to changes in assumptions. More details of the modelling are provided in Annex B.

Projected costs

[7] http://www.ifs.org.uk/ELSA
[8] http://www.pssru.ac.uk/

69. With the central set of assumptions we project the costs increasing from just over £300 million in 2016/17 and 2017/18 to around £1.8bn in 2025/26.

Figure 16: Projected costs for older adults



£ billions, 16/17 prices	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Older People										
Cap and means test	0.32	0.33	0.45	0.73	1.07	1.32	1.47	1.57	1.68	1.79

70. The costs in the early years are driven by the extension to the meant test, which will see around 23,000 people benefit immediately when the reforms are implemented.

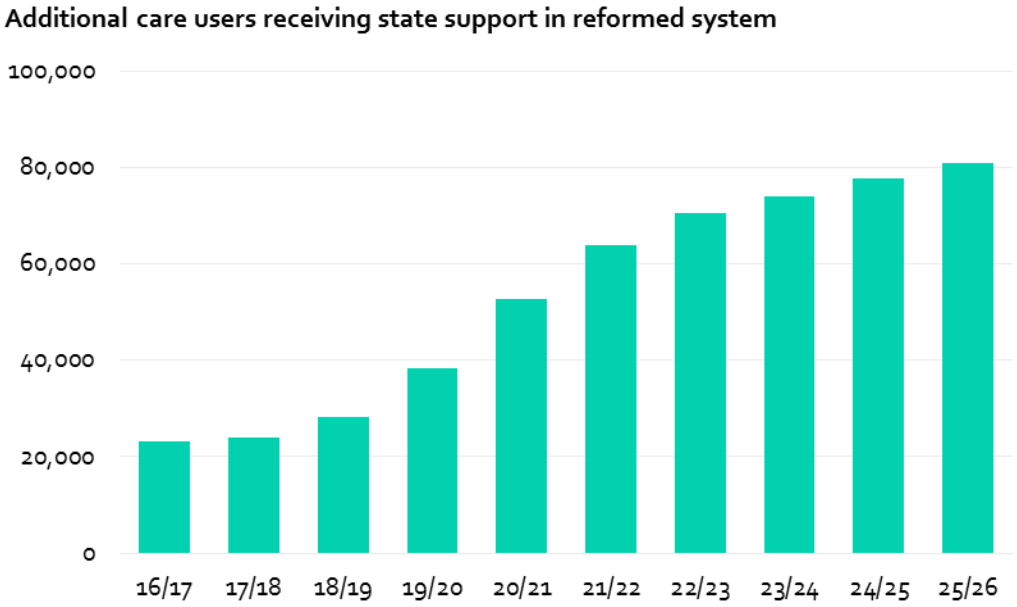
71. The costs increase from 2018/19 as people with different levels of care costs start reaching the cap. For example, with care home fees of £500 people will take just over 5 years to reach the cap, while with care home fees of £700 people will take around 3 years. The variation of care home fees across the country explains the gradual increase in costs.

72. By the end of 2018/19 we estimate around 19,000 people will have reached the cap, increasing to over 100,000 by 2021/22 and 130,000 in 2025/26. We note that some of these people will already be receiving state support with the care and support costs through the means test.

73. By 2025/26 the reforms will have reached steady state and around 80,000 additional people receiving state support with their care costs.

Figure 17: Projected number of additional people receiving state support and numbers reaching the cap

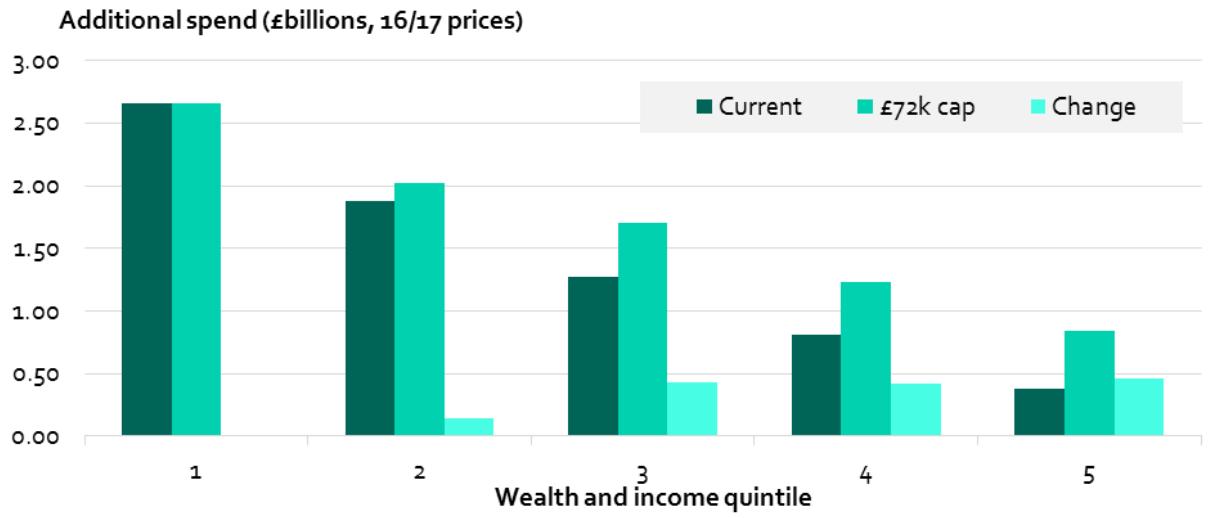
	16/17	*17/18*	*18/19*	*19/20*	*20/21*	*21/22*	*22/23*	*23/24*	*24/25*	*25/26*
Additional people supported	23,000	24,000	28,000	38,000	53,000	64,000	71,000	74,000	78,000	81,000
Number reaching the cap	0	0	19,000	37,000	74,000	101,000	115,000	121,000	128,000	132,000



Source: DH modelling

74. State support is extended to these additional individuals through the combination of the cap and the means test. As the cap provides a universal element to a means tested system, the additional spend goes to those above the lowest quintile (who already receive high levels of state support) and is thus less progressive than current highly means tested system.
75. However, the reformed social care funding system remains highly progressive with nearly two-thirds of state support focused on the lowest two quintiles. See the specific impacts section for the specific definition of the quintiles.

Figure 18: Social care funding by combined income and asset quintiles of older people receiving Adult Social Care under the current and the proposed system in 2025/26.



Source: DH modelling

Key assumptions and uncertainty

Demand projections for formal care and support

76. The modelling assumes the demand for formal care and support grows according to the PSSRU aggregate modelling which projects social care demand from demographic trends, this includes the number of self-funders. The key assumptions are the 2012 ONS based population projections (low migration variant as used by the Office of Budget Responsibility in their central projections) and that care and support need prevalence by age and gender band remains constant in the future. Various publications provide further details of the projections and the methodology and assumptions used[9]. We assume that these projections are not significantly affected by the implementation of the reforms.

77. There is uncertainty around how increased life expectancy will impact on the number of people who develop a care and support need and more generally whether we will see a compression or expansion of morbidity in the future. The note that the consequence of increasing life expectancy with constant prevalence of care and support need is that the average proportion of life expectancy with a care and support need will increase. We believe that this is a robust central and potentially conservative assumption.

Eligibility criteria

78. The modelling is based upon estimates of current social care eligibility; this should be consistent with the implementation of the national minimum eligibility criteria in April 2015.

Uptake of the reforms

79. The central assumption regarding the uptake of the reformed system is that 80% of self-funders will come forward to be part of the funding reform system. This was informed by local authority intelligence and uptake rates of other state benefits.

80. The 80% uptake assumption is potentially quite conservative. There is evidence that uptake of cash benefits where the benefit to the individual is immediate is below this level. For example, take up is estimated to be between 62% and 68% for pension credit and between 78% and 84% for housing benefit[10]. There is also academic work that points towards non-uptake of Attendance Allowance stating "implying that, among over-65s who are not currently receiving AA, at least a third could expect to be successful if they were to make a claim"[11].

81. By contrast, registering for the cap provides no immediate cash benefit for a self-funder and there is uncertainty as to whether any support would ever be received as it depends on how long they spend in care and how much their care costs. This creates much weaker incentives to participate compared with the cash benefits upon which the central uptake assumption is based.

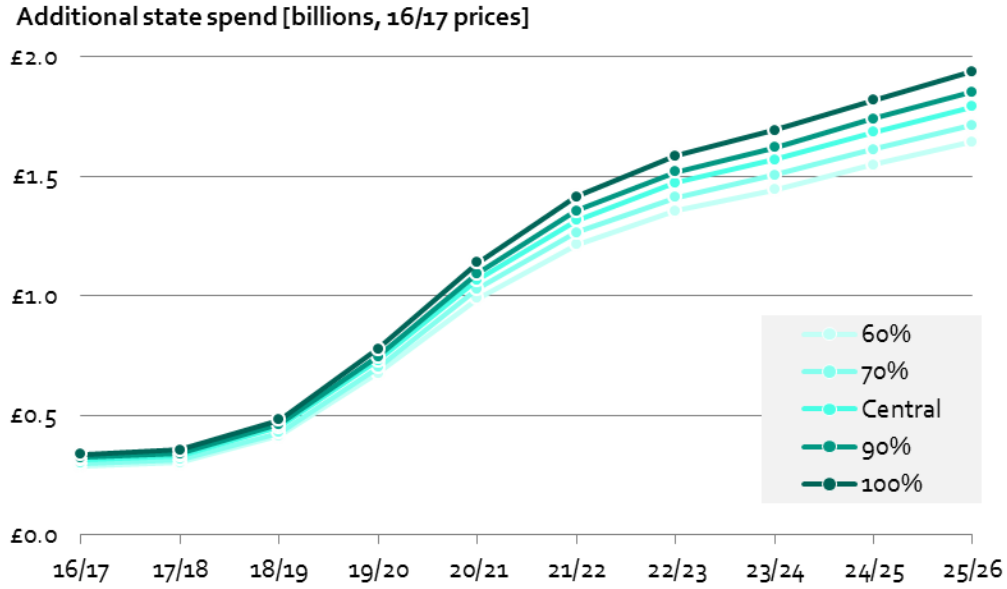
82. We present sensitivity analysis on the uptake assumption. It shows that is makes only a small impact on the costs in the short run, but by 2025/26 if up take is 10% higher or lower than the central assumption then the costs would be £60 million higher or £80 million lower than the central estimate.

[9] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/121203_care_for_older_people_1.pdf

[10] https://www.gov.uk/government/collections/income-related-benefits-estimates-of-take-up--2

[11] https://www.iser.essex.ac.uk/research/publications/working-papers/iser/2009-19.pdf

Figure 19: Sensitivity analysis to uptake assumption



Unit cost of care and future projection

83. In the modelling we make assumptions on the local authority unit cost of care in the year of implementation and then projecting forward. The latest outturn data we have from the Health and Social Care Information Centre is for 2013/14, it shows the average local authority unit costs for residential care to be £540[12]. We present the derived unit costs from local authority returns in Annex D.

Figure 20: Unit costs of care – Health and Social Care Information Centre

£ per week	*2010/11*	*2011/12*	*2012/13*	*2013/14*
Nursing	£ 534	£519	£507	£533
Residential	£ 522	£522	£528	£540

84. From this data we assume that care costs increase in line with the latest OBR projections of average earnings[13]. Care costs are assumed to increase in line with average earnings due to the labour intensive nature of care and support. This assumption makes no requirement for efficiency gains in the provision of social care services. We note that since 2010/11 local authority care costs have remained roughly flat in cash terms.

Figure 21: Reproduced from Table 4.1 (OBR, Economic and Fiscal Forecast – December 2014)

% increase	Outturn	Forecast					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Average earnings	1.7	1.8	2.1	3.3	4.0	3.9	3.8

[12] Health and Social Care Information Centre, Personal Social Services: Expenditure and Unit Costs, England - 2013-14

[13] Office for Budget Responsibility, Economic and Fiscal Outlook – December 2014

85. There is uncertainty around the short and long term projection of care costs. We believe a short term assumption of increasing in line with average earnings, balances the risk between further below trend increases and pressures to catch up following the recent trend of costs remaining flat.

Figure 22: Projected average care costs 2013/14 – 2016/17

Average care costs	13/14	14/15	15/16	16/17
Nursing	£533	£544	**£552**	**£572**
Residential	£540	£551	**£559**	**£580**

86. We complete sensitivity analysis around the central assumption with 2 alternative assumptions:

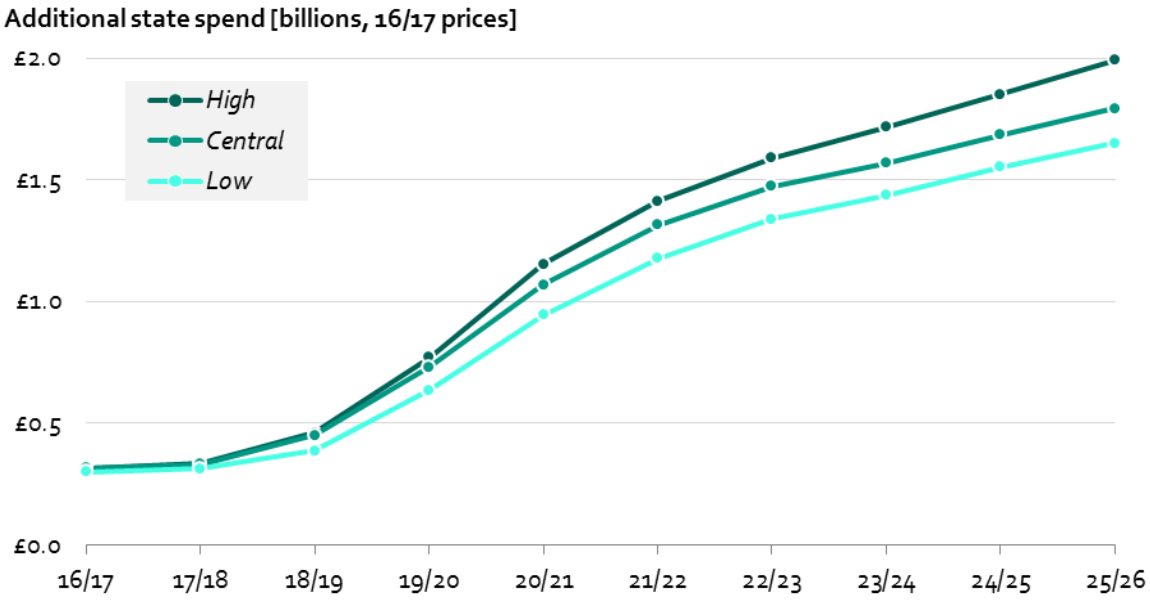
- High: increase with average earnings until 2015/16, followed by increase with one percent greater than average earnings for each year following until 2019/20, with average earnings again in the period following until 2025/26.
- Low: increase at the average rate 2010/11 – 2013/14, followed by average earnings until 2025/26.

87. The costs of the reforms are sensitive to this assumption, since the level of care costs impact:

- The time it takes the people to reach the cap;
- The likelihood that people reach the cap, and therefore the number of people who will reach the cap;
- And the amount of state support that people receive once they have reached the cap.

88. The analysis shows that under the different assumptions we project the costs of the reforms to be over £100 million lower or higher than the central projection by 2025/26.

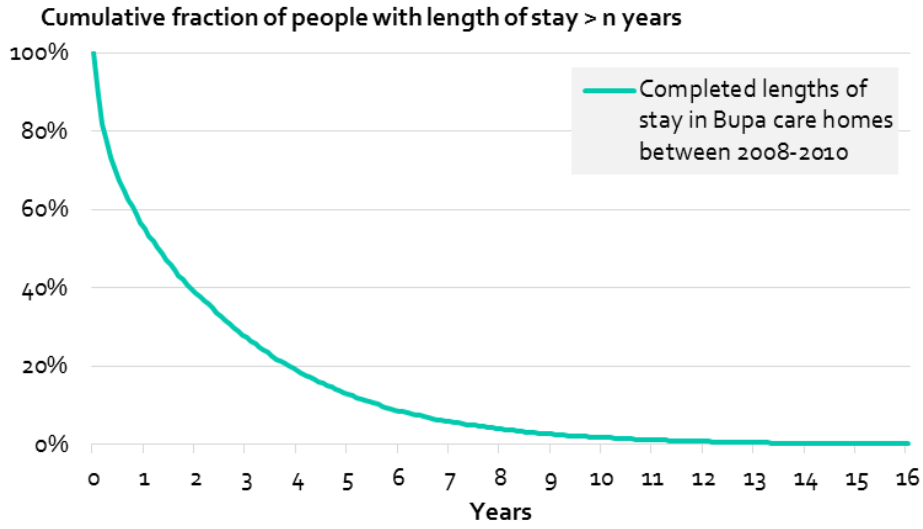
Figure 23: Sensitivity to care cost assumption



Lengths of stay in care

89. We use the distribution of lengths of stay from the PSSRU study of BUPA care homes[14] it shows a mean completed length of stay of 26 months and a median length of 15 months.

Figure 24: Completed lengths of stay (BUPA/PSSRU)



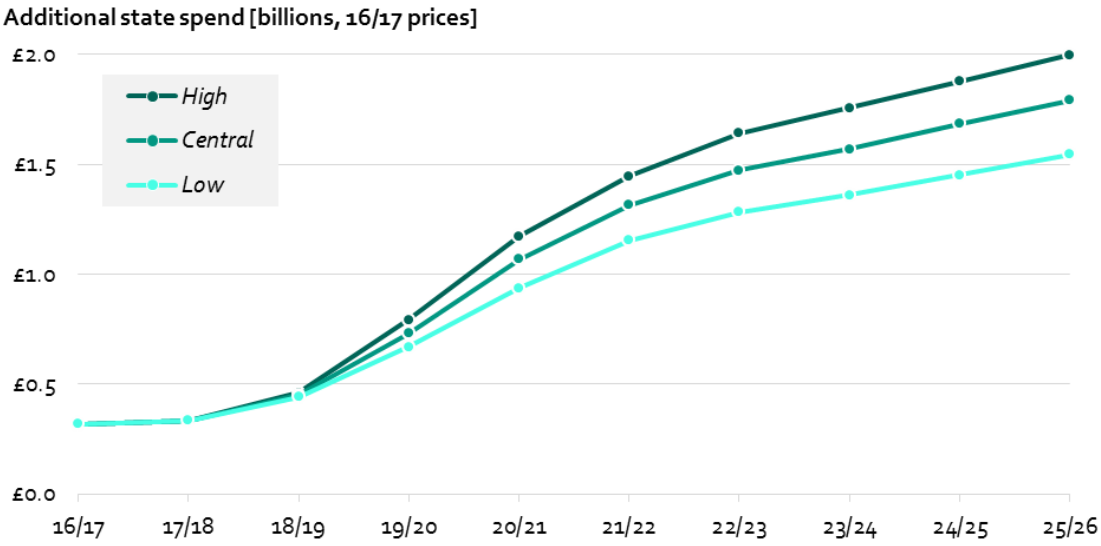
90. As our central assumption we assume that lengths of stay remain constant in the future. Further discussion on this assumption can be found the OBR Fiscal and Sustainability Report, 2013[15].

91. We recognise that the availability of analysis and data regarding the lengths of stay is somewhat limited and there is uncertainty around the lengths of stay. The other evidence available suggests that this uncertainty is in either direction and therefore lengths of stay could be either longer or shorter than our central estimate.

92. We present sensitivity analysis with a high and low scenarios:

- High: 10% longer residential and nursing, 20% longer community lengths of stay;
- Low: 10% shorter residential and nursing, 20% shorter community lengths of stay.

Figure 25: Sensitivity to lengths of residential and domiciliary care



[14] PSSRU, Lengths of stay in care homes http://eprints.lse.ac.uk/33895/1/dp2769.pdf

[15] http://budgetresponsibility.org.uk/fiscal-sustainability-report-july-2013/

Summary

93. While there are uncertainties around care costs, uptake and lengths of stay in care, it should be noted that increases in cost also result in increases in the number of people benefitting and vice versa. The underlying economic case is therefore unaffected by such potential variation in assumptions.

Cost of the reforms for those of working age

94. This is the amount of money transferred from the state to working age adults to protect them from unlimited care costs, through the introduction of a cap and a zero cap for those with an eligible care need between 18 and 25, and the increase in the minimum income guarantee.

Overview of the modelling

95. We take a different modelling approach to that of older people, using a cohort modelling approach. This is primarily due to the lack of high quality data on those of working age.

96. The DH analysis for working age adults takes intermediate outputs from PSSRU working age adult aggregate modelling for the projected costs of the current system and of a "zero cap" option to produce an estimate of the cost of the reform option between the two bounds.

97. The PSSRU working age aggregate model projects the number of working age adults with disability split into 3 categories, those with learning disabilities, physical or sensory impairments and those with mental health problems, and the public expenditure to support these. For more information on the PSSRU modelling see here[16].

98. DH modelling incorporates the latest data on the number of working age adults receiving state support with their care and support, and incorporates an additional assumption on the number of working age adults self-funding their care in residential care. There is no good data on this number, but it is unlikely that there is no one in this category. As these people will benefit from the reforms and therefore impact the cost estimates. We make the conservative assumption that there is the same proportion of people self-funding their care in residential care as in the community.

99. To model the preferred policy option, we have to make an assumption on the increase in the income allowance in community care reaching parity with older people in 2019/20. We assume an increase to £170.00 per week for single people of all ages in 2016/17 and a steady increase until 2019/20.

Projected costs

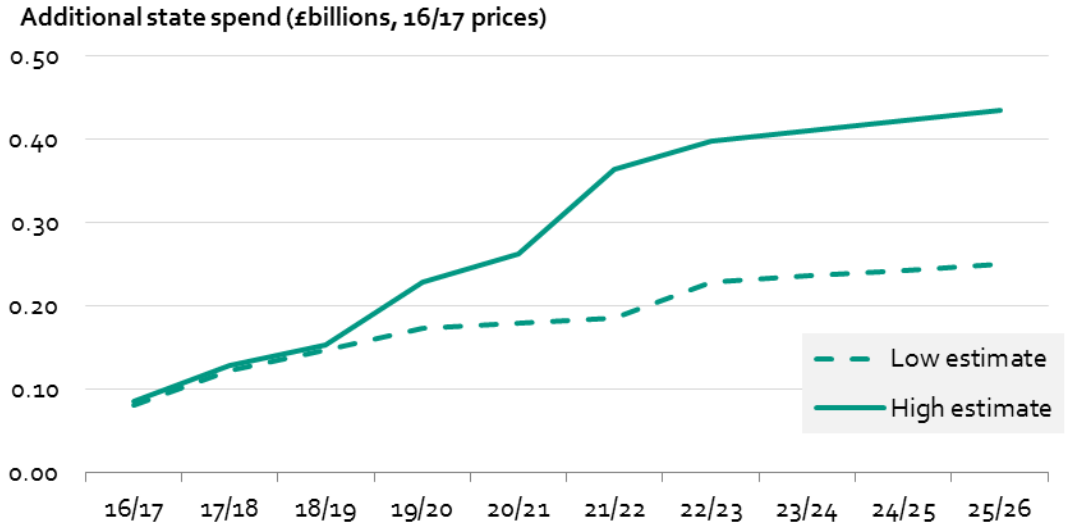
100. The estimated projected costs for the working age adult policy increase from around £100 million to between £250 million and £430 million.

