Title: Care and Support Legal Reform (Part 1 of the Care Bill) **IA No:** 6107 *This replaces previous IA number 6107, published on 12/04/2013.* **Lead department or agency:** Department of Health **Other departments or agencies:**	Impact Assessment (IA) **Date:** 09/10/2013 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Primary legislation

Summary: Intervention and Options

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, One-Out?**	**Measure qualifies as**
£10,897m	£0	£0	No	N/A

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

The legislative framework for adult care and support in England is outdated and in need of reform. It perpetuates a focus on crisis intervention and the provision of services, and does neither reflect the modern priorities of care, nor support efforts to build the system around the needs and outcomes of people and carers.

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

What are the policy objectives and the intended effects?

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

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

Two options have been considered:

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

Will the policy be reviewed? Yes

Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**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 (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: Norman Lamb Date: 28 December 2013

Summary: Analysis & Evidence

Policy Option 1

Description: MODERNISE CARE AND SUPPORT LEGISLATION

Price Base Year 2010	**PV Base Year** 2014	**Time Period Years** 10	**Net Benefit (Present Value (PV)) (£m)**					
			Low:	**9,879**	**High:**	**11,773**	**Best Estimate:**	10,897

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low	Optional		-224.3	-1,758
High	Optional		+10.3	+136
Best Estimate	-45.7		-114.7	-882

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

The main costs relate to improved legal rights for carers (rising to £175m pa). Additional costs relate to legal reforms providing for: access to independent advocacy in specific circumstances, new safeguarding arrangements, continuity of care when people move between local authority areas, and other transitional costs, including implementation of the national minimum threshold for eligibility. Cost savings are also identified in relation to public expenditure savings of improved support for carers. These cost savings outweigh other new costs overall. All the costs detailed fall on the Government and will be fully funded.

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

Direct costs where identified have been monetised. There may be additional costs where local authorities for example have increased demand for services due to improved information. These improvements should also allow for more effective and efficient service planning, but might identify additional need. These costs are discussed in more detail in the sections below.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low				
High				
Best Estimate	0		1,099	**10,015**

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

The monetised benefits relate to quality of life gains for carers from improved legal rights and improved access to support. There are also likely to be benefits to local authorities through better coordination, more proactive, preventative measures and planning of care and support functions, for example preventing crisis and escalation of need, including via improving information, personalisation, and assessment of carer need. Monetisable benefits are set out in more detail below.

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

People with care and support needs will benefit from improved wellbeing, better prevention of care and support need, greater clarity, consistency and equality of access to care and support and reduction of unmet need. Improved information, advice and cooperation between organisations will help people to navigate the system more easily and with greater freedom, flexibility and choice. This will improve the outcomes and experiences of people who use care and support services, carers and their families.

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

The Care Bill reforms and modernises the legal framework, including powers to make regulations and statutory guidance. Many impacts on local authorities cannot be considered until regulations have been made and hence further impact assessments will be required. Proposals assume commencement of legislation from April 2015, but are subject to Parliamentary approval.
(*Benefits discounted at 1.5%)

BUSINESS ASSESSMENT (Option 1)

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

Evidence Base (for summary sheets)

Introduction

This impact assessment provides analysis of the costs and benefits of the Government's intention to reform the existing law relating to care and support in Part 1 of the Care Bill. It should be read in conjunction with the parallel impact assessments which cover new legal provisions related to funding reform, deferred payment agreements, and oversight of the care and support provider market.

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

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

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

1. Consolidation and modernisation of the legal framework

This section of the impact assessment considers areas which are included in Part 1 of the Care Bill and which are the result of:

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

In this section, all proposals noted do not represent a change in policy or create substantial new costs on local authorities (with the exception of potential minor transitional costs). This section considers proposals related to clauses 1-8, 14, 17-19, 21-27, 30-33, 39-41, 59-67 and 70-71, 73-74 and 76-79.