101. The costs are substantially lower than for the older age group since there are few people of working age self-funding their care and support and those who are state supported currently contribute a lot less towards their care and support.

[16] http://www.pssru.ac.uk/pdf/DP2880-3.pdf

Figure 26: Projected costs for working age adults

£billions *16/17 prices*	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
High	0.09	0.13	0.15	0.23	0.24	0.25	0.40	0.41	0.42	0.43
Low	0.08	0.12	0.15	0.17	0.18	0.19	0.23	0.24	0.24	0.25



Key assumptions and uncertainty

Demand for care and support

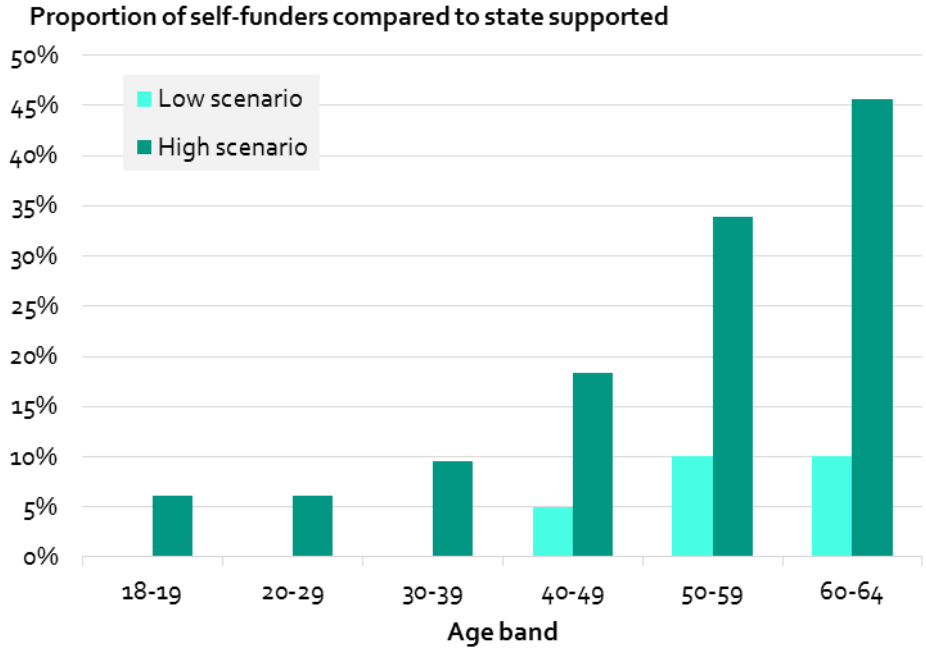
102. The key assumptions in the PSSRU modelling include the ONS population projections is that the prevalence rates of learning disability by age and gender change in line with the 'middle' projections of the future need for social care services among adults with learning disabilities by Emerson and Hatton (2008; Table 4)[17] and the prevalence rates of physical disability by age and gender remain unchanged as reported in the 1996/7 FRS.

Self-funders

103. The PSSRU modelling includes two sets of assumptions on the number of working age adults who are self-funding their care and support, which are derived from 1996/97 FRS. This implies there are people with physical disabilities and mental health problems who are self-funding their community care, with numbers increasing with age.

[17] CeDR Research Report 2008:6

Figure 27: Proportion of self-funders compared to state supported in community care for physical and mental disabilities



104. These assumptions imply there is no one of working age self-funding in residential care. As there is a lack of good data on this, we incorporate an additional assumption on the number of working age adults self-funding their care in residential care, as the same proportion as those in the community. We believe this is prudent given the uncertainty.

105. The two projected costs presented show the result of the two sets of assumptions on the number of self-funders. Due to the uncertainty we present the high estimate as the central estimate in this impact assessment.

Lengths of stay

106. We use mortality rates for those with Learning Disabilities to model the length of time people of working age will receive care and support18.

Cost of additional assessments, care managements and reviews

107. The extra costs for additional assessments and care management arise because for people to meter towards the cap they are required to be assessed and to have these assessments reviewed annually.

[18] CeDR Research Report 2008:6

Figure 28: Unit costs of assessments and reviews

	Cost (16/17)
Full Assessment	£550
Review	£275
Transitional Assessment	£468

108. The transitional assessments cost is based on 70% full cost assessment and 30% of assessment costing the same as reviews. This is because transitional assessments are for people already receiving care and support, therefore in many cases these assessments will be based on the services people are already receiving and existing evidence of ongoing need. Therefore they should have lower costs than assessments for people receiving care for the first time.

109. We have applied these costs to the projected number of additional people receiving care and support from the care and support funding model. These projections are set out below. The estimates of the flow of extra users are generated from the stock using an assumed average lengths of stay in care homes and domiciliary care. The average lengths of stay are derived from the data in the DH social care funding model. The figures therefore assume that when people move from community to residential care they receive a full cost assessment.

110. We have then applied the cost set out above to these figures along with the following assumptions:

- 20% extra ineligible people come forwards for an assessment and receive one at full cost. (alternatively 40% come forwards but the assessment is lower cost)
- The average number of reviews per year for these extra users is 1.2 as some individuals will have more than one assessment in the year due to changing needs.
- All additional state supported high intensity domiciliary care users receive case management with a cost of £1000 per year.

Figure 29: Projected number of additional assessments and reviews

Total assessments ('000s)	**15/16**	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**	**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
Transitional assessments	185	185	0	0	0	0	0	0	0	0	0
Assessments (eligible)	0	123	126	129	132	135	139	143	148	153	159
Assessments (non-eligible)	0	25	25	26	26	27	28	29	30	31	32
Total	**185**	**332**	**151**	**154**	**158**	**162**	**167**	**172**	**177**	**184**	**190**

Total reviews ('000s)	**15/16**	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**	**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
Reviews	**0**	**259**	**454**	**466**	**479**	**492**	**506**	**525**	**543**	**558**	**572**

111. There is uncertainty around the current costs of assessments, around how assessment for the cap will be conducted compared to traditional assessment. Social services department report it is an area they are looking to reform and SCIE have produced guidance[19]. We therefore present +10% and -10% sensitivity to our central estimate.

Figure 30: Projected costs of additional assessments, reviews and care management

£ million, 16/17 prices	***15/16***	***16/17***	***17/18***	***18/19***	***19/20***	***20/21***	***21/22***	***22/23***	***23/24***	***24/25***	***25/26***
Central estimate	109.6	255.1	205.3	220.0	229.8	241.1	253.2	268.0	282.5	297.6	312.6
10% higher	109.6	280.7	225.9	242.0	252.8	265.2	278.6	294.8	310.7	327.4	343.8
10% lower	109.6	229.6	184.8	198.0	206.8	217.0	227.9	241.2	254.2	267.8	281.3

[19] http://www.scie.org.uk/care-act-2014/assessment-and-eligibility/

112. The set up costs for 2015/16 including for early assessments, capacity building and local information costs. The level of these costs has been agreed with local authorities at £146m. This was done through extensive engagement and joint working[20].

113. The £146 million funding that has been made available is specifically to support local authorities to prepare for the 2016/17 reforms. This includes:

- £30 million to support planning and preparation for implementation of the second phase of the reforms, including providing local information and taking other steps to raise awareness in advance of implementation and ongoing investment in programme management skills and capacity, to ensure robust local arrangements are in place; and,
- £116 million to enable local authorities to undertake early assessments towards the cap during 2015/16 to manage capacity demands.

114. Both elements above will be vital to ensure a smooth start to the new system and to manage both the flow of people contacting their local authority and expectations. This note builds on previous advice and sets out the intended purpose of those funds.

Benefits

115. The assessment process is an important intervention in its own right. It is the first step in ensuring that the care and support system is personalised as it identifies the person's strengths and the network that supports them.

116. The assessment helps people understand and think about their own needs, as well identifying what those needs are and what outcomes the person wants to achieve. It can also identify the impact the adult's needs are having on other people, which for example, could result in their carer being offered a carers assessment.

117. It is during this contact that local authorities suspicion may be raised that a person is at risk of harm and abuse which will result in a safeguarding enquiry being initiated. In many cases, it is as part of the assessment process that discussions begin about how eligible needs might be met or what support might be available to meet those needs that are not eligible.

118. The assessment looks at the holistic needs of the person and the information gathered during the process is central to the eligibility determination, care planning and future reviews.

Change in the total costs of Attendance Allowance (AA), Disability Living Allowance (DLA) and Personal Independence Payment (PIP) for people aged 65 and over

119. AA, DLA and PIP are benefits available to those who have a physical or mental disability and need assistance with activities of daily living. They are not means tested and are therefore available to anyone who can show they require assistance. Uptake of these benefits compared to those who would be eligible is currently difficult to accurately quantify, but it is not believed that there is 100% take up among those eligible for the benefits[21].

120. Take up is likely to be higher amongst those who have higher needs and contact with their local authority as the local authority will want to support people to maximise their income to support their wellbeing and enable them to access the care and support they need.

[20] https://www.gov.uk/government/consultations/care-act-2014-funding-allocations-for-new-adult-social-care-duties

[21] The take-up rate of Disability Living Allowance and Attendance Allowance: Feasibility study (DWP) http://niesr.ac.uk/sites/default/files/publications/021007_143834.pdf

121. Care home residents who receive local authority support have payment of their AA or the care component DLA or the daily living component of PIP discontinued after 28 days of stay under current practice.

122. There are two counter acting factors that impact on the number of people receiving disability benefits.

- The reforms result in more care home residents receiving local authority support through the extended means test and cap on care costs. This therefore results in a reduction in the numbers for whom AA, DLA or PIP is payable.
- The implementation of the reforms and the increased contact between self-funders and local authorities mean that there is a likely to be an increase in the take up of AA.

Reduction in AA, DLA and PIP payable

123. The reforms result in more care home residents receiving local authority support through the extended means test and cap on care costs. This therefore results in a reduction in the numbers for whom AA, DLA or PIP is payable.

124. The proportion of self-funders in care homes who are currently receiving the disability benefit effects the number of people for whom disability benefits would no longer be payable. Figure 31 shows the numbers for take up assumptions of 80%, 90% and 95%.

Figure 31: Number of people in care homes for whom AA, DLA or PIP would no longer be payable

	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
95%	15,300	15,900	19,200	27,600	38,700	47,400	52,300	54,600	57,000	59,300
90%	14,500	15,100	18,200	26,100	36,700	44,900	49,600	51,700	54,000	56,200
80%	12,900	13,400	16,200	23,200	32,600	39,900	44,100	45,900	48,000	49,900

125. These assumptions result in savings to disability benefits that would increase from around £55 - £65 million in 2016/17 to £220 - £260 million in 2025/26.

Figure 32: Savings to disability benefits from reduction in AA, DLA and PIP payable

£ million, 16/17 prices	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
95%	66.8	69.3	83.7	120.1	168.6	206.4	227.9	237.7	248.2	258.2
90%	63.3	65.7	79.3	113.8	159.7	195.5	215.9	225.1	235.1	244.6
80%	56.3	58.4	70.5	101.2	142.0	173.8	191.9	200.1	209.0	217.5

Increase in take up of AA (of those not claiming but would be eligible)

126. Although not increasing eligibility, there is always a risk of increased take up as a result of reform implementation raising the profile. In this case, we do think an increase in take up is likely to occur as a result of increased between self-funders and local authorities.

127. The increase in the take up will depend on:

- the current take up of self-funders in care homes and the community, and
- the proportion of those who are not currently claiming who as a result of contact with local authority do so.

128. As with any change dependent on behaviour there is large uncertainty around the potential increase in take up of AA. DH will continue to work with DWP to understand the potential impact and include this appraisal in the final impact assessment.

Summary of Costs

Costs of Option 1

129. As our central estimate, we project the total care and support costs of the policy to increase from around £0.7 billion in 2016/17 to around £2.5 billion in 2025/26. The majority of the costs result from the costs of the policy for older people.

Figure 33: Summary of costs

£ billions, 16/17 prices undiscounted	*15/16*	*16/17*	*17/18*	*18/19*	*19/20*	*20/21*	*21/22*	*22/23*	*23/24*	*24/25*	*25/26*
Older People											
Cap and means test Assessment, Case Management and Review Costs	0.11	0.32 0.26	0.33 0.21	0.45 0.22	0.73 0.23	1.07 0.24	1.32 0.25	1.47 0.27	1.57 0.28	1.68 0.30	1.79 0.31
Working Age											
all costs		0.09	0.13	0.15	0.23	0.26	0.36	0.40	0.41	0.42	0.43
Total care and support cost	**0.11**	**0.66**	**0.67**	**0.82**	**1.19**	**1.57**	**1.93**	**2.14**	**2.26**	**2.40**	**2.54**
Benefits											
Reduced eligibility		-0.06	-0.07	-0.08	-0.11	-0.16	-0.20	-0.22	-0.23	-0.24	-0.24
Potential increased take up								To be quantified in the final IA			
Net cost to benefits		**-0.06**	**-0.07**	**-0.08**	**-0.11**	**-0.16**	**-0.20**	**-0.22**	**-0.23**	**-0.24**	**-0.24**
Net Cost	**0.11**	**0.59**	**0.60**	**0.74**	**1.07**	**1.41**	**1.74**	**1.92**	**2.04**	**2.17**	**2.30**

130. Net economic costs and net government costs are equal as all costs for this policy will be borne by the government.

The differences from the previous projected costs

131. The projected costs of the reforms for older people are lower than those in the previously published Impact Assessment. This is due to two main reasons:

132. Residential and nursing care fees are now projected to be around £560 per week in 2015/16, which is around £50 lower than previously projected. Lower care fees mean that people take longer to reach the cap, and consequently fewer people reach the cap.

Figure 34: Comparison of outturn of care fees compared to previous projection

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Nursing	£ 534	£519	£507	£533	£543	£554
Residential	£ 522	£522	£528	£540	£550	£561
Previous modelling assumption	£ 538	£550	£564	£575	£586	£610

*shaded represents projections

133. Our central assumption now assumes that only 80% of eligible self-funders will come forward for the reforms. This is based discussions with local authorities and their local intelligence and the take up rates seen by other state benefits.

134. The profile of projected costs of the reforms for older people has changed. This is due to:

135. Lower average care costs result in a longer average time for people to reach the cap compared to the previous impact assessment.

136. Improvements in the modelling including a variation of care home fees in the model mean that it now better captures the variation in the point in time after April 2016 that people will start reaching the cap.

137. The projected costs of the reforms for working age adults have been revised to take account of the policy set out in the draft regulations.

138. Savings to benefits now take into account the projected impact of the reforms on the uptake of disability benefits cancelling out the savings from people becoming ineligible due to the reforms.

139. Inclusion of the increased assessment costs in 2016/17 for the stock of people already self-funding their own care and support needs.

Costs of Option 2: Do nothing

140. The do nothing option would not incur the additional costs of the proposed option. Costs would simply rise in line with rising care costs and demographic pressures and people would still face unlimited care costs.

141. With the aging population more people would be forced to deplete all their assets to pay for care, placing increased strain on families, friends and local communities.

Benefits (of capped cost model)

142. The Monetised benefits of the reforms include:

- **Peace of mind to everyone from knowing that they will not face unlimited care costs**. Everyone will benefit from the peace of mind from knowing that they do not risk facing unlimited care costs. This is an insurance benefit which accrues even to individuals who do not encounter catastrophic care costs.
- **Financial benefits to both older people and working age adults who receive state support.** Individuals who currently do not receive state support will be financially better off as a result of the reforms. This represents a transfer from the state to the individuals receiving state support.

143. The non-monetised benefits of the reforms include:

- **Encouraging people to take responsibility and to plan and prepare** for their care needs in later life.

- **Creating a space for financial services products** which enable people to further mitigate their risks and gain additional peace of mind benefits.
- **Wider benefits from supporting other objectives for the care and support system** including supporting preventative services and the provision of information and advice.

Monetised benefits

144. This impact assessment splits the financial benefits of the reforms into the direct financial transfers and the additional "peace of mind" benefits generated through this social insurance system.

Peace of Mind Benefits

145. Funding reform is a type of social insurance and people generally value insurance more highly than the value of the expected payout. Purchasers of insurance pay more for insurance than they expect to get out of it: this is because insurance premiums need to cover admin costs, profits and the accumulation of reserves, as well as benefit payments.

146. People are often willing to pay more than the expected benefits for financial protection because most people are risk averse and worry about the uncertainty surrounding future losses e.g. in this case care costs. Insurance gives them peace of mind.

147. A capped cost system will lead to a net welfare gain for the population since risk-averse people would be willing to pay premiums exceeding the costs.

148. We calculate this welfare gain by using information on loss ratios from long-term care insurance markets in the USA, where the loss ratio is 60% for individual policies. The loss ratio is the proportion of premium income that the insurer pays out on claims.

149. We estimate that for each pound of long-term care risk transferred to the state, an individual picked at random from the over 65-year-old population would be willing to pay around £1.43. Further details on the approach to valuing peace of mind benefits are at Annex A.

150. There are several assumptions in this work, most notably it assumes constant risk aversion and that the USA data is applicable to the UK. Since we do not have data for working age adults we have assumed that this figure is applicable to individuals of all ages.

151. This means that there are peace of mind benefits of 43% above the value of the state support provided to individuals needing care and support.

Figure 35: Monetised benefits of the reforms

£ billions, 16/17 prices undiscounted	*16/17*	*17/18*	*18/19*	*19/20*	*20/21*	*21/22*	*22/23*	*23/24*	*24/25*	*25/26*
Financial transfers to older people	0.25	0.27	0.37	0.62	0.91	1.12	1.26	1.34	1.45	1.55
Financial transfers to working age adults	0.09	0.13	0.15	0.23	0.26	0.36	0.40	0.41	0.42	0.43
Additional peace of mind	0.17	0.20	0.26	0.41	0.57	0.72	0.80	0.85	0.91	0.96
Net Benefits	**0.51**	**0.59**	**0.78**	**1.26**	**1.74**	**2.21**	**2.46**	**2.61**	**2.78**	**2.94**

152. There are several potential sensitivities that could affect the value of peace of mind benefits. These could either reduce or increase the peace of mind benefits.

Reducing peace of mind benefits

- Higher average wealth in the USA may create a greater demand for insurance.
- Lower levels of social insurance (in other areas) in the USA may create a greater demand for insurance.

Increasing peace of mind benefits

- The methodology assumes that no individuals are willing to pay more than the market price if, as consumer surplus indicates, some individuals are willing to pay more than the market price then the average peace of mind benefit would be higher.
- Peace of mind benefits will occur before spending on the policy. For example, people may already have some peace of mind from knowing that a cap on care costs will be introduced in 2016. This would tend to increase the effect as people value benefits now more than future ones.

153. Since this is a relatively uncertain value we have tested the various values for peace of mind benefits. As long as the benefits are greater than 20% then the policy has a positive net present value. This means that even if the value of the peace of mind benefits is half what we have estimated the policy is still justified in terms of its monetised costs and benefits.

154. For the purposes of this impact assessment we have assumed that all peace of mind benefits occur when funds are spent. This is the most conservative assumption we could make – any proposals which spread the benefits over a longer time period (and therefore with the benefits occurring before the costs) will increase the merit of these proposals.

155. One potential option is for all the benefits of the policy to occur at once – in this view the state has effectively given everyone a free care insurance policy.

156. In this view the entire net present value of the policy would occur in 16/17 (or arguably before this, from when the policy was announced). Assuming an individual's value of the insurance policy at any point in time is based upon its net present value, as in societies at large, then these two different views would not affect the overall NPV of the policy.

Non-monetised Benefits

Encourages people to take responsibility and to plan and prepare for their care needs in later life

157. Through providing protection from unlimited care costs the proposals provide people with greater certainty and incentives to plan for their future care needs. People will be informed that they will be protected from unlimited care costs and this will encourage them to plan for and manage the cost they do face.

158. By putting in place plans for future care needs this will reduce the need to make pressured decisions in a crisis, which are often not in person's best interests.

Support for wider government objectives around planning, preparation and prevention

159. The overarching government policy objective is to secure better outcomes and experience of care for service users, their carers' and families. The reforms are designed to support this overarching objective – two areas where the proposals for funding reform could make a particularly significant contribution are around prevention and intervention.

160. In the current system, many people funding their own care will have very little contact, if any, with their local authority. The introduction of a cap on care costs will encourage people to make contact and provide an opportunity for them to access information and advice from their local authority and to make choices about the care services available in their local area.

161. While the proposals create no direct benefits in this area they may support other government polices to enable people to access information and advice around their care operate more effectively, making effective use of this additional contact individuals have with local authorities.

Space for financial services products

162. Some people may choose to plan for the future by using financial products. The current options for people to protect themselves are limited to immediate needs annuities. The financial services industry support the reforms, since the limit on people's care costs will provide greater incentives to provide relevant products that people see the benefit of purchasing.

163. The Government expects the financial services industry to work creatively to amend existing products and develop new products that support people in making choices about how to plan for their care costs.

Potential Risks

164. The costs and benefits within this impact assessment represent the most likely effects of the policy. However in any social care system there are several key assumptions on drivers of demand which will affect the overall projected future level of spending on social care.

165. Risks on the assumptions that lead to uncertainty in the cost projections are commented on in the costs section and covered in the sensitivity analysis presented in Annex B.

Effects on local authority processes and systems

166. The reforms will bring many more people into contact with local authorities and this may create challenges as well as opportunities. The Department of Health, in collaboration with the LGA and ADASS, has set up a joint programme board to work on implementation issues and mitigate risks.

Effects on the number of disputes

167. This is covered in Part II of this impact assessment covering the implementation of a new appeal system for social care.

Impact of the reforms on the demand for care and support

168. The costs and benefits of these reforms are based upon the estimates of projected social care users produced by the PSSRU aggregate model. This model projects both publicly and privately funded future social care users.

169. The PSSRU projections are produced by a group of academic experts and subject to a peer review process.

170. However there is the possibility that the significant changes to the social care funding system proposed could influence the underlying demand for care and support. The department has identified two possible influences:

- The impact on informal care provision.
- The impact on unmet need.