2. Substantial policy reforms

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

2A. Assessment, eligibility and continuity of care (clauses 9, 11-13 and 37-38)
2B. Assessment and provision of support for carers (clauses 10 and 20)
2C. Access to independent advocacy (clauses 68-69)
2D. Care and support for people in prison and approved premises (clause 75)
2E. Safeguarding adults from abuse and neglect (clauses 42-47)
2F. Implementation of legal reform

This impact assessment does not consider the following areas and relevant clauses, which are the subject of four separate assessments:

i. Provisions to reform the funding system for care and support (clauses 15-16, 28-29 and 72);
ii. Provisions relating to deferred payment agreements (clauses 34-36);
iii. Provisions relating to oversight of the care and support provider market and responsibilities for continuity of care in the case of provider failure (clauses 49-58); and,
iv. Provisions to apply the Human Rights Act 1998 to "care and support services" (clause 48).

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[1] http://lawcommission.justice.gov.uk/docs/lc326_adult_social_care.pdf
[2] http://lawcommission.justice.gov.uk/docs/lc326_adult_social_care_impact_assessment.pdf

Overview of costs and savings

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

Table 1: Summary of costs and savings (£m, central estimates, including indicative costs)

Proposal	*Year1 2015/ 16*	*Year2 2016/ 17*	*Year3 2017/ 18*	*Year4 2018/ 19*	*Year5 2019/ 20*	*Year6 2020/ 21*	*Year7 2021/ 22*	*Year8 2022/ 23*	*Year9 2023/ 24*	*Year10 2024/ 25*	*Total*
Continuity of care											
Total recurring costs	4.0	9.0	12.2	12.2	12.2	12.2	12.2	12.2	12.2	12.2	110
Support for carers - assessments											
Total recurring costs	15.0	20.0	25.0	25.0	25.0	25.0	25.0	25.0	25.0	25.0	235
Support for carers - services											
Total recurring costs	30.0	60.0	90.0	120.0	150.0	150.0	150.0	150.0	150.0	150.0	1,200
Recurring savings	100.0	178.0	256.0	323.0	390.0	390.0	390.0	390.0	390.0	390.0	3,197
Access to advocacy											
Total recurring costs	13.0	31.0	45.0	61.0	61.0	61.0	61.0	61.0	61.0	61.0	516
Care and support in prisons											
Total recurring costs	6.0	7.0	8.0	8.6	8.6	8.6	8.6	8.6	8.6	8.6	81
Safeguarding - Boards											
Total recurring costs	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	60
Implementation of legal reform											
Transition cost total	31.0	14.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	46
Recurring savings	12.4	15.6	15.6	15.6	15.6	15.6	15.6	15.6	15.6	15.6	153
Total transition costs	31.0	14.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	45.7
Total recurring costs	74.0	133.0	186.2	232.8	262.8	262.8	262.8	262.8	262.8	262.8	2,203
Total costs	105.0	147.7	186.2	232.8	262.8	262.8	262.8	262.8	262.8	262.8	2,249
Total costs (discounted)	101.4	137.9	167.9	202.9	221.3	213.8	206.6	199.6	192.8	186.3	1,830
Total recurring savings	112.4	193.6	271.6	338.6	405.6	405.6	405.6	405.6	405.6	405.6	3,350
Total savings (discounted)	108.6	180.7	245.0	295.1	341.5	330.0	318.8	308.0	297.6	287.5	2,713
Net value (NPV)	-7.1	-42.8	-77.0	-92.2	-120.2	-116.2	-112.2	-108.4	-104.8	-101.2	-882.3

Table 2: Summary of monetised benefits (£m)

Proposal	*Year1 2015/ 16*	*Year2 2016/ 17*	*Year3 2017/ 18*	*Year4 2018/ 19*	*Year5 2019/ 20*	*Year6 2020/ 21*	*Year7 2021/ 22*	*Year8 2022/ 23*	*Year9 2023/ 24*	*Year10 2024/ 25*	*Total*
Carers – benefits of legal reform											
Recurring benefits	344.6	612.6	880.6	1,103.3	1,340.0	1,340.0	1,340.0	1,340.0	1,340.0	1,340.0	10,988
Total benefits (discounted)	339.5	594.6	842.1	1,046.1	1,243.9	1,225.5	1,207.4	1,189.5	1,172.0	1,154.6	10,015