Informal Care Provision

171. Informal carers do vital work supporting people with care needs. In 2011 there were around 5.8 million people in England and Wales providing unpaid care (informal care).[22]

172. There is a theoretical argument that informal care may be reduced through these reforms. This is because at present people may undertake caring to protect people (such as their parents) from facing unlimited care costs. Since the state will be providing that protection – and in some circumstances directly funding peoples care - there is potentially a lower incentive to undertake caring activities.

173. We do not consider this effect likely for two main reasons:

- Evidence suggests that financial gain is not the major motivation for informal care provision and hence we are unlikely to see a reduction in informal care provision. Additionally the provisions of the bill, to support carers and help them undertake caring activities will mitigate any effect.
- The financial benefit individuals could potentially gain from reduced informal care provision is remote. Decisions on informal care are likely to occur early in care pathways when the prospect of receiving state support from the cap is unlikely to be a major influence on people's decisions about care.[23]

174. We have also looked at evidence from Scotland where they have introduced greater state support for people with care needs than England. Bell, Bowes and Heitmuellero (2006) analysis of these reforms found that the number of carers and the amount of care provided did not reduce compared to the rest of the UK. However, there was a change in the composition of care. The number of hours of intensive personal care fell, but the amount of low-intensity care increased.

175. They argued that their analysis rules out any "immediate catastrophic fall in informal care arising from the introduction of free personal care" while they cannot make longer term projections they found that the money set aside by the Scottish government to fund a reduction in informal care may have been unnecessary.

176. These results are supported by recent work from the Office of Health Economics in 2013 which compared Scotland and England before and after the reforms as a natural experiment [24] using a similar methodology. This found that there was a 3-5% rise in informal care in Scotland after the introduction of free care.

177. We therefore think it unlikely that there will be significant negative changes in informal care provision due to these reforms. Even if an effect were to occur the increased costs to state would be mitigated by the benefits of freeing informal carers to return to work.

178. Informal care is, and will remain a vital component of the care and support system. The Care Act provides greater support to carers than ever before. We will work with local government and the care and support sector to understand and mitigate any negative impacts.

Unmet need

179. The reforms may help facilitate access to hard to reach individuals who are currently in need of care and support but not receiving it. This would be a significant benefit of the policy. It would lead to welfare improvements for these individuals, which would likely be in excess of the costs of the extra support they received.

180. We do not expect any significant impacts in this area but through our engagement we will be exploring how the opportunities of funding reform can be used to support the Government's wider objectives in ensuring everyone has access to care services.

[22] Census 2011 Data.
[23] The extended means test only applies in residential care where there is little scope for informal care provision
[24] Schaffer, Sarah Karlsberg. (2013) *The effect of free personal care for the elderly on informal caregiving.* Research paper 13/01. London: Office of Health Economics.

181. Any impact of these reforms on unmet need are expected to be small. We are unable to estimate the size of this effect due to a lack of sufficient data. We will carefully monitor the impact of these reforms on demand for formal care using data returns from local authorities.

Impact on the care market

182. Section 18 of the Act (duty to meet needs for care and support) consolidates a number of existing duties to provide certain types of adult social care services[25]. In doing so, it modernises the legal framework to remove historic anomalies between the way in which entitlements to residential care and to other types of care and support are established.

183. Section 18(3) provides a duty to meet eligible needs where an individual has financial resources above the limit set out in regulations, but asks the local authority to meet their needs. Such people would be required to pay for the costs of their care and support in full (and may pay an additional administrative charge to the local authority for making arrangements on their behalf), but the local authority would be required to meet their eligible needs.

184. This provision is not wholly new– under existing legislation local authorities may have duties to provide or arrange for services even where persons have financial means for example in relation to non-residential services and, in relation to residential accommodation, where a person cannot make their own arrangements for such accommodation and has no one available to do so on their behalf. However, a provision for an absolute duty to meet needs, regardless of whether people are able to make their own arrangements, represents an extension reflecting practice in many authorities.

185. The purpose of this provision is to give people who are able to afford to pay for the costs of their care home the same rights in accessing local authority support as they already have in other settings. The care market is often difficult for individuals to navigate, and lacking transparency, therefore many people without local authority support find it difficult to judge different options or to arrange a contract with a care provider. As a result, some individuals may therefore make less optimal decisions for meeting their own needs than they may with better information and support. This provision's primary focus is to allow people who might struggle to arrange care on their own to access local authority assistance to do so.

186. In consultation, some respondents have suggested that the provision in Section 18(3) of the Act may give rise to a risk of destabilising the care home market, with consequent additional costs for local authorities. The contention is that some people who would otherwise arrange and pay for their own care may use the Act to access care which is arranged at a lower cost, because local authorities are often able to contract with certain providers at more favourable rates. If widespread, this could lead to a change from current purchasing practices as more wealthy individuals seek to use a local authority route to care at a lower cost.

187. As noted above, the Act requires the local authority to meet the eligible needs of the individual. The Act and supporting guidance set out a variety of ways a local authority could exercise the duty to meet needs to support self-funders, including arranging care directly for the individual, making a direct payment, or in some circumstances brokering arrangements on behalf of the person. It is not the case that the duty must be fulfilled through direct commissioning of care, or that this must always be at a standard rate. Where the local authority does arrange (i.e. commission directly) care, there will be a range of providers available and these are likely to be on a range of rates.

188. There is a lack of robust empirical evidence to support analysis of any potential impact arising from this provision. Studies have shown that, on average, local authorities pay lower prices than self-funders for care packages, including accommodation and living costs[26]. However, this does not represent a like for like comparison, since it cannot be shown that the care paid for is equivalent.

[25] Including, for example, Sections 21 and 29 National Assistance Act 1948, and Section 2 Chronically Sick and Disabled Persons Act 1970.

[26] Laing and Buisson

Self-funders are often choosing to pay more to enter more expensive care homes, or choose a larger room, for instance. This will be reasonable in many instances, since many of these individuals have higher income and assets and are making a legitimate decision to enter a care home of their choice which may be more expensive than the local authority rate. Moreover, local authorities can reasonably negotiate lower prices as a bulk purchaser, and given the lower risk of local authorities defaulting on payments.

189. These lower prices may reflect both the local authorities' ability to negotiate a better a deal as a bulk purchaser but also the fact providers may face lower costs when contracting with a local authority. In particular there is a lower risk of local authorities defaulting on payments, and care homes taking local authority clients are unlikely to needs to spend as much on advertising.

190. The scale of impact also depends on a local authorities' ability to negotiate a better a deal as a bulk purchaser but also the number of contracts with different providers, and they may have a range of different agreed rates within an individual contract. Such contracts and framework agreements will vary over time. It is therefore unlikely that a local authority will have a single rate for all care homes it arranges care with which can be compared with the market rate for self-funders.

191. In addition, it is not possible to demonstrate how the Care Act may change an individual's behaviour and to determine how likely it may be for a more wealthy individual to choose a different care home from their original preference, solely on the basis that one may be available at a lower cost. Evidence from different sources suggests that care home choices are usually made at a point of crisis, and cost is one of a series of considerations, alongside other matters such as perceptions of quality, amenities and location (e.g. access to family)[27]. Whilst on average 40,000 individuals per year will seek a new care home placement, it is not possible to estimate how many of that number may decide to limit their choice of care home to access lower prices, when other options are both available and affordable to them.

192. Based on the analysis above, we do not believe that there is sufficient evidence at this time to estimate what if any costs will occur, or to quantify those costs. It is therefore not possible, based on existing evidence, to accurately predict what the scale could be of any disparity between care costs paid by local authorities and self-funders. We have begun a programme of research through to 2015/16 to better understand the likelihood and scale of any impact, and to consider how we might best mitigate risks. This research included running a stakeholder market simulation event in late 2014, facilitated by the Office of Public Management (OPM).

Economic considerations of the impact

193. If an impact were to occur this would tend to be economically neutral.

Figure 36: Relationship between price and quantity of care and provider profits

Price(Private Care)* Quantity (Private Care) + Price(LA) * Quantity (LA) – Costs = Profits

194. If as is often the case, the price of private care is higher than local authority arranged care then if individuals moved to this lower price then all else being equal this would reduce provider profits. This effect would be economically neutral since the value of the lost profit would be equal to the increased consumer surplus.

[27] For example, a study by Alzheimer's Society on choices made for people with dementia ranked "costs of care" as the seventh most important factor in choosing a care home. http://www.bgs.org.uk/pdf_cms/pubs/Alzheimer_low_expectations_care_homes.pdf

195. As a result of this, local authorities might have to increase the prices they pay, in such a circumstance this would simply transfer money from the local authority to the provider. The benefits of this transfer in economic terms would be neutral.

196. However, the benefits of these reforms go beyond the simple calculation set out above. Promoting transparency within the market and prices which better reflect the true costs of care for all individuals should increase allocative efficiency within the market by promoting a more appropriate use of resources. In particular, if local authorities are currently paying prices below the cost of providing care, this may encourage them to place too many people in residential settings potentially to the detriment of the welfare of these individuals and the efficiency of the care and support system.

197. Therefore were any impact to occur we would consider it at worst to be economically neutral but the benefits of a better functioning market where prices accurately reflect costs are likely to deliver substantial additional benefits.

Review and Evaluation

198. Funding reform will be reviewed, monitored and will form part of the proposed evaluation on the Care Act.

199. The Care Act legislates for a five-yearly review by the Secretary of State which must review the level of the cap, daily living costs and means test threshold. Having regard to the financial burden of the state, local authorities, adults with needs for care and support and trends in healthy life expectancy.

200. Data is monitor the reforms will be collected by the Health and Social Care Information Centre, including the number of people benefiting from the extended means test and the number who reach the cap.

201. Funding reform is expected to be one of the areas of focus in a proposed evaluation on the Care Act reforms. This would cover the impact on local authorities implementing the reforms and also the impacts on users and carers, including whether the health and wellbeing benefits of the reforms are being realised.

202. The joint programme office set up by DH, ADASS and the LGA will continue to provide implementation support to local authorities including assisting in preparation for funding reform in April 2016. A local modelling exercise will be run in Spring 2015 to help local authorities understand the local impact of the reforms and assist their planning and preparation

203. We have revised and updated our assurance strategy and approach to assessing local readiness for implementation. We have evolved our approach to provide a robust approach to overseeing and supporting delivery by local authorities and partners which:

- brings together improvement resources across LGA, ADASS and DH;
- aligns and coordinates support with the Better Care Fund;
- builds on the stocktake surveys and addresses limitations through follow up discussions, targeted support and the offer of “deep dive” reviews to councils to stress test their plans.

Specific Impact Tests

Equalities

204. The Department of Health conducted extensive engagement with care users and members of the care sector on the reform of social care, including funding reform. The engagement found support

for a capped costs model. There has been extensive engagement with older people's disabilities groups to ensure that their views are fully reflected in the policy.

205. The scheme will not discriminate on the basis of protected characteristics of, disability, gender reassignment, pregnancy and maternity, race, sexual orientation, sex or religion or belief. Insofar as the scheme proposes variations in the cap based on age, this is considered to be a proportionate means of achieving a legitimate aim as set out below.

206. The direct financial beneficiaries of these reforms will reflect the makeup of people in receiving care and support – as such we expect they will cater mainly to disabled and older people, predominantly women.

207. Within this, through engagement and consultation we will work to identify and eliminate inadvertent consequences from these reforms for people with protected of their characteristics.

208. Through engagement and consultation we will work to ensure that all individuals are able to access and benefit from these reforms regardless of their characteristics.

209. The impact of these reforms on specific characteristics is listed below.

Disability

210. Those with eligible care needs will likely have some form of disability, so the proposals will primarily benefit disabled people. People will get the same protection.

211. The financial benefits of the reforms will be focused upon disabled people who will benefit from protection from unlimited care costs. They will also likely benefit from greater peace of mind. This should help advance equality of opportunity between disabled persons and others including the reduction of disadvantages suffered by disabled people and encourage them to better participate in public life. There should be no adverse impact on good relations between these groups.

Age + Sex

212. Those benefitting from the proposals are predominantly likely to be those who are old (92% over 75) and female (78% are female)[28]. This is justified since these are the groups who currently face the highest depletion of assets due to care will benefit the most financially from the cap on costs.

213. In developing detailed proposals for the level of the cap for working age adults of different ages we have worked to ensure that our proposals are equitable for all groups and have kept the Public Sector Equalities Duties at the forefront of our considerations. The government has committed to introducing a zero cap for those who develop care needs before they turn 25. The fundamental principle behind the cap on care costs is that people have had an opportunity to build up a degree of wealth over the course of their working lives and have the opportunity to plan and prepare for the possibility of care and support needs in the future. The proposals are justified since they recognise that those born with, or who develop a care and support need early in life, have limited or no opportunity to plan and prepare in the same way as older people not least because of barriers to education, employment and training that mean that they cannot plan and prepare in the same way as people who develop care and support needs in later life. The policy set out in the draft regulations and guidance for working age adults will create more consistency between the treatment of older people and those of working age with the equalisation of the minimum income guarantee.

214. The Dilnot Commission recognised this challenge and as a result developed proposals that were based on the assumption that, while it is reasonable to expect someone who develops care needs

[28] Care of Elderly UK Market Survey, 2011-12, Laing and Buisson (2012)

in later life to have planned for this possibility and build assets, this cannot be said to the same degree for younger people who were either born with, or who develop a care and support need in early life. The Dilnot Commission therefore recommended that people who develop a care and support need during their working life should be assessed in broadly the same way as an older person under an overarching cap on care costs system but that people who develop care needs before retirement age should benefit from a lower cap which recognises their likely lesser ability to accumulate assets.

215. Basing the proposals for the cap on age reflects the above and also the outcome of engagement with stakeholders in determining priorities, which highlighted the need to equalise the MIG for working age people in comparison with older people. However, this means that the idea of a tiered cap would necessarily become less of a priority in order to meet the constraints of the funding envelope. While this is a shift from the position set out by the Dilnot Commission, it does reduce the number of points at which a person's age is an issue in the level of cap they receive.

216. The age of 25 has been chosen as it aligns with the age limits for Special Educational Needs and Disabilities (SEND) and the apprenticeship scheme 'AGE 16-24'. The principal reason for the approach set out above is to meet the essential priority to protect those born with a care and support need or who develop one in early life. This is simply an uninsurable risk that leaves families in fear of catastrophic costs and can prevent people from fully living their lives. Providing this peace of mind will help support people to stay in education and training and enter employment along with the charging framework that disregards all earnings. For those over 25, they will still benefit from the peace of mind of being protected from catastrophic costs and will receive the added support of being left with more income after charges.

217. It is believed that the proposals protect those born with a care and support need or who develop one in early life and eliminate the current inequality in the income people of working age are left with after charges compared with those of pension credit age.

Race

218. The reforms will not discriminate on the basis of race. However, it is possible that due to differences in the need for formal care there may be different distributions of benefits among different ethnic groups. The Joseph Rowntree Foundation notes that minority ethnic groups are more likely to be living in larger houses with one or more carers[29]. This may mean they receive fewer benefits from the reforms. However, the proposals are nonetheless believed to be justified since the reduced benefits reflect a lower need for formal care and support and hence a lower need of protection from unlimited care costs.

Religion or Belief

219. The reforms will not discriminate on the basis of religion or belief. Some particular religions require specifically designed financial products to abide with religious beliefs. The capped part of the reforms, along with greater consistency in assessment allows for the development of financial products. In order for those with religious requirements to benefit, carefully designed financial products would have to be provided in the private sector. We are continuing to engage extensively with the sector to help ensure that suitable products are available for all sections of society.

Gender Reassignment, Sexual Orientation and Marriage and Civil Partnership

220. None of the changes to the system will impact differentially on these groups. However since these individuals may be less likely to have children (who often form part of extended support networks for older people) they may have a higher risk of unlimited care costs (since they rely on more formal

[29] *Changes in communal provision for adult social care: 1991-2001*, Joseph Rowntree Foundation (2006)

care) and hence a greater benefit from these reforms. Couples, either Married or in a Civil Partnership will benefit equally from the protection of the cap and extended means test.

Pregnancy and maternity

221. No differential impact identified - pregnant women are likely to be of working. While mothers may have lower lifetime assets and thus might receive a lower benefit from these changes (as they are already protected by the existing system).

Socio-economic status

222. All socio-economic groups should benefit from these reforms. The reforms provide universal protection from unlimited care costs ensuring everyone can benefit from peace of mind due to knowing that they are protected from unlimited care costs whatever their future wealth and income.

223. To provide the maximum financial security to individuals who do not know their income and assets in old age, the reforms offer universal protection from unlimited care costs.

224. Adding the universal element of the cap to the existing means tested system will lead to the direct financial benefits of the reforms being focused upon higher income and asset quintiles.

225. Those with low incomes and wealth when they develop care needs will be financially unaffected by the current proposals, since their wealth is already protected by the current means test. However they will still benefit from increased peace of mind as they know whatever their wealth they will be protected from unlimited care costs.

226. Individuals in higher income and asset quintiles who receive little or no support under the current system will gain direct financial benefits from the cap. As demonstrated by the chart below.

Figure 37: Social care funding by combined income and asset quintiles of older people receiving Adult Social Care under the current and the proposed system in 2025/26.

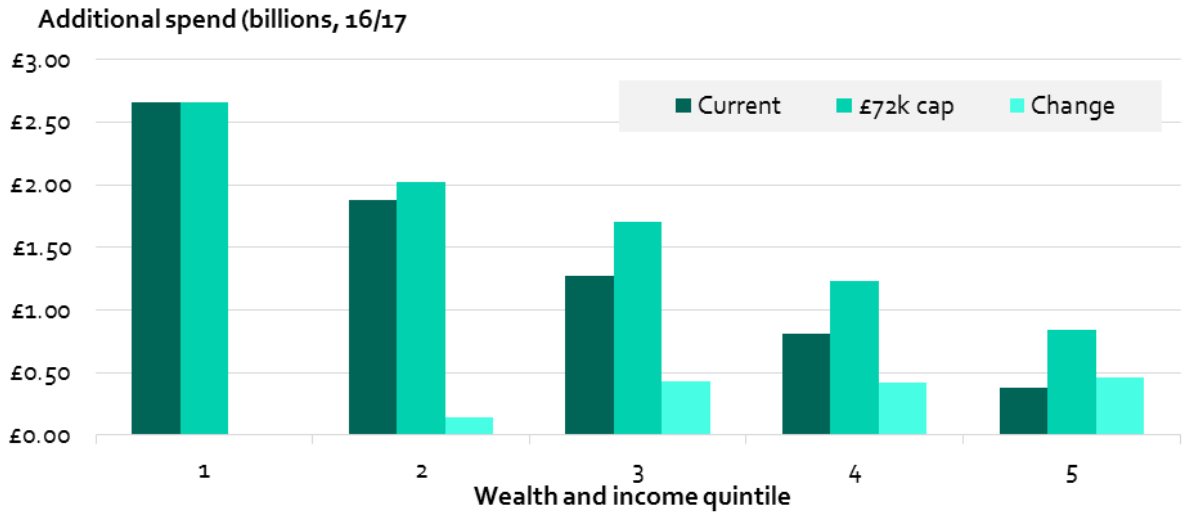


Figure 38: A table showing the quintiles to which a person with particular wealth and income will belong.

	Income						
Assets	£5k	£8k	£10k	£13k	£15k	£18k	£20k
No assets	1	1	1	2	2	2	2
£50k	2	2	2	2	3	3	3
£70k	2	2	3	3	3	3	3
£100k	3	3	3	3	3	3	3
£150k	3	3	3	3	3	3	4
£200k	3	3	4	4	4	4	4
£300k	4	4	4	5	5	5	5

One in, two out

227. The impacts presented in this impact assessment do not fall under the one in, two out rule as the capped cost model does not involve new burdens on business or civil society.

Sunset clause

228. As above, the obligation to include a sunset clause does not apply as social care funding reform does not involve new regulation on business or civil society.

Micro enterprise exemption from regulation

229. Funding reform does not involve new regulation on business or civil society.

Small Firms Impact Test

230. Funding reform has no impact on small firms. We discuss regulatory impacts below relating to financial providers, which are exclusively larger businesses.

Competition

231. Funding reform itself has no direct impact upon the operation of competition. With regards to the market for financial services, the changes in limiting care costs to £72,000 and our work with the sector will help stimulate entry into the market, the creation of new products and greater competition. While the small existing market for INA's may be negatively affected this will be more than the compensated for by the opportunities for these providers in the new liberated market for financial products to provide people with additional protection up to the cap.

232. There are no direct impacts upon the competition in the care sector since these reforms will affect how care is funded and the balance of costs between individuals and the state. See earlier "potential risks" section for a wider discussion.

Environmental and sustainability impacts:

233. These reforms have no impact upon the environment or sustainability.

Human rights

234. The proposals are believed to be compliant with the UK's obligations under the European Convention on Human Rights.

Justice system impacts

235. There are no implications from funding reform for the justice system.

Rural proofing

236. Funding reform will benefit everyone no matter where they are in the country. We will be considering any differential impacts upon rural areas, during our engagement on the detail of implementing these reforms.

237. The Department of Health has commissioned a review of the adult social care relative needs formulae. This review of the funding formulae will take account of the reforms to the social care funding system and will consider rural impacts. The review is being carried out by independent experts at LG Futures and the Personal Social Services Research Unit at the University of Kent. Further information can be found at http://www.lgfutures.co.uk/adultsocialcarernf

PART II - SOCIAL CARE APPEALS

Background – case for change

238. The Government intends to reform the existing means of care and support redress under part 1 of the Care Act 2014. The reform would be implemented, through the Act and supporting regulations and guidance, in April 2016. The proposals and this Impact Assessment should be read in the context of the March 2011 report of the Law Commission[30], the recommendations of which have greatly influenced the approach to reforming legislation.

239. The lack of a formalised appeal structure was highlighted in evidence following the Law Commission's consultation on Care and Support as well as the Joint Committee in its report on the draft bill of the Care Act 2014. Given the importance of care and support decisions to enable people to achieve the life outcomes they want, the ability to appeal certain local authority decisions is central to a more accountable and more equitable care and support system. The ability to appeal certain care and support decisions will enable the person to have an independent review of the local authority's original decision, to ensure it was reasonable with reference to regulation, guidance and local policy. The appeals system is particularly important because it applies to a vulnerable section of the population, where local authorities' decisions have a big impact on their quality of life.

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

Policy objectives

241. The primary objective of the policy is to modernise the care and support redress system to be fairer and more equitable. The need for reform was highlighted in evidence from the Law Commission and the Joint Committee. The ability to challenge decisions will ensure that that the care and support system will deliver greater accountability, at a local level, to challenge decision-making that plays such a central role to peoples' quality of life.

242. The intended effect is that this will deliver fairer outcomes, increase the confidence of those users, and improve local accountability and local decision making.

Policy options

243. The do nothing option would mean retaining the existing complaints system. As noted above, evidence from the Law Commission's consultation as well as the Joint Committee's report indicated that reform of the existing system of redress was needed. The do nothing option would not support the overall aims of the reformed care and support system.

244. The preferred option is to introduce the right to appeal certain care and support decisions, strengthening local accountability and improving overall fairness and equity for the care and support system.

[30] Law Commission (2011), Adult Social Care consultation analysis, Consultation paper 192, available online at http://lawcommission.justice.gov.uk/docs/ASC_Consultation_Analysis_full-version.pdf

245. This appeals system would enable people to request an appeal in relation to certain care and support decisions. These include specific decisions related to assessment, eligibility, care planning, direct payments, personal budgets, independent personal budgets, deferred payment agreements, transition for children to adult care and support and independent advocacy support. We are seeking further views on the scope of the appeals system as part of this consultation.

Summary of identified costs

246. The costs of administering the appeals process are calculated by applying a percentage appeal rate to the number of several types of appealable events (social care assessments, carers' assessments and social care reviews) in order to derive estimated numbers of appeals. Unit costs are then applied alongside probabilities of moving to subsequent stages of the appeals process.

247. The main costs relate to administering the appeals process (equal to circa £23.87m per annum in the 'main' scenario for 2016/17). We seek views on this costing and the assumptions within it as part of the consultation.

Summary of identified benefits

248. Local authorities have already received sufficient funding to meet the local population's care and support needs. The main benefit of the appeals system is an efficiency gain arising from the (arguably greater) value of spending on successful appellants, net of the value of (arguably inappropriate) spending that will no longer be made because the overall budget is fixed. We present two case studies from the Local Government Ombudsman to illustrate the kind of cases that were successful in their existing complaints system. We have also calculated the total administrative cost (excluding LGO reviews) divided by the estimated number of successful appellants, which gives a value of £419. The benefits of the policy therefore exceed the costs if the value of spending on a successful appeal, net of the value of the spending that will no longer be made due to the fixed budget, is greater than £419. The appeals system may also affect decision-makers' behaviour when making future assessment and eligibility decisions (a learning effect that applies even in cases where no appeal is made), which would reduce the £419 threshold.

249. Other benefits include equity gains (if society values spending on successful appellants more highly than other spending, or if society values greater consistency of decisions between local authorities), and a possible reduction in the number of Judicial Reviews and complaints (as more decisions will be challenged within the appeals system).

Key assumptions

250. We seek comment on the assumptions in this impact assessment as part of the consultation, including key parameters such as appeal rates and the estimated cost of an independent review. (Summary tables of relevant data and assumptions on these two points are presented in the relevant sections of this impact assessment). Appeal rates within a new appeals system are difficult to predict because they are driven by a variety of economic, informational and behavioural factors. We consider a 'low' scenario in which appeal rates in the new system are similar to complaints rates in the current system (where around 1.4% of assessments are estimated to result in an assessment-related complaint). Because people may be more likely to appeal in the new system than they are to complain in the current system (e.g. due to higher awareness), we use data from other government appeal systems to consider a 'main' scenario with an appeal rate of 3.4% of assessments. The appeal rate could nonetheless be higher. Our appeal rates for carers' assessments and reviews are based on assessment appeal rates due to limited available data. The estimated £558 unit cost of an independent review will differ according to the staff hours required and the delivery model chosen (e.g. if local authorities could reduce costs by sharing independent reviewers).

251. The administration of the appeals system will be funded by the Department of Health which will sit alongside funding for care and support to Local Authorities for meeting the local population's care and support needs. Where an appeal results in overturning the original decision, the local authority should be responsible for any remedial action. Remedying any such shortfall in meeting the local authority's existing duties would not be a new burden and it would not be appropriate for central Government to provide additional funding for these costs. To do so would in effect duplicate funding where a local authority has not met their statutory duties, having already received funding to meet the local population's care and support needs. This impact assessment therefore considers the impact of the appeals system within a fixed budget. The main benefit of the policy arises from the (arguably greater) value of spending on successful appellants, net of the value of (arguably inappropriate) spending that will no longer be made because the overall budget is fixed.

Review and evaluation

252. See the Review and Evaluation section in Part I of this impact assessment.

253. The consultation document (under 'reporting and accountability') states that the local authority should ensure it is capturing and monitoring data relating to the appeals process to ensure there is accountability and transparency in the volume, type and outcomes of the appeals system at each stage of the process. It also states that local authorities should publish anonymised case summaries.

Additional costs of the appeals system

254. The additional cost of the appeals system can be estimated by estimating the cost of its constituent stages and parts. The appeal process can be broken down into three main stages:

- Initial review by the local authority
- Review by an independent reviewer
- In a small number of cases, review by the Local Government Ombudsman

255. Of these, only the second stage (review by an independent reviewer) and to some extent the third stage represent new burdens to local authorities, as people are already entitled to complain to local authorities through their Adult Social Care complaints process. The volume of appeals can be estimated by first identifying the number of 'appealable events' in a given year – such as eligibility assessments, the setting of personal budgets, the setting of independent personal budgets, carers assessments and social care reviews. Appeal probabilities can be applied to estimate the number of people making an initial appeal (the first stage), and further probabilities can then be applied to estimate the number of people reaching the second and third stages. The additional cost of the second and third stages can be estimated by applying an appropriate unit cost per appeal, accounting for staff costs, administration and the need for advocacy in a percentage of cases.

256. The costing for appeals on eligibility, personal budgets and independent personal budgets is first described in detail below. Subsequent sections of this document then describe the costings for appeals on carers' assessments and on social care reviews, highlighting the ways in which they are different.

Time period and price year

257. The costing covers a ten year period of 2016/17 to 2025/26 and uses constant 2016/17 prices (i.e. it is in real terms). Appeals will not be possible for decisions made before April 2016, although the complaints system will operate as usual.

Additional cost of appeals on eligibility, personal budgets and independent personal budgets

258. Appeals on eligibility, personal budgets and independent personal budgets are all linked to the outcome of assessments. Assessments which result in no new services will generate some appeals on eligibility, assessments resulting in immediate provision of services will generate some appeals on the level of the personal budget, and assessments resulting in eligibility for the cap will generate some appeals on the level of the independent personal budget. These appeals are therefore modelled together.

Number of appealable events (i.e. assessments)

259. Returns to the Health and Social Care Information Centre (HSCIC) suggest that 603,415 assessments for clients aged 18+ were carried out in 2012/13[31].

260. We begin with this number of assessments in 2016/17 and increase it in subsequent years, consistent with the demand projections for younger adults (aged 18-64) and older people (aged 65+) used elsewhere in this impact assessment. We weight the demand projections using the share of assessments for younger adults (31.6%) and older people (68.4%) given in the HSCIC data cited above.

261. We also apply the appeal rate to the number of additional assessments arising from the Care Act, consistent with the numbers used elsewhere in this impact assessment.

Baseline assessments	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of baseline assessments	603,415	610,404	619,603	629,607	639,992	649,337	663,530	676,104	686,472	695,766

Additional assessments arising from the Care Act	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of additional assessments	332,245	151,348	154,456	157,953	162,149	166,599	172,169	177,351	184,028	190,206

Appeal rates

262. Exact appeal probabilities are driven by a variety of economic, informational and behavioural factors and are therefore difficult to predict. There are however several sources of relevant data. Information on the current complaints system is available from individual local authorities as well as the Local Government Ombudsman (LGO), who act as the final stage of the process. We use this to inform our 'low' scenario. Data are also available from other areas of government. Attendance Allowance operates a tribunal appeal system and deals with a similar client group. We use these rates to inform the higher appeal rates of our 'main' scenario. Appeal numbers and rates are also available from the education sector.

263. Data from the existing adult social care complaints system can also help inform the likely appeal rate. Local authorities are required to produce an annual complaints report, some of which are available online. We used an online search to obtain complaints reports for a sample of 45 local authorities, totalling 6,513 complaints per annum. This equals around 20,000 complaints per annum when extrapolated to England level using the Adult Social Care Relative Needs Formula. Complaint rates can be estimated by dividing the number of complaints by the annual number of assessments carried out by each local authority. The results give a mean rate of 4% (with a range of 2.17% to 4.96% between the top and bottom quartiles). However, these numbers overestimate the assessment appeal rates because not all complaints will relate to assessments; they cover a wide range of issues including care provided or commissioned by the local authority. Data from the LGO state that they received 2,456 social care complaints in 2013, of which 442 relate to assessment

[31] Health and Social Care Information Centre (2013), *Community Care Statistics, Social Services Activity, England, Final Release 2012-13,* Table A11.a, available online at http://www.hscic.gov.uk/catalogue/PUB13148.

and care planning, and 429 relate to fees, grants and payments[32]. These categories represent around 35% of the total. The remaining complaints cover residential care, transport, safeguarding and care providers. Applying the 35% figure to the local authority complaints numbers reduce the mean assessment appeal rate to 1.41% (with a range of 0.76% to 1.73%). We use an assessment appeal rate of 1.4% in our 'low' scenario.

264. We derive the 'main' scenario from the existing appeals system for Attendance Allowance (AA), which is a needs-tested disability benefit for people aged over 65. Of 292,720 AA applications in 2013/14, there were 4,970 Tribunal appeals (a rate of just under 1.7%)[33]. Some of these appeals will have been preceded by an initial appeal to the Department of Work and Pensions (DWP). Conservatively assuming that all appeals initially approached the DWP first, that the successful half of these did not pursue the appeal further and that the unsuccessful half all pursued the appeal to a Tribunal, the initial appeal rate would be double the Tribunal appeal rate (i.e. 3.4%, or 9,940 initial appeals). These calculations are conservative in two further respects. Firstly, Tribunal rates fell drastically in the period January-March 2014, potentially relating to the new 'mandatory reconsideration' requirement in which appellants must first request a reconsideration of the DWP's decision before filing a Tribunal appeal. The new system also ensures that AA applicants are clearly informed why their application or reconsideration has not been successful. Secondly, the above calculations also assume that all AA appeals relate to AA assessments; in reality some will relate to other circumstances, such as where AA recipients had the benefit reduced or removed.

265. Appeal rates are also available from the education sector. In the school admissions system over 2013/14, 1,443,870 admissions to all maintained and academy schools resulted in 50,555 appeals being lodged by parents (a rate of 3.5%)[34]. In the system for permanent exclusions from school over 2011/12, 5,170 permanent exclusions resulted in 420 appeals being lodged (a rate of 8.12%)[35], showing the potential for higher appeal rates, although this appeal process has since been changed.

266. Following the evidence discussed above, we adopt an appeal rate of 1.4% for our 'low' scenario, and 3.4% for our 'main' scenario. Whilst the 'main' scenario reflects a significant increase in the number of appeals, we acknowledge that appeal rates could still be higher than in the 'main' scenario. Within these averages, we acknowledge that some categories of assessment will have higher appeal rates than others. For example, a person whose level of need has been judged ineligible for services may be more likely to appeal than someone who has been judged eligible but is dissatisfied with the level of their personal budget, as a bigger difference in quality of life may be at stake in the former case. Separately, a person whose level of need has been judged ineligible may be more likely to appeal if they would otherwise be entitled to immediate provision of services, rather than just be entitled to meter towards the cap. The cap may (or may not) yield benefits several years into the future and therefore has a lower expected monetary value than immediate provision of services. We do not have sufficient evidence to estimate assessment appeal rates for different types of appellant.

267. The key appeal rate assumptions are summarised in the following table.

Summary of appeal rate assumptions	**Value**	**Basis**
Percentage of assessments resulting in an appeal (low scenario)	1.4%	Data from the current complaints system

[32] Local Government Ombudsman (2014), *Review of Adult Social Care complaints 2013*, available online at http://www.lgo.org.uk/news/2014/may/lgo-publishes-complaints-statistics-english-adult-social-care-providers-first-time/

[33] Ministry of Justice (2014), *Tribunal statistics quarterly: January to March 2014*, available online at https://www.gov.uk/government/statistics/tribunal-statistics-quarterly-january-to-march-2014

[34] Department for Education (2014), *Admissions appeals in England: academic year 2013 to 2014*, available online at https://www.gov.uk/government/statistics/admissions-appeals-in-england-academic-year-2013-to-2014

[35] Department for Education (2013), *Permanent and fixed period exclusions from schools in England: 2011 to 2012 academic year*, available online at https://www.gov.uk/government/statistics/permanent-and-fixed-period-exclusions-from-schools-in-england-2011-to-2012-academic-year

Percentage of assessments resulting in an appeal (main scenario)	3.4%	Data from the Attendance Allowance Tribunal system

Number of appeal events at each stage of appeal

268. The initial number of appeals is calculated by multiplying the number of appealable events and the appeal rate.

269. We assume that each appeal results in an initial local authority review.

270. A percentage of these local authority reviews will proceed to an independent review. Evidence from the LGO[36] suggests that 48% of assessment and care planning complaints were ultimately upheld[37]. We assume that 48% of appeals are upheld at the local authority review stage, and that the remaining 52% of appeals will proceed to the independent review stage. We assume that there are no drop-outs, as appeals which are unsuccessful at the local authority review stage will automatically be referred to the independent review stage. We acknowledge that lower rates of appeals upheld are sometimes seen in other contexts; for example in Attendance Allowance Tribunals the figure is typically 25-30%[38].

271. The overall profile of appeal events for assessments (which cover appeals on eligibility, the level of personal budgets and the level of independent personal budgets) is as follows for both the 'low' and 'main' scenarios. The numbers are higher in 2016/17 because assessments in that year will cover both the flow of new self-funders as well as part of the stock of existing self-funders.

Number of assessment appeals LOW scenario	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of LA reviews	13,099	10,665	10,837	11,026	11,230	11,423	11,700	11,948	12,187	12,404
No. of independent reviews	6,812	5,546	5,635	5,733	5,840	5,940	6,084	6,213	6,337	6,450

Number of assessment appeals MAIN scenario	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of LA reviews	31,812	25,900	26,318	26,777	27,273	27,742	28,414	29,017	29,597	30,123
No. of independent reviews	16,542	13,468	13,685	13,924	14,182	14,426	14,775	15,089	15,390	15,664

272. The new system has an ambiguous effect on the number of LGO reviews. The increased overall volume of appeal activity (relative to the current complaints system) may increase the number of LGO reviews. Alternatively, a higher number of issues may be resolved before they get to the LGO, resulting in fewer LGO reviews. Ultimately, we assume that the number of LGO reviews will increase in line with the increase in the number of assessments carried out as a result of the Care Act reforms. Taking LGO complaints about assessment and care planning (442 in 2013-14) and complaints about fees, grants and payments (429 in 2013-14) as a baseline, this would result in around 230 additional LGO reviews. The numbers change slightly over time due to the effect of the demand projections.

273. The profile of additional LGO reviews is as follows. We do not vary it between the 'low' and 'main' scenarios.

[36] Local Government Ombudsman (2014), *Review of Adult Social Care complaints 2013*, available online at http://www.lgo.org.uk/news/2014/may/lgo-publishes-complaints-statistics-english-adult-social-care-providers-first-time/

[37] Meaning that the complaints were successful from the point of view of the complainant

[38] Ministry of Justice (2014), *Tribunal statistics quarterly: January to March 2014*, available online at https://www.gov.uk/government/statistics/tribunal-statistics-quarterly-january-to-march-2014

Number of additional LGO reviews LOW / MAIN scenario	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Percentage increase in assmts	55.1%	24.8%	24.9%	25.1%	25.3%	25.7%	25.9%	26.2%	26.8%	27.3%
Estimated additional LGO reviews	480	216	217	219	221	223	226	228	233	238

Unit costs for each stage of appeal

274. We calculate unit costs for each review by an independent reviewer, and for each review by the LGO, as follows.

275. Evidence is available from the NHS Continuing Health Care (NHS CHC) process to inform the likely time requirement for each decision by an independent reviewer. NHS CHC appeal panels can involve more than six hours of input by the Chair. However, the time requirement for social care appeals is likely to be lower than for NHS CHC, as some appeals will relate to less subjective areas such as financial appeals, fewer social care appeals will involve complex medical evidence. We therefore assign six hours of independent reviewer time per appeal. We apply a unit cost of £49.65 per hour, which is based on the cost of a senior social worker as reported in the annual Unit Costs of Health and Social Care publication[39]. Senior social worker costs are used as a proxy; independent reviewers may come from a variety of backgrounds from inside and outside of social work, but will have a similar level of stature and experience. The unit cost includes a full range of on-costs such as employers' National Insurance, pension contributions and buildings. We exclude senior social workers' qualification costs because the independent reviewers do not need to be senior social workers; the introduction of independent reviewers should not result in increased need for social work qualifications.

276. We also incorporate time for the local authority to make its case, time for administration, and time for medical input in a subset of cases. Because no equivalent independent review process is up and running, some degree of assumption is required, although we later sense check the overall unit cost against the LGO process and the current complaints system. For each independent review, the local authority may be represented by a variety of staff including complaints managers. Following a similar argument to the previous paragraph, the unit cost of an hour of a social worker's time (again including all on-costs apart from social workers' qualification costs) is used as a proxy. Three hours of time is applied at a cost of £39.72 per hour. Two hours of an administrator's time is then applied at a cost of £22.69 per hour, based on the 'administrative occupations' classification in the Annual Survey of Hours and Earnings, adjusted upwards with social worker on-costs excluding social workers' qualification costs. Lastly, it is assumed that three hours of medical input will be required in 25% of cases, with half of these requiring input from a community nurse and the other half requiring input from a General Practitioner. Unit costs of £48.15 per hour and £134 per hour respectively are taken from the Unit Costs of Health and Social Care. All on-costs (including qualification costs are included here) as medical qualifications are required for these tasks.

277. We calculate the overall unit cost as £531 per independent review, excluding the cost of advocacy which is captured separately below. We would expect the independent review cost to be lower than the £909 cost per LGO complaint as reported below, as LGO deal with potentially more complex complaints that have not been resolved at earlier stages of the system. The unit cost is higher than appears to be the case in the current complaints system; net current expenditure on complaints procedures of £8.274m in 2013-14[40] divided by the 20,000 annual complaints estimated above gives a unit cost of £414.

[39] Personal Social Services Research Unit (2013), *Unit Costs of Health and Social Care 2013*, available online at http://www.pssru.ac.uk/project-pages/unit-costs/

[40] Health and Social Care Information Centre (2014), *Personal Social Services: Expenditure and Unit Costs, England - 2013-14, Final release, National expenditure table*, available online at http://www.hscic.gov.uk/catalogue/PUB16111

278. The £531 cost quoted above is in 2013 prices. The unit cost of independent review increases to £557.19 when expressed in 2016 prices using the HM Treasury GDP deflator[41]. The components of the unit costs are summarised in the following table.

Summary of assumptions for the unit cost of an independent review	Number of hours	Cost per hour including on-costs (2013 prices)
Independent reviewer time	6 hours	£49.65
Time for the local authority to make its case	3 hours	£39.72
Administration	2 hours	£22.69
Community nurse input	3 hours (only in 12.5% of cases)	£48.15
GP input	3 hours (only in 12.5% of cases)	£134
Total cost £531 (2013 prices), £557.19 (2016 prices)		

279. We derive the unit cost of a review by the LGO using information from their annual report and accounts for 2013-14[42]. A unit cost of £909 per complaint is implied by dividing the total running cost of the core business (£10.657 million) by the 11,725 complaints considered during the year. This should capture the full cost of each appeal because it is based on the LGO's overall budget. For each LGO appeal, we use the unit cost of £909. This increases to £953 when expressed in 2016/17 prices.

Cost of providing advocacy to a percentage of appellant

280. Some appellants will require advocacy to help them understand the appeals process and make their case. We follow the advocacy costing from the June 2014 Impact Assessment[43]. In terms of the cost of advocacy for an assessment, that costing is on the basis of 17 hours of support at a cost of £30 per hour in 2013 prices, giving an overall cost of £510. We assume that this cost would apply to each independent review. We follow the need and take-up rates from the aforementioned Impact Assessment, with 10% of appellants requiring advocacy and a 70% take-up rate. These assumptions, on average, add £35.70 to the unit cost of each independent review. This increases to £38.13 when expressed in 2016 prices.

Summary of the additional cost

281. The additional cost of independent review relating to assessments (which include appeals on eligibility, the level of personal budgets and the levels of independent personal budgets) is summarised in the table below.

Total cost of appeal events LOW, undiscounted, 2016/17 prices	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Assessment, PB and IPB appeals	£4.06 m	£3.30 m	£3.35 m	£3.41 m	£3.48 m	£3.54 m	£3.62 m	£3.70 m	£3.77 m	£3.84 m

Total cost of appeal events MAIN, discounted, 2016/17 prices	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Assessment, PB and IPB appeals	£9.85 m	£7.75 m	£7.61 m	£7.48 m	£7.36 m	£7.23 m	£7.16 m	£7.06 m	£6.96 m	£6.84 m

[41] HM Treasury (2014), *GDP deflators at market prices, and money GDP: December 2014 (Autumn Statement)*, available online at https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-december-2014-autumn-statement

[42] Local Government Ombudsman (2014), *Annual report and accounts 2013-14: Accountable, efficient, transparent*, available online at http://www.lgo.org.uk/publications/annual-report/

[43] Department of Health (2014), *Impact assessment: draft regulations and guidance for implementation of Part 1 of the Act in 2015/16*, available online at https://www.gov.uk/government/consultations/updating-our-care-and-support-system-draft-regulations-and-guidance

Additional cost of appeals on carers' assessments

282. We apply similar parameters for the costing of appeals on carers' assessments, although the number of carers' assessments is of course different, resulting in different numbers of appeal events. Different advocacy costs are also applied.

Number of appealable events (i.e. carers' assessments)

283. Returns to the HSCIC suggest that 373,615 carers' assessments (either single or joint) took place in 2012/13[44]. The June 2014 Impact Assessment[45] estimates two scenarios of either 230,000 or 250,000 additional assessments going forward. We use the higher number for conservativeness. Similar to the assessment appeal calculations, we use the above numbers for 2016/17 and increase them in subsequent years using demand projections for younger adults and for older people that are consistent with other parts of this impact assessment. We weight the projections for younger adults by 30% and older people by 70%, similar to the age split for assessments and reviews.

Baseline Carer's assessments	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of Carer's assessments	373,615	377,965	383,716	389,976	396,479	402,321	411,237	419,127	425,618	431,429

Additional Carer's assessments arising from the Care Act	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Additional Carers assessments	250,000	252,911	256,759	260,948	265,299	269,209	275,174	280,454	284,797	288,685

Number of appeal events at each stage of appeal

284. We use the same appeal probability as the previous section as well as the same probability of progressing from a local authority review to the independent review stage. This results in the following profile of appeal events relating to carers services (either over eligibility or over the level of carers' services provided).