1. CONSOLIDATION AND MODERNISATION OF LEGISLATION

Background – case for change

1.1 How adult care and support is defined and delivered is determined by the law which underpins it. The key elements, including the responsibilities of those who commission and provide care and support, the range of support available and the rights of people who use care and support, are established in statute. Well-crafted legislation makes a fundamental difference to the ease of implementation on the ground and the clarity provided for professionals and the public.

1.2 Unfortunately, the current legal framework is anything but well-crafted and has been roundly criticised as opaque, complex and anachronistic. Over 60 years, a patchwork of legislation has grown and evolved. There are well over a dozen existing Acts of Parliament and there is much overlap and duplication between the various statutes. In addition to the primary legislation, there is a vast array of regulations, directions, circulars and guidance. The net result is complexity and confusion for those who have to navigate through the law – including social workers, care users and carers.

1.3 The Law Commission acknowledged this problem and conducted a three-year review into social care legislation. In May 2011, it published its report with 76 recommendations for reform to Government.

1.4 The law provides the underpinning framework for care and support and is critical to the way care is delivered on a day-to-day basis to people who need it. It therefore needs to align with and support the Government's policy objectives for adult care and support. The law has failed to keep pace with the shared ambitions of Government, the care sector and people who use care and support. Moreover, ONS population projections suggest that the number of people aged 85 and over will rise from 1.3m in 2008 to 3.3m in 2033, suggesting that a failure to act now will only exacerbate the problems already encountered.

1.5 As a result of its piecemeal development, the current legislation also has significant gaps and fails to reflect existing care and support priorities and established practice. Such gaps include:

- the absence of clear underlying principles to reflect the modern focus of care and support upon the promotion of individual well-being and prevention of need;
- a lack of focus on or support for local authority relationships with other organisations and the need to join up services;
- outdated and limited provisions which restrict access to universal information and advice on care and support;
- failure to reflect local authority responsibilities to promote diversity and quality in the care and support provider market;
- the legislative framework does not support the cultural and systemic change needed for personalisation and self-directed support; and,
- a lack of provisions to support transition into adult care and support for children.

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

1.6 As set out in the Government's *A Vision for Adult Social Care,* a considerable proportion of care needs could be avoided, reduced or delayed as a result of earlier intervention.[3] The *Vision* stated that prevention is best achieved through community action working alongside statutory services, and described local government's role as being a catalyst for social action. The *Vision* described carers as the first line of prevention and articulated the need to properly identify them and offer personalised support.[4]

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[3] Department of Health, *A Vision for Adult Social Care: Capable Communities and Active Citizens*, 2010.

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

1.7 During the *Caring for our future* engagement, we heard that the current system is geared too much towards intervention at the point of crisis rather than helping individuals to postpone or prevent the onset of illness or loss of independence. Assessment and eligibility systems focus on whether people are 'needy' enough to be in the system. A recent DH survey suggested that around 80% of local authorities currently set their eligibility criteria threshold at substantial or critical levels of need, meaning that they do not make support available to people who are assessed as having moderate or low needs. Only 2% provide funding at "low" levels, indicating that investment is not focused on avoiding people's needs from getting worse. Support for people to be proactive in early planning of their care needs helping them navigate the system that can be confusing. However, many local authorities do invest and there are good practice examples of local authorities investing in prevention and early intervention measures.

1.8 A health and social care system that intervenes at crisis points rather than in a preventative manner is likely to deliver poorer outcomes. For example, too many older people are admitted to hospital as emergencies that could be avoided if the right community services were in place.[5] It should be noted that there is a scarcity of evidence on the cost-effectiveness of prevention.