Number of carers assessment appeals LOW scenario	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of LA reviews	8,731	8,832	8,967	9,113	9,265	9,401	9,610	9,794	9,946	10,082
No. of independent reviews	4,540	4,593	4,663	4,739	4,818	4,889	4,997	5,093	5,172	5,242

Number of carers assessment appeals MAIN scenario	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of LA reviews	21,203	21,450	21,776	22,131	22,500	22,832	23,338	23,786	24,154	24,484
No. of independent reviews	11,026	11,154	11,324	11,508	11,700	11,873	12,136	12,369	12,560	12,732

285. The impact of additional LGO reviews is already captured in the calculations in the previous section.

Other differences in modelling appeals over carers' assessments

286. The same unit costs are applied as in the previous section. The June 2014 Impact Assessment[46] reports different advocacy costs for carers' assessments; we reflect these in the advocacy costs for carers' appeals. We assume that each independent review requires 5 hours of advocacy at a rate

[44] Health and Social Care Information Centre (2013), *Community Care Statistics, Social Services Activity, England, Final Release 2012-13*, Table A11.a, available online at http://www.hscic.gov.uk/catalogue/PUB13148.

[45] Department of Health (2014), *Impact assessment: draft regulations and guidance for implementation of Part 1 of the Act in 2015/16*, available online at https://www.gov.uk/government/consultations/updating-our-care-and-support-system-draft-regulations-and-guidance

[46] Department of Health (2014), *Impact assessment: draft regulations and guidance for implementation of Part 1 of the Act in 2015/16*, available online at https://www.gov.uk/government/consultations/updating-our-care-and-support-system-draft-regulations-and-guidance

of £30 per hour in 2012/13 prices, giving £150 in total. Following the Impact Assessment, we assume that 10% of carers' appeals require advocacy, adding £15 on average to the unit cost of each independent review. This increases to £16.02 when expressed in 2016/17 prices.

Summary of the additional cost

287. The resulting cost of independent review for carers' appeals is presented in the table below.

Total cost of appeal events LOW, undiscounted, 2016/17 prices	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Carers appeals	£2.60 m	£2.63 m	£2.67 m	£2.72 m	£2.76 m	£2.80 m	£2.86 m	£2.92 m	£2.96 m	£3.01 m

Total cost of appeal events MAIN, discounted, 2016/17 prices	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Carers appeals	£6.32 m	£6.18 m	£6.06 m	£5.95 m	£5.84 m	£5.73 m	£5.66 m	£5.57 m	£5.47 m	£5.35 m

Additional cost of appeals on social care reviews

Number of appealable events (i.e. social care reviews)

288. HSCIC information highlights the substantial number of social care review events carried out each year – over 1.4 million in 2012/13[47]. These social care reviews look at whether changes to a person's care package are warranted, perhaps because their condition has worsened or got better since their assessment was carried out.

289. We begin with this number of reviews in 2016/17 and increase it in subsequent years, consistent with the demand projections for younger adults (aged 18-64) and older people (aged 65+) used elsewhere in this impact assessment. We weight the demand projections using the share of reviews for younger adults (29.4%) and older people (70.6%) given in the HSCIC data cited above.

290. We also apply the appeal rate to the number of additional reviews arising from the Care Act, consistent with the numbers used elsewhere in this impact assessment.

Baseline reviews	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of baseline reviews	1,453,345	1,470,301	1,492,751	1,517,202	1,542,603	1,565,414	1,600,283	1,631,128	1,656,484	1,679,169

Additional reviews arising from the Care Act	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of additional reviews	259,308	454,147	466,070	478,833	491,993	506,121	525,181	542,596	557,765	571,841

Number of appeal events at each stage of appeal

291. We apply an appeal probability of 1% events in the 'main' scenario (and 0.7% for the 'low' scenario, i.e. half of the assessment appeal rate in the 'low' scenario). We argue that appeals are most likely to be registered after the first assessment rather than in subsequent reviews, providing that a client's condition is unchanged. However, reviews may generate appeals if services are withdrawn, or if the client argues that their condition has worsened but they are not granted additional services. We otherwise apply the same probability of moving onto independent review as in previous sections.

292. The number of appeal events relating to reviews are summarised in the table below.

[47] Health and Social Care Information Centre (2013), *Community Care Statistics, Social Services Activity, England, Final Release 2012-13,* Table A1, available online at http://www.hscic.gov.uk/catalogue/PUB13148.

Number of review appeals LOW scenario	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of LA reviews	11,989	13,471	13,712	13,972	14,242	14,501	14,878	15,216	15,500	15,757
No. of independent reviews	6,234	7,005	7,130	7,266	7,406	7,540	7,737	7,912	8,060	8,194

Number of review appeals MAIN scenario	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of LA reviews	17,127	19,244	19,588	19,960	20,346	20,715	21,255	21,737	22,142	22,510
No. of independent reviews	8,906	10,007	10,186	10,379	10,580	10,772	11,052	11,303	11,514	11,705

293. The impact of additional LGO reviews is already captured in the calculations above.

Other differences in modelling appeals over reviews

294. The same unit costs are applied as elsewhere, although advocacy costs are again different following the June 2014 Impact Assessment[48]. Advocacy of 8 hours of a rate of £30 per hour in 2012/13 prices is assumed to apply in 5% of cases, following the upper bound take-up rate presented in that IA. This adds £12 to the cost of each independent review on average. This increases to £12.81 when expressed in 2016/17 prices.

Summary of the additional cost

295. The resulting cost profile of independent review for social care reviews is presented in the table below.

Total cost of appeal events LOW, undiscounted, 2016/17 prices	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Review appeals	£3.55 m	£3.99 m	£4.06 m	£4.14 m	£4.22 m	£4.30 m	£4.41 m	£4.51 m	£4.59 m	£4.67 m

Total cost of appeal events MAIN, discounted, 2016/17 prices	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Review appeals	£5.08 m	£5.51 m	£5.42 m	£5.34 m	£5.26 m	£5.17 m	£5.12 m	£5.06 m	£4.98 m	£4.90 m

Overall number of appeal events at each stage of appeal

296. The following table shows the total number of local authority reviews and independent reviews. Previous tables have presented these numbers separately for appeals relating to assessments, carers assessments and reviews.

Total number of appeals LOW scenario	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of LA reviews	33,818	32,968	33,515	34,111	34,737	35,325	36,188	36,959	37,633	38,242
No. of independent reviews	17,586	17,143	17,428	17,738	18,063	18,369	18,818	19,218	19,569	19,886

Total number of appeals MAIN scenario	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
No. of LA reviews	70,142	66,594	67,682	68,869	70,119	71,289	73,006	74,540	75,894	77,117
No. of independent reviews	36,474	34,629	35,195	35,812	36,462	37,070	37,963	38,761	39,465	40,101

Overall additional costs of the appeals system

297. Undiscounted additional costs are summarised in the tables below for each scenario. A 10% uplift is applied to the total cost to capture the cost of appeals that are within the scope of the appeals

[48] Department of Health (2014), *Impact assessment: draft regulations and guidance for implementation of Part 1 of the Act in 2015/16*, available online at https://www.gov.uk/government/consultations/updating-our-care-and-support-system-draft-regulations-and-guidance

system but have not been modelled due to limited available data. (For example, deferred payment agreements, continuity of care, transition from children to adult care and support, and independent advocacy support).

Total cost of appeal events LOW, undiscounted, 2016/17 prices	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	**Total**
Assessment, PB and IPB appeals	£4.06 m	£3.30 m	£3.35 m	£3.41 m	£3.48 m	£3.54 m	£3.62 m	£3.70 m	£3.77 m	£3.84 m	**£36.07 m**
Carers appeals	£2.60 m	£2.63 m	£2.67 m	£2.72 m	£2.76 m	£2.80 m	£2.86 m	£2.92 m	£2.96 m	£3.01 m	**£27.94 m**
Review appeals	£3.55 m	£3.99 m	£4.06 m	£4.14 m	£4.22 m	£4.30 m	£4.41 m	£4.51 m	£4.59 m	£4.67 m	**£42.46 m**
Additional LGO reviews	£0.46 m	£0.21 m	£0.21 m	£0.21 m	£0.21 m	£0.21 m	£0.22 m	£0.22 m	£0.22 m	£0.23 m	**£2.38 m**
TOTAL	£10.67 m	£10.13 m	£10.30 m	£10.48 m	£10.67 m	£10.85 m	£11.11 m	£11.35 m	£11.55 m	£11.74 m	**£108.85 m**
TOTAL INCLUDING UPLIFT	£11.73 m	£11.15 m	£11.33 m	£11.53 m	£11.74 m	£11.93 m	£12.22 m	£12.48 m	£12.71 m	£12.92 m	**£119.74 m**

Total cost of appeal events MAIN, undiscounted, 2016/17 prices	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	**Total**
Assessment, PB and IPB appeals	£9.85 m	£8.02 m	£8.15 m	£8.29 m	£8.44 m	£8.59 m	£8.80 m	£8.98 m	£9.16 m	£9.33 m	**£87.60 m**
Carers appeals	£6.32 m	£6.39 m	£6.49 m	£6.60 m	£6.71 m	£6.81 m	£6.96 m	£7.09 m	£7.20 m	£7.30 m	**£67.86 m**
Review appeals	£5.08 m	£5.70 m	£5.81 m	£5.92 m	£6.03 m	£6.14 m	£6.30 m	£6.44 m	£6.56 m	£6.67 m	**£60.65 m**
Additional LGO reviews	£0.46 m	£0.21 m	£0.21 m	£0.21 m	£0.21 m	£0.21 m	£0.22 m	£0.22 m	£0.22 m	£0.23 m	**£2.38 m**
TOTAL	£21.70 m	£20.32 m	£20.65 m	£21.01 m	£21.39 m	£21.75 m	£22.27 m	£22.73 m	£23.15 m	£23.52 m	**£218.49 m**
TOTAL INCLUDING UPLIFT	£23.87 m	£22.35 m	£22.72 m	£23.11 m	£23.53 m	£23.92 m	£24.49 m	£25.01 m	£25.46 m	£25.87 m	**£240.34 m**

298. As pointed out earlier in this document, the 'low' scenario uses data on the current propensity to complain within the current complaints system. The 'main' scenario allows for a higher appeal rate that mirrors other government appeal systems. It is nonetheless possible (although difficult to quantify) that appeal rates, and therefore costs, could exceed those in the 'main' scenario.

299. Discounted costs (using the HM Treasury Green Book discount rate of 3.5%) are as follows:

Total cost of appeal events LOW, discounted, 2016/17 prices	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	**Total**
Assessment, PB and IPB appeals	£4.06 m	£3.19 m	£3.13 m	£3.08 m	£3.03 m	£2.98 m	£2.95 m	£2.91 m	£2.87 m	£2.82 m	**£31.0 m**
Carers appeals	£2.60 m	£2.54 m	£2.49 m	£2.45 m	£2.41 m	£2.36 m	£2.33 m	£2.29 m	£2.25 m	£2.20 m	**£23.94 m**
Review appeals	£3.55 m	£3.86 m	£3.79 m	£3.74 m	£3.68 m	£3.62 m	£3.59 m	£3.54 m	£3.49 m	£3.43 m	**£36.29 m**
Additional LGO reviews	£0.46 m	£0.20 m	£0.19 m	£0.19 m	£0.18 m	£0.18 m	£0.18 m	£0.17 m	£0.17 m	£0.17 m	**£2.08 m**
TOTAL	£10.67 m	£9.79 m	£9.61 m	£9.45 m	£9.30 m	£9.14 m	£9.04 m	£8.92 m	£8.77 m	£8.62 m	**£93.30 m**
TOTAL INCLUDING UPLIFT	£11.73 m	£10.77 m	£10.58 m	£10.40 m	£10.23 m	£10.05 m	£9.94 m	£9.81 m	£9.65 m	£9.48 m	**£102.63 m**

Total cost of appeal events MAIN, discounted, 2016/17 prices	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	**Total**
Assessment, PB and IPB appeals	£9.85 m	£7.75 m	£7.61 m	£7.48 m	£7.36 m	£7.23 m	£7.16 m	£7.06 m	£6.96 m	£6.84 m	**£75.28 m**
Carers appeals	£6.32 m	£6.18 m	£6.06 m	£5.95 m	£5.84 m	£5.73 m	£5.66 m	£5.57 m	£5.47 m	£5.35 m	**£58.13 m**
Review appeals	£5.08 m	£5.51 m	£5.42 m	£5.34 m	£5.26 m	£5.17 m	£5.12 m	£5.06 m	£4.98 m	£4.90 m	**£51.84 m**
Additional LGO reviews	£0.46 m	£0.20 m	£0.19 m	£0.19 m	£0.18 m	£0.18 m	£0.18 m	£0.17 m	£0.17 m	£0.17 m	**£2.08 m**
TOTAL	£21.70 m	£19.63 m	£19.28 m	£18.95 m	£18.64 m	£18.31 m	£18.11 m	£17.87 m	£17.58 m	£17.26 m	**£187.33 m**
TOTAL INCLUDING UPLIFT	£23.87 m	£21.60 m	£21.21 m	£20.85 m	£20.50 m	£20.14 m	£19.93 m	£19.65 m	£19.34 m	£18.98 m	**£206.07 m**

Benefits of the appeals system

300. Local authorities have already received sufficient funding to meet the local population's care and support needs. The primary benefit of the appeals system relative to the do-nothing option comes from the (arguably greater) value of spending on successful appellants, net of the value of (arguably inappropriate) spending that will no longer be made because the overall budget is fixed. This efficiency gain has not been monetised because the value of social care spending is highly specific to the individual concerned. The spending on successful appellants will take the form of eligibility for support, the level of personal budgets, the level of independent personal budgets and other issues. We present below two case studies from the Local Government Ombudsman to illustrate the kind of cases that were successful in their existing complaints service. We also estimate the value which needs to be placed on each successful appeal if the benefits of the policy are to offset the costs. Following the assumptions set out earlier in this impact assessment, we

assume that 48% of local authority reviews are successful from the point of view of the appellant, alongside 48% of independent reviews. Using the summary tables at the end of the above costs section, this gives 521,848 successful appeals in the main scenario across the ten year period. Dividing the ten year cost (excluding the 10% uplift) of £218.49m by 521,848 gives a value of £419 (in 2016/17 prices). The benefits of the policy therefore exceed the costs if the value of spending on a successful appeal, net of the value of the spending that will be displaced due to the fixed budget, is greater than £419. The appeals system may also affect decision-makers' behaviour when making future assessment and eligibility decisions (a learning effect that applies even in cases where no appeal is made), which would reduce the £419 threshold.

301. The second benefit of the appeals system relates to improvements in equity, if society values spending on successful appellants more highly than other spending, and if society values greater consistency of decisions between local authorities.

302. A third benefit is a potential reduction in the number of Judicial Reviews (JRs) relative to the do-nothing option, as the appeals system will provide greater capacity for resolving disputes. Judicial Reviews are associated with significant costs both to public expenditure and to the claimant. Treasury Solicitors estimate a £8,000-£25,000 cost to a public body for defending a non-immigration JR from pre-action to a final hearing[49]. The Public Law Project estimated a cost of £10,000-£20,000 to a claimant bringing a straightforward JR[50]. Summing the midpoint of the two estimates gives a cost of £31,500 per JR that the appeals system might avoid. Some JRs will of course have a higher cost, with others having a lower cost e.g. if they are withdrawn early on in the process. It is difficult to judge how many JRs might be prevented by the appeals system, although the fact that 97 JRs were lodged in 2013 in the areas of Care Standards and Community Care provides some context.

303. A fourth benefit is a reduction in the number of complaints within the current complaints system. It is estimated above that approximately 20,000 adult social care complaints are made to local authorities per annum. The appeals system would enable people to request an appeal in relation to certain care and support decisions; these are currently handled in the complaints system alongside other complaints. It is therefore likely that the appeals system would generate a reduction in the number of complaints.

Case studies from the Local Government Ombudsman

304. The following case studies are presented from Local Government Ombudsman (2014)[51].

LGO Case Study 1 - Ignoring the evidence

305. Peter has autism, epilepsy and moderate learning disabilities. He lives at home with his mother. After his NHS funding was withdrawn the council assessed his needs but failed to comply with its legal duty to agree an aftercare plan.

306. Care professionals raised concerns that the care package offered would not meet Peter's needs but our investigation showed that the council failed to take into account all the relevant evidence. As a result Peter and his mother were left without the support they needed and Peter was unable to access respite. Their frustration was further increased when the council's response to the complaint contained inaccurate information.

307. We recommended that the council reassess and expedite the process of identifying Peter's needs so a care package could be agreed. We also recommended that they apologise for the way they

[49] Cited in Ministry of Justice (2013), *Judicial Review: Proposals for Further Reform*, available online at https://consult.justice.gov.uk/digital-communications/judicial-review/supporting_documents/Judicialreviewproposalsforfurtherreform.pdf

[50] Public Law Project (2007), *How to fund a judicial review claim when public funding is not available*, available online at http://www.publiclawproject.org.uk/data/resources/118/PLP_2006_How_to_fund_JR_without_legal_aid.pdf

[51] Local Government Ombudsman (2014), *Review of Adult Social Care complaints 2013*, available online at http://www.lgo.org.uk/news/2014/may/lgo-publishes-complaints-statistics-english-adult-social-care-providers-first-time/

carried out the original assessment and for how they responded to the complaint. We also recommended a financial remedy.

LGO Case Study 2 - Disregard for dignity

308. Rebecca had a care package that provided her with support for preparing meals, collecting her pension and with showering. Following a reassessment the council reduced the amount of time that she received support for. In particular Rebecca was offered reduced support for showering as they felt it could take less time if she did fewer tasks herself. Rebecca considered it was important to shower herself to maintain her privacy.

309. When the assessment was carried out, the council failed to complete the section for considering risk to the service user.

310. When we investigated the complaint we found that the council had not demonstrated that it had considered the risk to Rebecca of reducing her care package. In particular the council gave insufficient regard to the importance of Rebecca's dignity and privacy when relying upon carers to carry out intimate tasks. We recommended that the council review Rebecca's care plan and carry out a proper risk assessment; apologise for failing to carry out adequate reviews and provide a financial remedy.

ANNEX A – Peace of Mind Methodologies

Loss Ratio Approach

A1. We used findings from the long-term care insurance (LTCI) market in the USA to estimate willingness to pay for insurance against care costs, over and above the actuarially fair premium. In particular, we looked at LTCI loss ratios.

A2. The loss ratio is the amount that an insurer pays out on claims divided by the amount it collects in premiums. From the provider's perspective, the loss ratio is less than one to allow for administration costs, profits and the accumulation of reserves. The size of the loss ratio is a supply-side decision.

A3. On the demand-side, however, individuals face a binary choice given the size of the loss ratio: buy insurance or do not buy insurance. If the individual buys insurance given a loss ratio less than one, then on average they will be worse off in monetary terms. In turn, this means that the individual must perceive that they will be better off in other ways. We suggest that people are willing to accept the monetary cost because they value the peace of mind that insurance provides; essentially, they are buying the peace of mind. Therefore, by isolating how much 'worse off' in monetary terms the individual is on average, we estimate how much 'better off' they are in terms of their peace of mind.

A4. Using information from the USA, we estimate that between 40% and 60% of the total premiums collected by LTC insurers is not paid out on claims. Our hypothesis is that, on average, those who buy LTCI pay 40% of their premium for the peace of mind that coverage brings. In the following, we define the Peace of Mind (POM) Ratio as 1-loss ratio.

A5. Work from PSSRU on immediate needs annuities in the UK suggests a similar premium where INA's cost around £100,000 but have an actuarial value of only around £70,000. This means that around 40% of the premium is paid for the peace of mind supporting the results from the US.

The Buyers of LTCI

A6. Most older people in the US do not have LTCI. A study by American Health Insurance Plans (AHIP) (2007), a trade body for health insurers in the US, finds that only 16% of over 65 year olds are covered by LTCI. For our purposes, this means that 16% of older people think the benefit of LTCI is greater than or equal to the cost. Therefore, we expect most buyers to have been willing to pay more for the insurance than they had to.

The Non-Buyers

A7. The AHIP study also surveyed non-buyers (representing the remaining 84% of the older population), to ascertain how much they would have been willing to pay for insurance. The study finds that 15% of non-buyers were willing to pay (at least) the market premium, but could not afford to do so. A further 15% of non-buyers would not be willing to pay for LTCI under any circumstances. Using the study, we also estimate that the remaining 70% of non-buyers would have bought insurance had it cost 73% of the market premium.

A8. Clearly, different people are willing to pay different amounts for long-term care insurance. Some non-buyers would be willing to buy LTCI if the premium was lower, or, equivalently, if the loss ratio was higher. Using the information in the AHIP (2007) study, we estimate the average acceptable loss ratio to be around 0.7. This means that on average, an older person picked at random would be willing to purchase LTCI, if for every pound of premium she paid, she received 70 pence of coverage. In turn, this means that on average the individual would be willing to pay 30 pence (or 43% of the actuarially fair price) for the peace of mind that insurance brings (i.e. the POM ratio is 30%).

Caveats

Transferring Lessons from the USA

A9. In our analysis, we rely on people in the UK having similar risk preferences to people in the USA. We do not have evidence on the validity of this assumption. However, these results appear to correlate with the limited evidence from the Immediate Needs Annuity Market in the UK.

Constant Risk Aversion

A10. In our methodology, we implicitly assume that each pound of risk that the state covers is of a constant value to the individual. In practice, we do not expect this assumption to be realistic. Holt and Laury (2002), for example, find that increasing the scale of payoffs increases the level of risk aversion. Therefore, we expect insurance that removes low probability but with high loss risks to be of greater value to the individual than insurance that covers against lower cost but greater probability risks.

A11. We do not adjust for varying risk aversion, because we do not know the extent and pattern of the variation.

Sustainability of the Scheme

A12. Insurance only delivers peace of mind if the insured believe that the insurer will pay out. In terms of the universal protection from the cap on care costs, this means that the welfare gain will only apply if people believe that the funding system will be in place for their lifetime. In turn, this means that there is some trade-off between comprehensiveness and sustainability. A fully comprehensive insurance product, such as the NHS, will only provide peace of mind if it is believed to be sustainable.

A13. The government has thus committed to a fully funded scheme which is sustainable in the long term. We have therefore set the cap at a level which is affordable.

ANNEX B – Overview of DH social care funding model

Introduction

B1. The DH social care funding model (v2014) is an excel based model which runs using VBA code. It is designed to estimate the impact of different funding reform options, in particular to estimate the public spend on older adult social care and the distributional impact of the different reforms.

B2. The model is a cross-sectional model that retro speculatively simulates the uncompleted care journeys of a representative cross section of care users in the cross-sectional month being interested. It independently models each quarter of the years 2015/16 to 2025/26. For each financial each it models the week in the middle of each quarter.

B3. The model uses a base sample of the ADL (activity of daily living) disabled 65+ population from wave 5 of the English Longitudinal Study of Ageing (ELSA)[52]. It models 6 care settings separately; nursing homes, residential homes and 4 levels of home care (low, medium, high and very high intensity). The base sample provides the individual wealth characteristics used in the model.

B4. The base sample is statically aged using weightings derived from projections from the PSSRU (Personal Social Services Research Unit[53]) aggregate model of the number and characteristics of care users in year in question.

B5. For each care setting the model runs a representative sample (through weighting the base sample) through an individual care pathway model.

B6. Each individual in the sample is assigned a random care pathway from a derived distribution of all uncompleted care pathways using PSSRU survey data. The individual care pathway model computes the state and private spend for each month of the care pathway, this is dependent on the individuals characteristics (income, wealth, household type, housing tenure) and the funding system being modelled. The quantities of the cross-sectional point are aggregated using the weights to produce population level estimates.

B7. The quarterly estimates are aggregated to produce estimates for each financial year.

B8. The model can be run multiple times to average out the statistical randomness in the results, and the results produced are not projections of the future but projections under the set of assumptions used, the results are therefore sensitive to changes in assumptions.

Model Structure

B9. The schematic below illustrates the general structure of the model, and how it links with the PSSRU aggregate model.

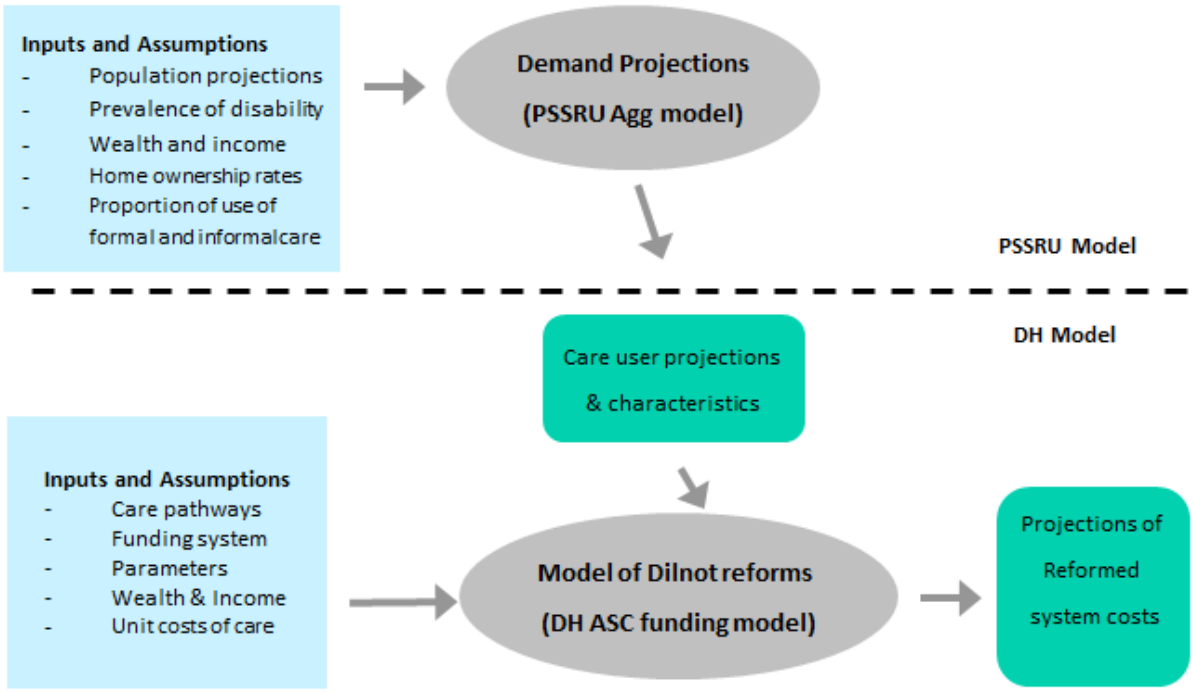
B10. The PSSRU model is a cell based model that is recognised as the leading academic model to project the future demand for adult social care. We use outputs from the PSSRU model as inputs into the DH social care funding model to provide a projection of the care user population in future years, and also the characteristics of the care users.

B11. The DH social care funding model uses assumptions on the make-up of older people's care pathways, their wealth and income to model the impact of the reforms options. The key outputs are the costs of the reforms, and the number of additional people who receive state support with their care and support costs.

[52] http://www.ifs.org.uk/ELSA

[53] http://www.pssru.ac.uk/

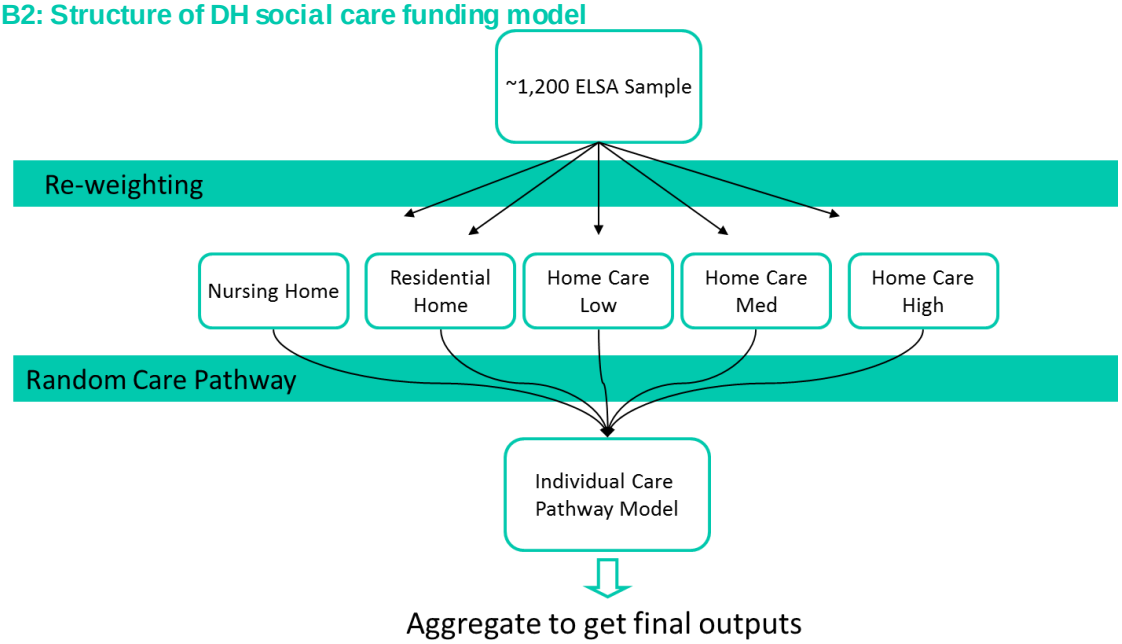
Figure B1: Overview of DH social care funding model



DH Social care model construction

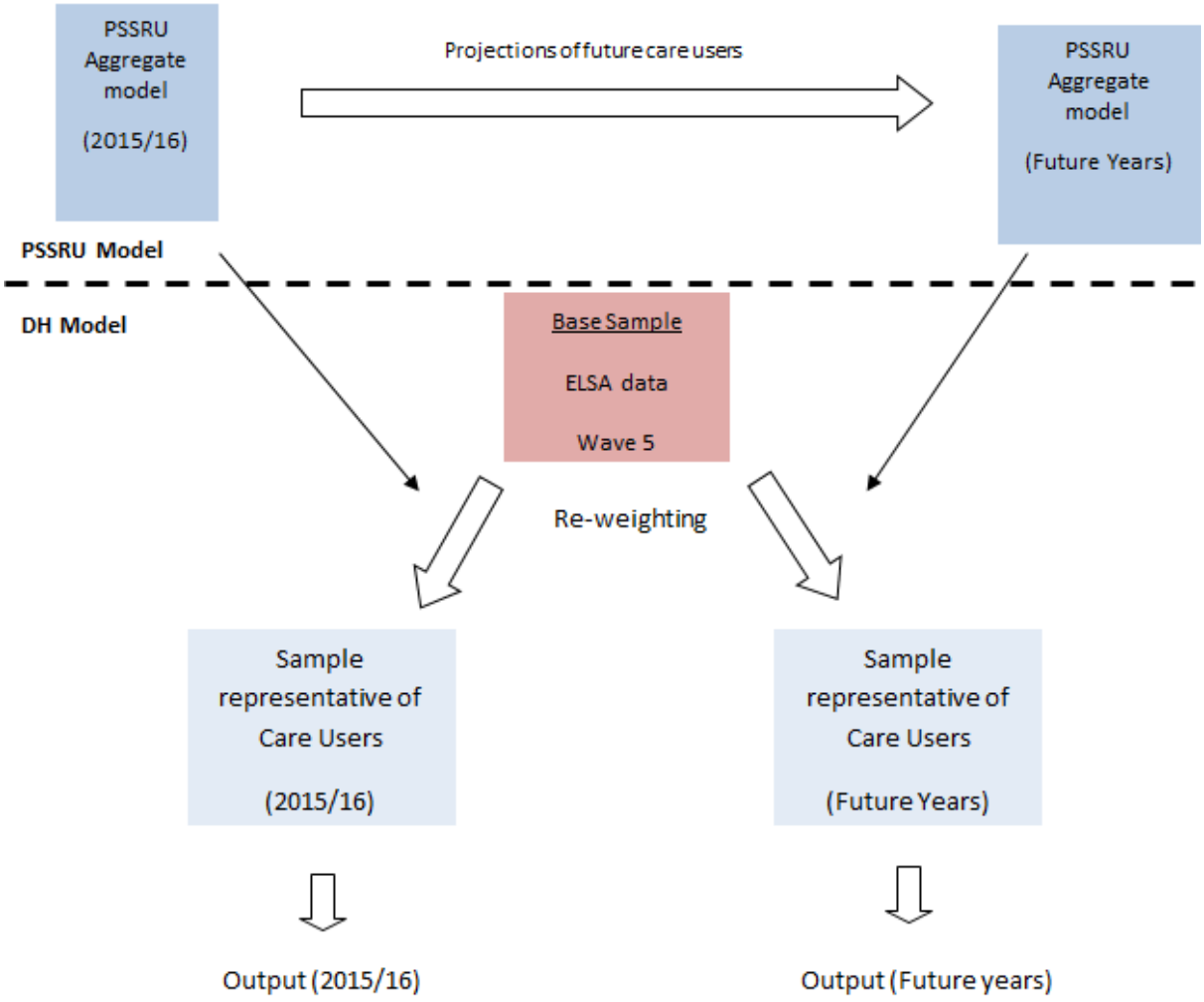
B12. For each care setting the model runs a representative sample through an individual care pathway model. The same base sample is used for each care setting. The representative sample is generated by weighting the sample for each year and care setting using weighs derived from outputs from the PSSRU aggregate model of the number and characteristics of care users. The results are then aggregated across on the individuals to produce to final outputs.

Figure B2: Structure of DH social care funding model



B13. The diagram below illustrates on the estimates for future years are produced. The PSSRU aggregate model projects the number of social care users in future years, and their characteristics. The base sample is re-weighted using the characteristics for each of the years in the model, to produce a sample that represents the care population in that year. This sample is then run through the DH social care funding model to model the costs of the current system and the reform options.

Figure B3: Static ageing in DH social care funding model



Re-weighting process

B14. A weighting process is used in the modelling in order to produce a representative sample of care users.

ELSA base sample

B15. The model includes a base sample of individuals from the ELSA (English Longitudinal Survey of Ageing) wave 5. We use the subsection of people in the survey who are: aged > 65, report at least one ADL (activity of daily living). We use the ELSA cross-sectional weights, which are designed to correct for non-response bias.

Weighting to the care population

B16. The ELSA base sample does not represent the care population. We use information on the characteristics of care users from outputs of the PSSRU aggregate model[54].The output provides the following disaggregation.

Figure B4: Disaggregation in PSSRU aggregate model

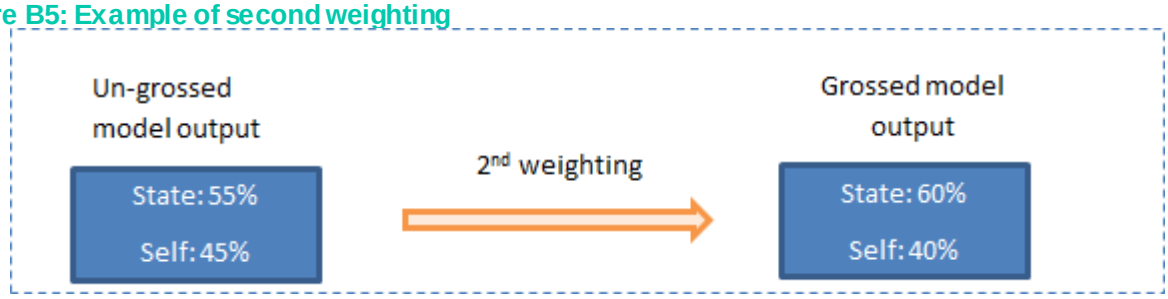
Year	Gender	Age	Marital Status	Home Ownership	Care Setting
2015 ->	Male Female	65-69 70-74 75-79 80-84 85+	Single Couple	Owner Renter	Residential Nursing Community care (by intensity)

B17. For each of the settings in the model, we use this information to re-weight the ELSA base sample for each care setting in the model.

Weighting to the projected number of state and self-funders

B18. We run the model for the current funding system, for each individual in the base sample the model projects whether they are state funded or self-funded at the point of time in question. We then apply a second weighting so that the model output matches the projection of state and self-funders from the PSSRU projections of the current system. With regional fees we apply these second weightings for each of the fee levels.

Figure B5: Example of second weighting



Projection assumptions

B19. There are simplifying assumptions around the inflation of different financial quantities. In this version of the model, we assume that all individual financial quantities and all financial parameters uprate in line with average earnings. These include:

- Level of cap, general living costs;
- Means test thresholds, income allowances;
- Wealth of the older population, including home ownership proportions
- Income of older population
- Cost of care.

B20. To support this care costs are assumed to increase in line with average earnings, and the cap will be uprated in line with average earnings. There will 5 yearly review is scheduled to analyse the

[54] http://eprints.lse.ac.uk/40720/1/2811-2.pdf

balance between state and individual among other things. These assumptions mean that the simulation part of the model is all run in 2015/16 care cost prices. The output is then simply uprated by the care cost inflation assumption for each of the projected years.

B21. The model outputs will be sensitive to more nuanced assumptions, but the impact will be small in the short/medium term.

Individual Pathway Model

B22. The main part of the model is the individual pathway model that simulates the care pathway for the individuals in the model.

B23. Each individual in the model are assigned a random un-completed care pathways. For residential care and nursing care they are assigned a completed spell in domiciliary care (or no previous domiciliary care) and then an uncompleted spell in residential care. For domiciliary care they are assigned an uncompleted spell in domiciliary care. The distributions from which the random un-completed pathways are selected are constructed using the 2011 BUPA Survey, PSSRU Admissions to care homes survey 2005, User Experience Survey 2006.

B24. As an update for the v2014 model the care pathways are different for residential and nursing care and dependent on the gender of the individual. The diagram below graphically illustrates this:

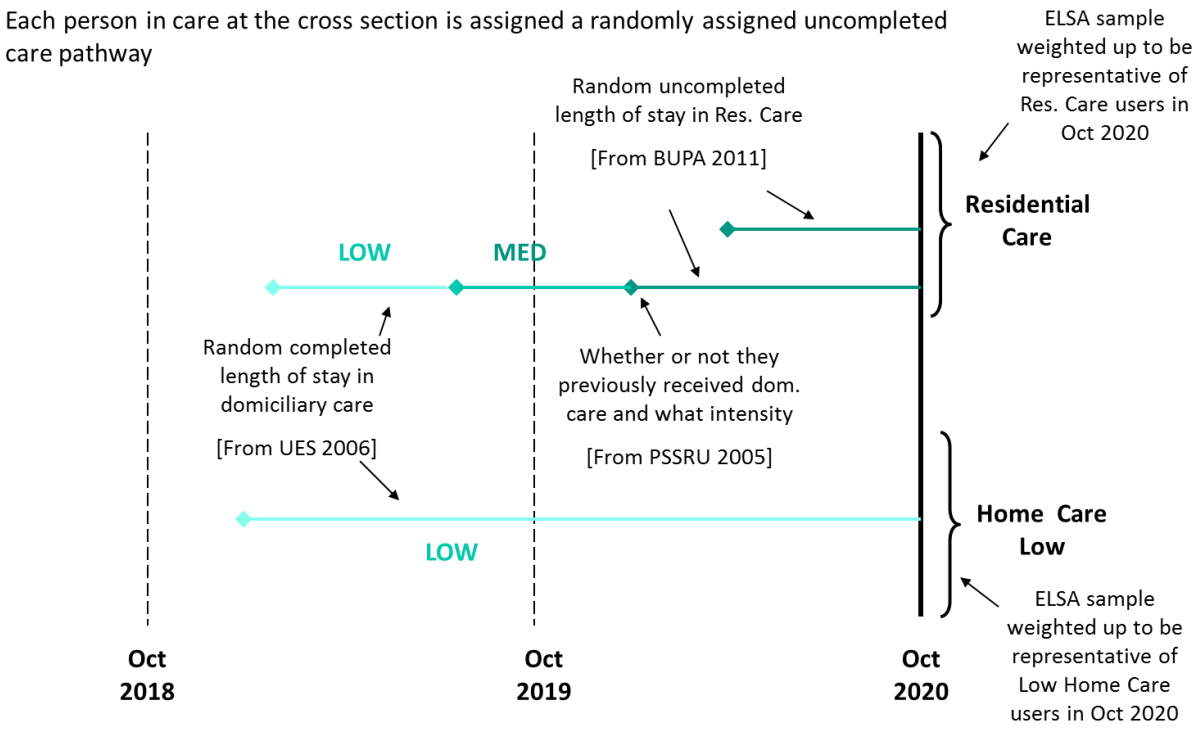
B25. For example when modelling October 2020:

- The starting point it the projected number of social care users in October 2020. This comes from the PSSRU aggregate model;
- The ELSA base sample is weighted to represent the care population;
- Each individual in the sample is assigned an uncompleted care pathway;
- The DH social care model then simulates the uncompleted care pathway back up to the point been modelled;

B26. The diagram below, shows three example:

- Person A: entered residential care around Feb 2020 and is still in residential care in October 2020;
- Person B: entered community care in December 2018, has a period in low intensity then medium intensity and enters residential care round December 2019 and is still in residential care in October 2020;
- Person C: entered low intensity community care in November 2018 and s still in low intensity home care in October 2020;

Figure B6: Modelling care-pathways in DH social care funding model



Overview of PSSRU aggregate model

B27. There are many different academic papers documenting the PSSRU model, which provides reports on the projections and documents the model structure[55].

B28. The PSSRU model is a cell based model that projects:

- The number of older people with disabilities;
- The number of people who use formal social care services;
- The number of people who qualify for state support; and
- The cost to the state.

B29. Eligibility for adult social care is assessed by judging whether people are unable or have difficulty in performing activities of daily living (ADLs), which include been able get dressed, bath yourself. Therefore models that project demand for social care use the inability to perform ADLs as the measure of disability that affects how likely they will be eligible for social care. For example the PSSRU aggregate model uses 6 disability groups.

[55] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/121203_care_for_older_people_1.pdf

Figure B7: Disability groups in PSSRU aggregate model

The six disability groups used in the model are as follows:
1. People able to perform ADL (personal care) tasks and IADL (domestic care) tasks without difficulty or need for help.
2. People who have difficulty performing IADL but not ADL tasks.
3. People who have difficulty bathing.
4. People with difficulty with other ADL tasks.
5. People who cannot perform at least one ADL task without help.
6. People who live in the community and cannot perform two or more ADL tasks without help, and people who are in care homes or long-stay hospital.

B30. The diagram below shows the other characteristics that the PSSRU aggregate model splits the population into:

- Age [5 groups]
- Gender [male / female]
- Disability [6 groups]
- Housing tenure [owner / renter]
- Household type / informal care [8 groups] – community
- Previous household type [married / single] – residential

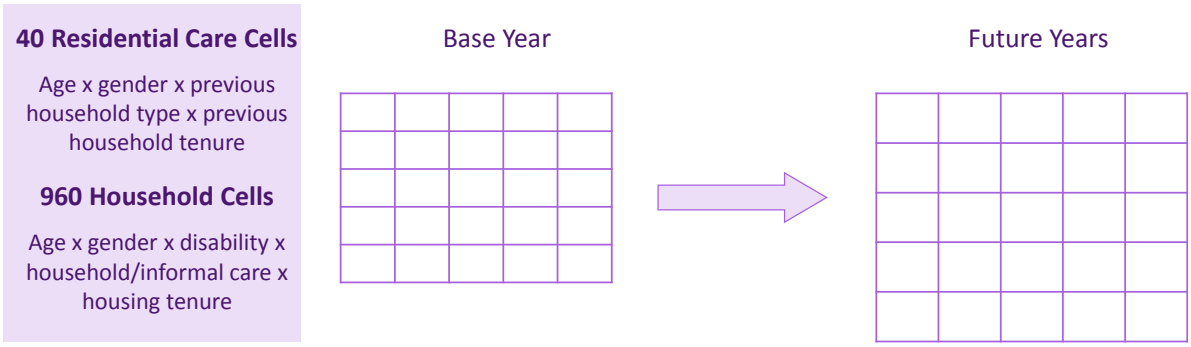
Figure B8: Household/informal care groups in PSSRU aggregate model

The eight different Household type/informal care classification used in the model are as follows:
1. Single, living alone, no informal care
2. Single, living alone, with informal care
3. Single, living with children
4. Single, living with others
5. Couple, living with partner only, no informal care
6. Couple, living with partner only, with informal care
7. Couple, living with partner only, with informal care from outside the household
8. Couple, living with partner and others

B31. The household population includes all cells: 5 x 2 x 6 x 2 x 8 = 960. The residential care population only includes those in the most disabled group and doesn't disaggregate by the 8 household type/informal care groups but 2 previous household types: 5 x 2 x 2 x 2 = 40.

B32. The graphic below illustrates the structure of the model.

Figure B9: Schematic of structure of PSSRU aggregate model



Residential Care

- Estimates the proportion of disabled older people in residential care for each subgroup, using local authority data on number of supported residents and estimates of privately funded care home residents.

Non-residential care

- Estimates the probability of receipt of services for each cell (using GHS data)

- Uses unit costs to calculate total expenditure on the services

- Breaks down total expenditure by source of funding: NHS, LAs and service users

B33. The PSSRU model includes key assumptions on the drivers of social care need and whether people would be eligible for state support, these include:

- 2012 based ONS population projections – uses low migration projection as the central assumption. The 2012 population projections use data from the 2011 census.
- The prevalence of disability in the older population, the central assumption is that age-gender prevalence of disability stays constant (defined by the number of ADLs/IADLs an individual reports). There is uncertainty around this assumption, analysis by DH strategy group concluded that the latest evidence suggests that we have seen a compression rather than an expansion of morbidity, while modelling from Carol Jagger (Newcastle University) suggest that the age-gender prevalence of social care need is likely to increase in the future due to increased obesity prevalence rates leading to increased dementia. Therefore we are happy that constant age-gender prevalence is an appropriate central assumption.
- The proportion of care needs met informally stays constant in the future. However, there is other PSSRU modelling that suggests the amount of care provided by grown up children may reduce due to the increase in childless older adults.
- The rate of home ownership of the older population. This is important in understanding the proportion of older people who would qualify for state support.
- The proportion of older people in couples. This is important both in determining the amount of informal care provided by spouses and also whether people would be eligible for the housing disregard in residential care.
- The eligibility for state services remains the same in future years.
- There is uncertainty around these assumptions which impact the projected number of people with a social care need in the future and the proportion of those will be supported by the state. PSSRU have published sensitivity to the key assumptions.

B34. For the purpose of the modelling of the reforming it is important to remember that these assumptions impact the projected cost of the current system, as well as the costs of the reforms.

Overview of data and assumptions

Base sample

B35. The base sample is made up of 1,136 people aged 65+ with 1+ ADL from wave 5 (2010/11) of the ELSA survey. The sample provides the characteristics of the older people to run through the individual care pathway model. The characteristics used are:

Figure B10: ELSA variables (some derived) used in the model

To weight the sample	Age Gender Marital status Housing tenure
For use in funding system	Housing assets Non-housing assets Income (exc. disability benefits) Gender Marital status

B36. The ELSA survey does have people in receipt of community services but not people in residential care, therefore the sample will under represent people with high levels of disability. We use the sample of 65+ in the survey who have 1+ ADL to give a representative sample of the financial status of older disabled people. We bootstrap to increase the sample size to 6816. We make various assumptions in using the sample in this way:

- We uprate the sample from 2010/11 to 2015/16 by assuming housing wealth increases in line with OBR projections on house prices, non- housing assets increase in line with GDP and income increases in line with average earnings.
- We assume that the updated ELSA sample provides the financial status of older people at the cross section in the case when they did not require care and have therefore not spent down assets on care. We do no adjustment of assets for the people in the sample who report they are in receipt of care. We assume these people have not significantly spent down assets on care.
- We then assume that this is their financial status when they start their care journey in the model (months or years in the past) and that their status does not change through their care journey apart from any assets spend down to pay for care. Therefore we assume:
    i. The user's income (excluding disability benefits) remains the same[56] throughout their care journey.
    ii. The user's assets remain unchanged apart from any spend on assets for care.

[56] by remains the same we mean remains the same relative to all the financial parameters in the social care funding system

iii. The user's marital status remains unchanged through their care journey.

Projected characteristics of care users

B37. The DH Funding model models 6 care services separately:

- Nursing home
- Residential home
- Low intensity home care
- Medium intensity home care
- High intensity home care
- Very high intensity home care

B38. We use projections from the PSSRU aggregate model[57] of the characteristics of care users for years 2015, 2020 and 2025. The projections give the proportion of users grouped by the following characteristics:

- Age [5 groups: 65-69, 70-74, 75-79, 80-84, 85+]
- Gender [male, female]
- Marital status [single, married]
- Housing tenure [renter, owner]

B39. Due to the sample size of the base sample we could not re-weight using all of the variables, but the increased sample size means that in v2014 we can now weight the population separately by men and women

B40. We needed to split by marital status (as the application of the funding rules depend on whether the care user has a spouse living with them, for this we use marital status as a proxy) and through analysis we determined the importance of the other variables, we constructed weights for the following 14 groups:

Figure B11: Groups used for weighting

Male	Female
Single owner 65-74	Single owner 65-74
Single owner 75+	Single owner 75+
Single renter 65-74	Single renter 65-74
Single renter 75+	Single renter 75+
Married owner 65-74	Married owner 65-74

Number of eligible self-funders in residential and nursing care

B41. We use the PSSRU estimate of the number of self-funders; which is based on registered CQC bed data, occupancy rates (L&B survey), NHS CHC residents, and LA supported residents (HSCIC).

[57] Projections of demand for and costs of social care for older people in England, 2010 to 2030, under current and alternative funding system [PSSRU DP 2811/2 – December 2011]

B42. We assume that 10% of the total number of self-funders would be ineligible for state supported residential care on their assessed needs, and would be deemed eligible for high intensity community care.

Figure B12: Projection of number of self-funders in care homes

Self-supported

	15/16	16/17	17/18	18/19	19/20	20/21	…	25/26
residential care	74,692	77,247	79,803	82,358	84,914	87,469		107,460
nursing care	67,201	69,413	71,626	73,839	76,051	78,264		95,134

Self-supported – eligible [10% reduction applied]

	15/16	16/17	17/18	18/19	19/20	20/21	…	25/26
residential care	67,223	69,522	71,822	74,122	76,422	78,722		96,714
nursing care	60,481	62,472	64,463	66,455	68,446	70,438		85,621

Wealth and Income of care users

B43. The weighting of the base sample provides a sample of representative care users.

Uptake of the reforms

B44. There is the option to model reduced uptake of the reforms. We can split the non-uptake into two groups:

- People who only start metering when they need higher intensity community care
- People who do not want to deal with the state and only approach the state when they have spent down nearly all of their wealth.

Economic Projections

B45. The model uses the latest projections published by the office of budget responsibility in the Economic and Fiscal Outlook report, December 2014[58].For long run assumptions we use the OBR assumptions as used in their latest Fiscal and Sustainability report, July 2014[59].

Care cost data and assumptions

B46. For our central assumption we use data from the Health & Social Care Information Centre [HSCIC][60], this is data from returns completed by each Local Authority. The unit cost data is derived from returns on the level of activity and spend.

B47. Past data illustrates that between 2005/06 and 2010/11 unit costs increased by around 4% per annum in cash terms, compared to general inflation of around 2.7% pa (as measured by the GDP deflator). Since 2010/11 unit cost growth has been below general inflation.

B48. In the long run you would expect unit costs in social care to increase approximately in line with wage inflation, due to the dominance of staffing costs in the costs of delivering social care.

[58] http://budgetresponsibility.org.uk/economic-fiscal-outlook-december-2014/

[59] http://budgetresponsibility.org.uk/fiscal-sustainability-report-july-2014/

[60] http://www.hscic.gov.uk/searchcatalogue?topics=0%2fSocial+care&sort=Relevance&size=10&page=1#top

B49. The latest outturn data is for 2013/14, so we make assumptions on the inflation in care costs to the base year in the model and then for the forward projection period.

B50. As our central assumption, we assume that unit costs increase in line with average earnings from 2013/14. We use the projections published by the OBR in their December 2014 EFO and July 2014 FSR reports.

Figure B13: Assumption on the inflation of care costs

	14/15	15/16	16/17	17/18	18/19	19/20	20/21 ->
Care cost assumption	1.8%	2.1%	3.3%	4.0%	3.9%	3.8%	4.4%

B51. This produces the following trend in the national average care costs.

Figure B14: Assumed average care costs

	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21
Residential	£533	£543	£554	£572	£595	£618	£642	£670
Nursing	£540	£550	£561	£580	£603	£626	£650	£679
Home care (per hour)	£17.34	£17.65	£18.02	£18.62	£19.36	£20.12	£20.88	£21.80

B52. Six fees rates in residential and nursing care are used to capture the variation in care costs for different people in residential and nursing care.

B53. To replicate this variation in the model, we use the individual LA level data provided to the HSCIC and make an assumption for the level of the premium for those with high needs based on data from a Laing & Buisson survey of Local Authorities[61].

B54. We calculate six differential fee rates, selecting the mid points from the 6-tiles for nursing and residential care.

Figure B15: Distribution of care home fees

2013/14	Nursing	Residential
Fee 1	£422	£432
Fee 2	£473	£472
Fee 3	£510	£513
Fee 4	£541	£557
Fee 5	£585	£609
Fee 6	£674	£716

Modelling Community Care

[61] http://www.laingbuisson.co.uk/Home.aspx

B55. In reality people having their care and support need met in the community receive a variety of different services, including the traditional home care and day care services. With the introduction of direct payments, instead of the LA commissioning services for them people can choose to receive a direct payment (a cash payment equal to the monetary level of state support they are deemed eligible for) with which they self-commission services to meet their care and support needs. The table below shows the number of people receiving state support for the different kind of services

Figure B16: Number of state supported people in community care

Community Care	2010/11	2011/12	2012/13	2013/14
Home Care	244,390	224,230	208,125	204,130
Day Care	64,550	53,435	43,885	38,780
Meals	44,825	30,955	23,110	17,150
Short Term Residential - not respite	11,080	10,315	9,640	8,595
Direct Payments	34,880	41,925	42,760	43,545
Professional Support	77,275	59,230	38,020	35,570
Equipment & Adaptations	185,325	165,295	145,330	136,785
Other	43,615	39,825	25,510	24,160
Total Community	**534,585**	**482,680**	**417,740**	**395,090**

Source: HSCIC, numbers of supported users as of 31st March, note columns do not add to total as users can be receiving multiple services.

B56. To model community services, we simplify this position to group community care into 4 levels which we denote as a number of hours of home care, but can be interpreted as any package of care or direct payment of that monetary value. We use the distribution of the intensity of home care packages to inform the 4 levels.

Figure B17: Distribution of home care intensity

	2010/11	2011/12	2012/13	2013/14
Less than or equal to 2 hours	14%	12%	10%	10%
More than 2 hours and less than or equal to 5 hours	21%	20%	19%	18%
More than 5 hours and less than or equal to 10 hours	27%	27%	28%	27%
More than 10 hours inc overnight/live in/24 hour	38%	41%	43%	45%

Source: HSCIC

B57. To ensure we capture people with high intensity packages, we split the high category into two groups, people receiving equivalent of 12.5 hours and 22.5 hours of home care. The table below shows the groupings and the 15/16 value of their care package.

Figure B18: Unit cost of community care included in the DH social care funding model

	Hours per week	15/16
Very Low*	1	£18
Low	3.5	£63
Medium	7.5	£135
High	12.5	£225
Very high	22.5	£406

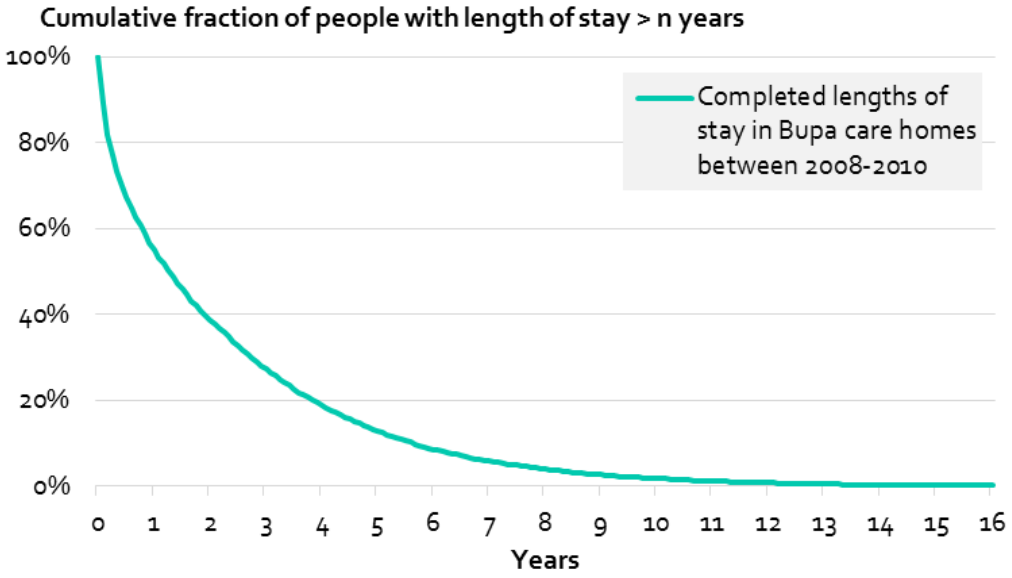
B58. We do not model very low for computational time reasons, but these people will not reach the cap.

Care Pathway information

B59. The DH funding model assigns random un-completed care pathways to each individual in each care setting. The random care pathways are selected from a derived distribution of un-completed care pathways for the 6 care settings. We construct the distributions using survey data:

Length of stay in care homes (PSSRU) [62]

Figure B19: Lengths of stay in care homes



B60. We convert the completed lengths of stay into uncompleted lengths of stay. To do this we make the following assumptions:

- Lengths of stay distribution has not changed

B61. We use separate distributions for residential care and nursing care, and for men and women. We adjust the overall distribution to take into account the results of statistical analysis completed by PSSRU. The analysis shows that:

- Men (residential), median length of stay is 13% lower than overall;
- Women residential), median length of stay is 73% higher;
- Men (nursing), median length of stay is 3% lower;

[62] PSSRU DP 2769 – Jan 2011 – Commissioned by BUPA

- Women (nursing), median length of stay is 30% higher

B62. We have not included dependence on age at this stage, partly due to the complexity of building this assumption into the model and also due to the difficultly of interpreting the statistical analysis. This is a factor that we intend to investigate in further updating of the model.

Admissions to care homes and home care survey 2005 (PSSRU) [63]

B63. This survey gives the proportion of people who were previously receiving domiciliary care before their admission to care homes.

Figure B20: Distribution of home care intensity

% receiving LA home care prior to care home	*frequency*	*what intensity?*
No	37%	
1 – 5 hours per week	10%	18.5%
6 – 10 hours per week	21%	36.4%
11 – 15 hours per week	13%	22.7%
16 – 20 hours per week	6%	9.9%
21 hours per week or more	7%	12.5%
Frequency not known	6%	
any	**63%**	

2006 User Experience Survey

B64. This survey gives the distribution of uncompleted length of stay in home care.

Figure B21: Distribution of uncompleted lengths of stay in home care [UES 2006]

weighted data	frequency
< 6 months	10%
6 months to 1 year	17%
1 to 2 years	21%
2 to 5 years	30%
5+ years	22%

B65. We make assumptions to disaggregate the distribution into 1 month intervals and interpolate to generate the tail of the distribution.

B66. These 3 data sources are used to produce distributions of un-completed care journeys:

- Residential and nursing home: uncompleted length of stay in care home, whether they had previously received home care and, if so, the length of the home care
- Low, medium, high home care: uncompleted length of stay in home care

B67. We randomly select a care pathway from the constructed distribution for each individual.

[63] PSSRU DP 2265/3 – July 2006

Projections of Care Pathways

B68. As in the OBR's projections (see published Annex in FSR 2013), our central assumption is that the lengths of stay does not change in the future.

Sensitivity Analysis

B69. We continue the discussion on sensitivity started in the main document around the potential uncertainty in costs due to variation in the underlying assumptions of the DH funding model.

B70. In the DH funding model there are further key assumptions which drive the cost of a capped cost model. These are the

- Proportion of self-funders who would meet the LA eligibility criteria.
- Future trends in the numbers of older people, unit costs of care and prevalence of disability

B71. We perform sensitivity analysis around these three assumptions, as well as providing discussion relating to further variation in the input assumptions.

Proportion of self-funders who would meet the LA eligibility criteria

B72. An input to the DH social care funding model is the projected number of self-funders under the current system from the PSSRU aggregate model. This projection is the total number of self-funders in residential care and is likely to include people who would meet their Local Authority's eligibility criteria. As our central assumption, we assume that 10% of the projected number of self-funders would be ineligible for state supported residential care on their assessed needs.

B73. Under the assumption that the features of self-funders, such as wealth or care journey, are unrelated to the level of their needs and, therefore, their eligibility, costs of the reformed system are directly proportional and scale as a one-to-one ratio with the number of self-funders.

B74. This means that if there were 10% more eligible self-funders than expected, the costs from the reforms would be 10% larger, with the opposite case also being true.

Unit costs of care

B75. The central assumption for care cost inflation is that, following 2015/16, it increases in line with the December 2014 OBR projections for changes in average earnings. This assumption applies to all components of care including residential, domiciliary, assessment, case management and review costs.

B76. This assumption feeds through from the PSSRU modelling of projecting the costs of the current system.

B77. Variation from this central assumption changes the cost of Option 1 by the same fraction as the current system. Below is a table showing the change in costs for high and low scenarios around average earnings.

Figure B22: Sensitivity analysis on long run projection of care costs

Scenario	*Impact of costs of reforms for older adults care in 25/26 (£billions and % change)*	
Care cost inflation: Central assumption Average earnings	-	-
High Scenario grow 1% more each year than central assumption	+0.18	+10%
Low Scenario grow 1% less each year than central assumption	-0.17	-9%

B78. It should be noted that this scenario may be misleading on the affordability of the reforms. Growth in average earnings is typically linked to growth in GDP and therefore in these scenarios the additional spend as a % of GDP would be unchanged.

Population projections

B79. The central assumption PSSRU modelling of the current system uses the ONS population projections from 2012. The central assumption assumes the low migration variant of the projections, in line with the projections produced by the OBR. Below we also show the impact on costs of the principal projection and the old age population structure variant.

Figure B23: Sensitivity analysis on population projections

Scenario	*Impact of costs of reforms for older adults care in 25/26 (£billions and % change)*	
Population projection: Central assumption ONS 2012: Low migration	-	-
High Scenario ONS 2012: Principal Projection	+0.00	0.2%
Higher Scenario ONS 2012: Low fertility, high life expectancy, low migration	+0.02	1.2%

Other assumptions and future trends

Prevalence of disability

B80. The central assumption in the PSSRU modelling of the current system is that age-gender prevalence remains constant. Variation around the central assumption may change either the number of older disabled people, the length of time they are disabled or both.

B81. Therefore, as an example, with increased prevalence of 10%, the smallest change to the reformed system, if it was purely numbers with a disability rather than length of time with a disability, would be a corresponding 10% increase in state costs.

B82. Increased prevalence could increase the lengths of time with a disability (of those who develop a disability), this would increase the costs by a different factor than 10%.

Trends in informal care

B83. The central assumption is that the proportions of older people receiving informal care remain constant for each sub-group by age, disability and other needs-related characteristics. Variation away from this central assumption will impact on the projected costs of the current system and

Option 1 through more or less older people receiving formal services and therefore starting their progression towards the cap.

Patterns of care

B84. The central assumption is that the proportions of older people receiving community care services and residential care services remain constant for each sub-group by age, disability and other needs-related characteristics. Variation away from this central assumption will impact on the projected costs of the current system and Option 1 through a change in the average unit of care and changes to the individual's lifetime costs of care.

Eligibility for state support

B85. The modelling assumes that local authority the proportion of self-funders with eligible care needs remains unchanged. If there is any extension or tightening of eligibility thresholds potentially as a result of the setting of a national minimum eligibility threshold then this could have consequential cost implications.

Up-rating of cap over time

B86. The modelling assumes that the cap is uprated in line with the assumption for care costs.

ANNEX C – Challenge raised in the consultation

C1. The consultation document seeks views on areas where challenges have been levelled at the cap that we wish to explore further.

C2. During the consultation that took place over summer 2013 and through subsequent engagement, several challenges to the detail of the approach were identified. In particular the challenges focused upon situations where people may not be fully protected by the cap on care costs.

- People who cannot afford daily living costs from their income;
- People in domiciliary care who might not be protected by the cap;

C3. The benefits of an insurance product depend not only on the amount of money it provides to people in the worst case but the extent to which it offers more or less complete protection. We therefore consider that gaps in the protection provided by the cap, which have a larger impact on the benefits provided than would be expected if simply considering the value of the insurance provided.

C4. For the peace of mind benefits provided by the cap to be effective, it is important that there are as few exceptions from the protection as possible. Large and recurring exceptions are likely to significantly undermine the confidence of people in the system. Therefore it is of importance that the cap is as comprehensive as possible.

C5. However any further changes would increase the costs of the policy. Any changes would need to be made at a Spending Review when the costs and benefits of different policies can be judged.

Level of daily living costs and financial support available

C6. The level of daily living costs for people in a care home is to be around £12,000 per year (£230 per week) in 2016/17, in line with the proposals of the Dilnot Commission. There was broad stakeholder support for the principle that a person should remain responsible for their daily living costs throughout their care journey, but it was felt that the notional figure proposed is higher than the actual daily living costs faced by many people who receive care in their own home.

C7. Stakeholders noted the impact of setting daily living costs at that level, including that people on low incomes would be required to make up the difference from their assets, even after they reached the cap.

C8. The consultation document asks questions around the level of daily living costs and the financial support available to those who cannot afford to pay the full amount of daily living costs. In particular:

- Set the level of daily living costs to reflect the minimum amount available under the new State Pension that will be introduced in 2016 and any relevant benefits.
- Disregarding any remaining capital from the financial assessment for people who have reached the cap and only consider their income in determining how much they can afford to pay towards their daily living costs. With the option of focusing the support on people whose assets are below the relevant upper capital limit, ensuring support is targeted as those with the least.

Rationale

C9. The consequences of this for those with low incomes are:

- They pay more from their assets before reaching the cap
- They continue paying from their assets after they reach the cap to cover the daily living cost amount.

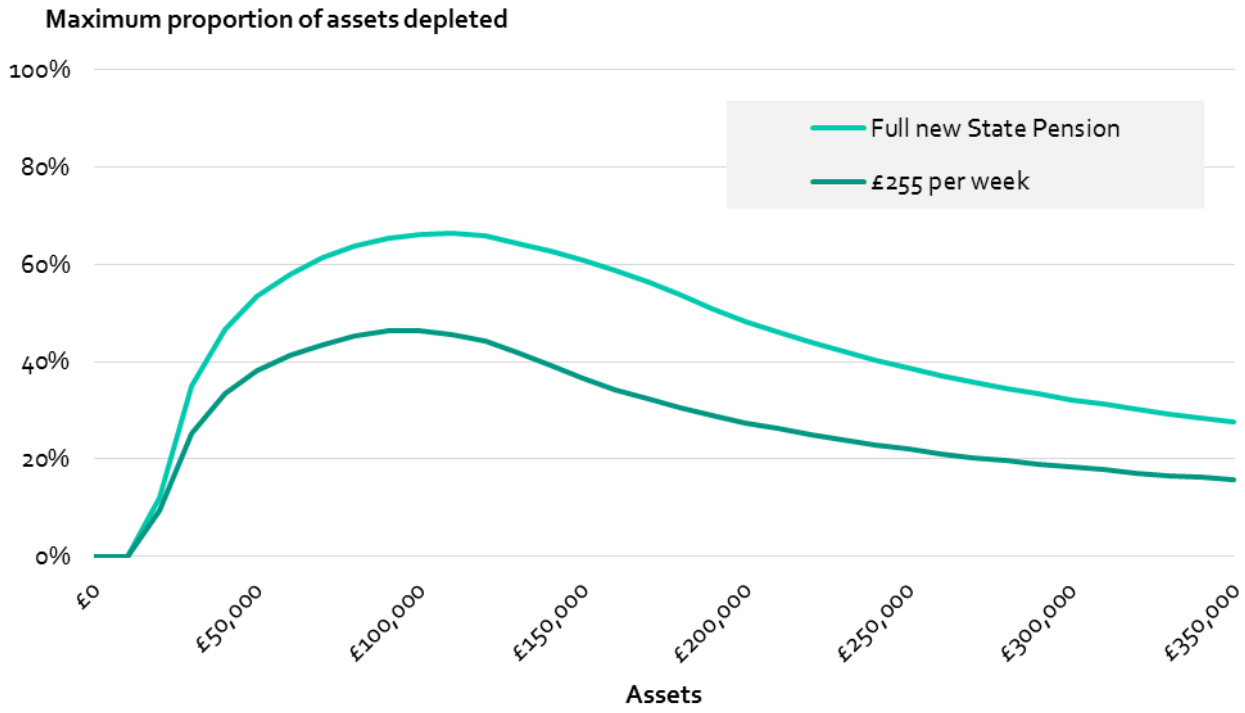
C10. Although local authority financial support would be available on the same basis as for care costs in these circumstances (i.e. means tested using the usual parameters), there was concern about how this fitted with the overall aims of the reforms.

C11. Additionally, for self-funders with low to modest incomes, following the receipt of state support after reaching the cap they lose their Attendance Allowance benefit leaving a further gap between the support received and the level of income they have. For example, a person with a full new State Pension will have a gap of around £70 per week between their income and the level of daily living costs which they would be required to cover from their assets despite having reached the cap.

C12. The reforms are designed to protect people from unlimited care costs and define a new partnership between them and the state. People will no longer face the risk of losing the majority of their assets to pay for care.

C13. The graph below illustrates that this aim is not achieved for those on modest income, for example on the full new State Pension people can potentially facing asset depletion in excess of 50%.

Figure C1: The maximum asset depletion for those on the new State Pension (around £160 per week) risks relative to those with an income £255 per week



Benefits

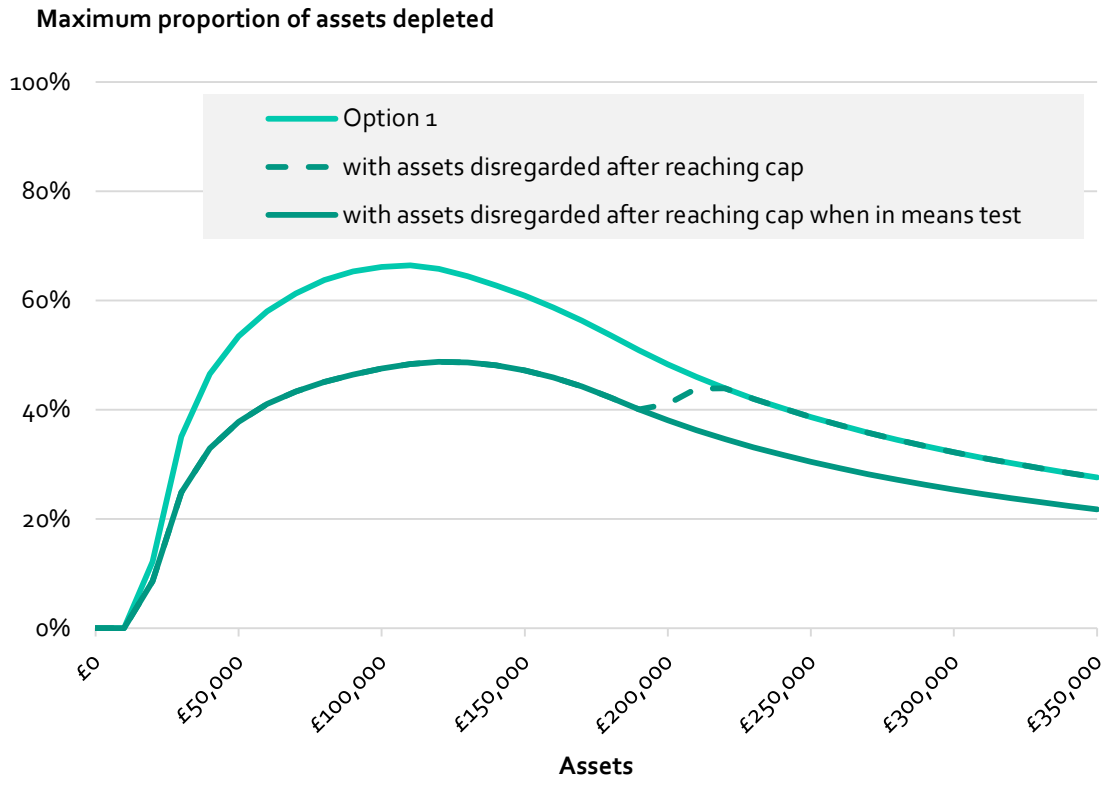
C14. The changes asked about in the consultation document addresses these issues. Reducing the level of daily living costs means that people with the full new State Pension would only spend £72,000 from their assets before reaching the cap. It also reduces the time it would take for people to reach the cap. For illustrative purposes, this analysis we use daily living costs of £213 per week.

Figure C2: Time to reach the cap under option 1 and with reduced daily living costs

Care home fee	Option 1 Time in care home to reach the cap	Reduced daily living costs Time in care home to reach the cap
£450	6 years, 4 months	5 years, 10 months
£500	5 years , 2 months	4 years, 10 months
£550	4 years , 4 months	4 years, 1 months
£600	3 years , 9 months	3 years, 7 months
£650	3 years , 4 months	3 years, 2 months
£700	2 years , 11 months	2 years, 10 months
£750	2 years , 8 months	2 years, 7 months

C15. Disregarding a person's wealth after the cap from their financial assessment means that they do not continue to deplete assets, and limits their asset depletion in the worst case scenario.

Figure C3: The maximum asset depletion for those on the new State Pension (around £160 per week) risks under option 1 and when capital is disregarded after reaching the cap



Below we include two tables showing the number of people who will receive a greater amount of state support in 25/26 as well as the additional numbers receiving state support in each year. With lower living costs, those who have reached the cap receive additional state support, while also

increasing the number of people who actually have reached the cap. Asset protection after the cap increases the amount of support low income individuals receive so that their assets are no longer depleted.

Figure C4: Additional people receiving a greater amount of state support by 25/26 relative to the £72k cap.

Policy change	Additional people
Daily living costs of £213	68,000
Wealth disregard after the cap	45,000
Wealth disregard after the cap for those in the means test	11,000

C16. The wealth disregard after the cap does not result in anyone receiving state support that would not otherwise. However, as illustrated by the table above, the amount some people receive is increased.

Figure C5: Additional people supported relative to £72k cap.

Policy change	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Reduced Daily living costs	0	0	200	1,900	3,400	3,600	3,000	2,500	2,500	2,600
Wealth disregard after the cap	0	0	0	0	0	0	0	0	0	0
Wealth disregard after the cap for those in the means test	0	0	0	0	0	0	0	0	0	0

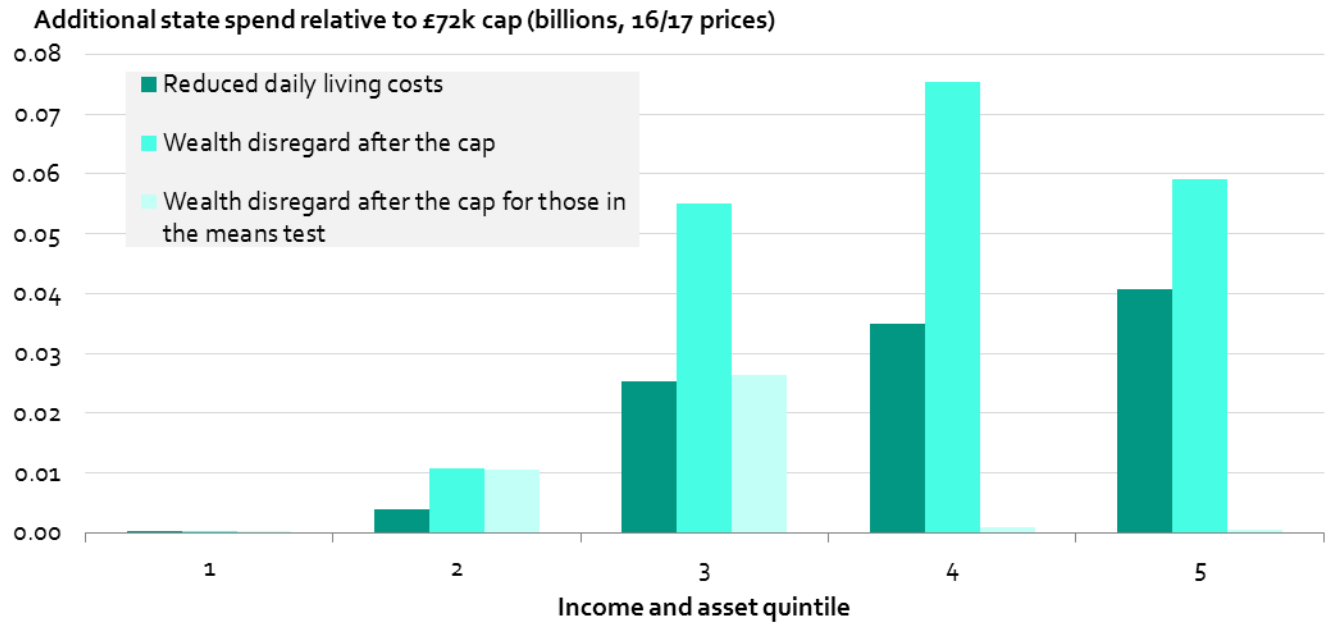
Costs

C17. The change in daily living costs would cost around £130 million by 2025/26, while disregarding wealth after the cap would cost around £250 million in 2025/26, or around £50 million in 2025/26 if restricted to those in the means test. The costs from the changes only occur once people start reaching the cap

Figure C6: Additional state spend relative to £72k cap (billions, 16/17 prices)

Policy change	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Reduced Daily living costs	0.00	0.00	0.01	0.06	0.11	0.12	0.12	0.12	0.12	0.13
Wealth disregard after the cap	0.00	0.00	0.02	0.06	0.13	0.17	0.20	0.22	0.23	0.25
Wealth disregard after the cap for those in the means test	0.00	0.00	0.00	0.01	0.02	0.03	0.04	0.04	0.04	0.05

Figure C7: Additional amount of state spend on each of the policy fixes by income and asset quintile relative to the £72k cap.



Wider Impact

C18. Disregarding assets for the financial assessment to daily living costs after the cap and only requiring income to be taken into account does create an asymmetry between how income and assets are treated, and hence creates an incentive to hold wealth in income products rather than in assets. We note that the social care charging system broadly treats assets and income equally but there are differences between primary housing and other assets.

C19. However, we believe the incentives are small due to the time between someone making a decision on how they want to save their wealth and when they may reach the cap, and the likelihood of people reaching the cap.

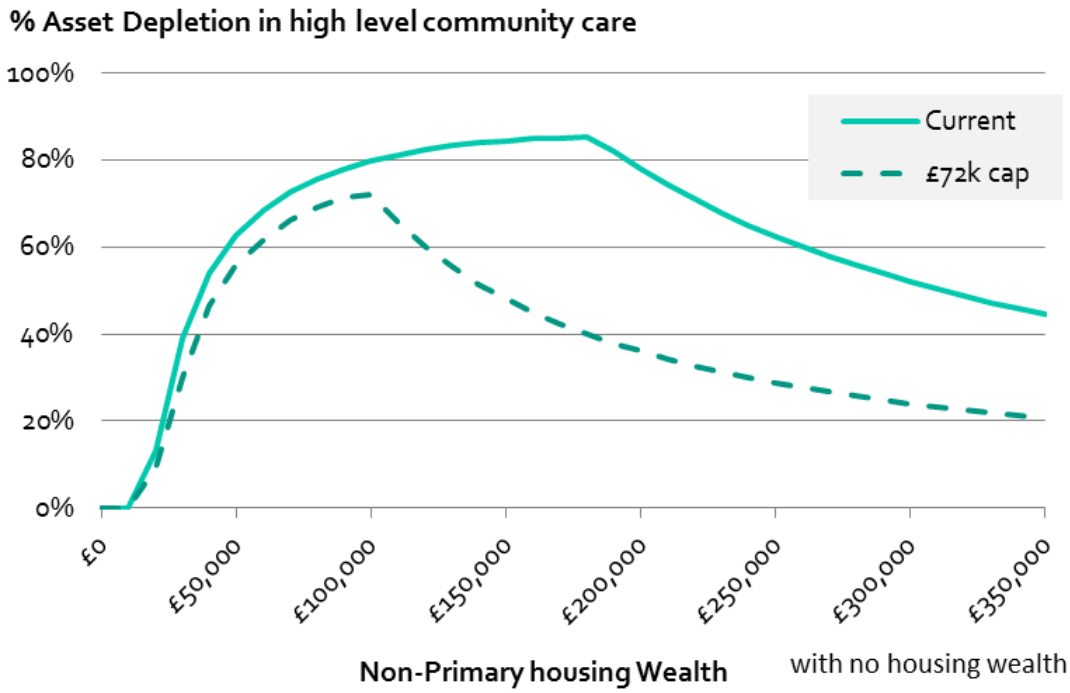
C20. Restricting the disregard to the means test means the additional support is not provided to those with low incomes and high assets, for whom it may not be deemed unfair for them to continue using their assets after reaching the cap.

Extended means test and minimum level of state support

Rationale

C21. A further criticism levelled from the previous consultation is with respect to those who benefit from the housing wealth disregard in domiciliary care, versus those with non-housing wealth who do not. This means that people in this situation can still face high levels of asset depletion.

Figure C8: Potential asset depletion in high level community care



C22. A policy change that would address the asymmetry in wealth treatment may be attained by extending the means test to £118,000 for those in domiciliary care who are not benefitting from a housing disregard.

C23. Another suggestion is that we could seek to go further and ensure people are better off under the means test threshold. In such a scenario, a minimum level of support could be provided, for illustrative purposes we analyse a minimum of £100 per week.

Benefits

C24. Around 8,000 people would benefit from the minimum support in the means test, while 5,000 – 6,000 people will benefit from the change to the domiciliary care means test.

Figure C9: Additional people receiving a greater amount of state support by 25/26 relative to the £72k cap.

Policy change	Total number receiving a greater amount of state support
Higher minimum level of state support	8,000
Extended means test for domiciliary care	6,000

Figure C10: Additional people supported relative to £72k cap

Policy change	*16/17*	*17/18*	*18/19*	*19/20*	*20/21*	*21/22*	*22/23*	*23/24*	*24/25*	*25/26*
Higher minimum level of state support	6,000	7,000	7,000	7,000	6,000	6,000	6,000	6,000	6,000	6,000
Extended means test for domiciliary care	5,000	5,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000

Costs

C25. We project the costs of these to changes to be around £40 - £50 million by 2025/26.

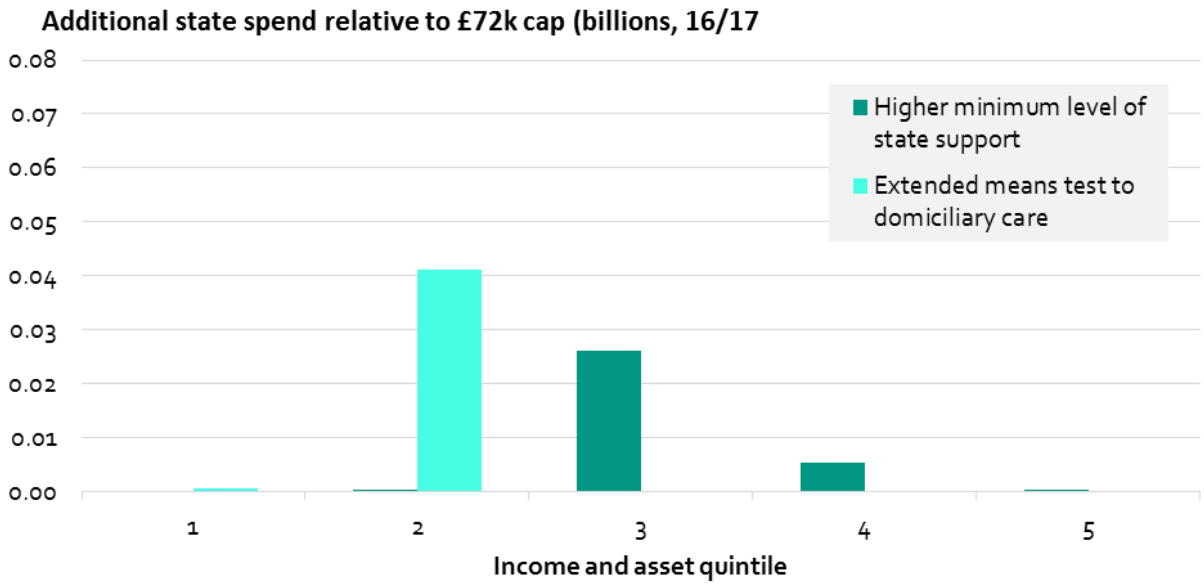
Figure C11: Additional amount of state spend on each policy fix relative to the £72k cap (£billions, 16/17 prices)

Policy change	*16/17*	*17/18*	*18/19*	*19/20*	*20/21*	*21/22*	*22/23*	*23/24*	*24/25*	*25/26*
Greater minimum level of state support	0.03	0.04	0.04	0.04	0.04	0.03	0.03	0.03	0.04	0.04
Extended means test to domiciliary care	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.05	0.05	0.05

Wider impact

C26. The extended means test to those in domiciliary care is entirely of benefit to those in the second quintile as everyone in this band has assets of less than £70,000. The greater minimum level of state support is predominantly spent on the middle quintile.

Figure C12: Additional spend on each asset and income quintile in 25/26 (billions, 16/17prices)



ANNEX D – LA care fees

D1. Below we reproduce a table of unit costs for older people in nursing and residential care, by local authority, that were used to derive care cost assumptions for the results presented in this Impact Assessment.

Figure D1: Table of care fees derived from PSS-EX1 return for 2013/14. Units are £ per week.

	Nursing	Residential
Barking & Dagenham	480	538
Barnet	537	601
Barnsley	399	399
Bath & N E Somerset	544	752
Bedford	545	545
Bedfordshire	No data	No data
Bexley	572	604
Birmingham	557	572
Blackburn	270	411
Blackpool	432	435
Bolton	537	496
Bournemouth	539	495
Bracknell Forest	616	590
Bradford	429	552
Brent	479	581
Brighton & Hove	558	629
Bristol	569	764
Bromley	646	607
Buckinghamshire	545	617
Bury	444	492
Calderdale	478	454
Cambridgeshire	556	447
Camden	493	714
Central Bedfordshire	516	537
Cheshire	No data	No data
Cheshire East	478	502
Cheshire West And Chester	450	464
City of London	542	530
Cornwall	498	439
Coventry	744	537
Croydon	510	888
Cumbria	520	558
Darlington	471	448
Derby	436	509
Derbyshire	452	546
Devon	537	654
Doncaster	455	515
Dorset	570	696
Dudley	482	573
Durham	501	531

	Nursing	Residential
Ealing	698	659
East Riding	572	453
East Sussex	557	703
Enfield	635	659
Essex	566	534
Gateshead	460	573
Gloucestershire	572	583
Greenwich	570	695
Hackney	623	658
Halton	490	461
Hammersmith & Fulham	701	585
Hampshire	683	617
Haringey	758	660
Harrow	556	612
Hartlepool	454	465
Havering	545	559
Herefordshire	631	588
Hertfordshire	509	562
Hillingdon	589	622
Hounslow	609	672
Isle of Wight	559	496
Isles of Scilly	No data	955
Islington	591	623
Kensington & Chelsea	651	1069
Kent	525	524
Kingston-upon-Hull	145	471
Kingston-upon-Thames	476	906
Kirklees	438	575
Knowsley	538	475
Lambeth	669	428
Lancashire	474	446
Leeds	485	611
Leicester	492	552
Leicestershire	519	494
Lewisham	698	606
Lincolnshire	442	436
Liverpool	535	448
Luton	615	468
Manchester	468	437
Medway Towns	442	556

	Nursing	Residential
Merton	663	529
Middlesbrough	435	482
Milton Keynes	771	487
N E Lincolnshire	383	438
N Lincolnshire	417	447
Newcastle upon Tyne	613	605
Newham	523	543
Norfolk	536	523
North Somerset	548	465
North Tyneside	489	484
North Yorkshire	510	609
Northamptonshire	567	489
Northumberland	447	497
Nottingham	500	510
Nottinghamshire	566	505
Oldham	494	434
Oxfordshire	699	621
Peterborough	521	449
Plymouth	693	766
Poole	644	632
Portsmouth	532	632
Reading	726	784
Redbridge	551	643
Redcar & Cleveland	415	388
Richmond upon Thames	636	860
Rochdale	406	431
Rotherham	478	553
Rutland	468	486
Salford	449	442
Sandwell	420	474
Sefton	496	459
Sheffield	550	355
Shropshire	521	452
Slough	697	618
Solihull	543	480
Somerset	509	496
South Gloucestershire	511	805
South Tyneside	568	487
Southampton	511	579
Southend	584	545
Southwark	518	545
St Helens	417	513
Staffordshire	420	487
Stockport	499	444
Stockton-on-Tees	471	494
Stoke-on-Trent	594	506
Suffolk	523	690
Sunderland	485	551
Surrey	521	687
Sutton	514	554
Swindon	502	562
Tameside	759	501
Telford and Wrekin	511	488
Thurrock	741	444
Torbay	458	423
Tower Hamlets	559	488
Trafford	493	576
Wakefield	418	462
Walsall	501	506
Waltham Forest	601	821
Wandsworth	714	648
Warrington	623	485
Warwickshire	468	551
West Berkshire	650	685
West Sussex	538	538
Westminster	607	872
Wigan	467	452
Wiltshire	541	587
Windsor & Maidenhead	572	525
Wirral	433	432
Wokingham	772	702
Wolverhampton	484	585
Worcestershire	478	489
York	488	537