1.9 Current barriers to an improved focus on prevention include:

- Risk aversion - local authorities see it as risky to spend on lower need rather than higher need;
- Pressure on resources - immediate needs are prioritised over longer term prevention;
- Barriers in shifting expenditure upstream, and concerns that prevention requires new investment leading to double running rather than divestment to a strategic prevention shift;
- Difficulties in identifying and targeting who can best benefit from prevention; and,
- Difficulties in measuring success.

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

1.10 Government intervention is required to remove organisational barriers to greater integration. This should facilitate increased joint commissioning across health, social care and public health and allow for the implementation of services that use the "whole person" approach. Incentives for individuals to take preventative steps should also be improved – for example by linking duties to integrate explicitly to a focus on preventing or reducing needs.

1.11 It is likely to be more efficient for Government to disseminate best practice on integration and prevention than for local areas to work alone to identify which models of integration work better. However, we recognise that local authorities are best placed to determine what approach works best for their population and they will continue to have flexibility to adapt and adopt approaches to integration to suit local circumstances.

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

1.12 The availability of information and its quality is a critical enabler for both consumers and commissioners to make choices and drive up quality. Better access to information can play an important role in enabling greater collaboration at local level. Together, increased access to quality information and joined up working across local public services can support better planning and prevention and enable more personalised approaches to care.

1.13 However, rather than being shaped around the needs of individuals, services have tended to develop based on systems, structures and funding flows. There are still significant barriers preventing people from having choice and control over how they are supported to achieve their desired outcomes. This has affected the extent to which care and support is personalised and

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

integrated with other public services, with consequential implications for quality of outcomes, user experience and efficient use of public resource.

1.14 Government needs to provide coordination and direction to ensure more consistent, comprehensive and joined-up access to information at the local and national levels to help inform people about the benefits of support and advice, and reduce the costs of searching for information, which is often required at short notice.

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

1.15 The *Caring for our Future* White Paper set out the government's intention to promote a diverse market of high quality care and support services, to improve service quality through individual choice and control.

1.16 A well-functioning market should match services to the needs and demands of users, efficiently and effectively. Where there is demand backed by willingness to pay, quality should increase. This is the same for care and support as in other markets. The effectiveness of the care market has significant implications for individuals, families, providers and local authorities.

1.17 In particular:

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

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

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

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

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[6] Evidence given to the Dilnot Commission by charities representing carers.

[7] Further proposals to improve support for carers are discussed in the corresponding Impact Assessment "Assessment, eligibility and portability for care users and carers".

[8] Laing & Buisson, Care of Elderly People Market Survey, 2012/13.

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

Although there can be reasonable variability between local authorities, the extent of the variation implies inconsistency in the effectiveness of commissioning strategies. In some areas at least, providers are not sufficiently incentivised to improve service quality. As well as reducing variation between areas, our proposals should shift the mean and improve the absolute levels of quality.

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

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

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

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

1.20 There are a number of cultural and organisational barriers to progress in local authorities making a universal offer of self-directed support to people using care and support. Reasons might include: perceived higher costs; low priority given to this principle by councils; inertia; vested interest; or the perception by individuals that a higher workload is required by a more responsive and flexible service.[10]

1.21 The current legal framework does not require councils to provide personal budgets. As the law stands, local authorities have had a power to offer direct payments since 1997, but individuals with eligible needs can only request, not demand them. If a local authority does not want to offer a direct payment, an individual can be refused. Personal budgets do not currently exist in law and the term currently only describes where a notional sum for care is allocated to an individual.

1.22 Individuals may therefore lack the knowledge, power or influence to encourage councils to change. Individuals may be put off by the perceived potential complexities of decision-making in relation to personal budgets and personalised support planning.

1.23 The absence of a clear statutory framework makes it difficult to set a consistent expectation of local authorities that all services should be personalised. Some are already making great strides in this area but legislation is required to make personalised care common practice.

1.24 Not all groups of users are able to access personal budgets and direct payments. Current regulations do not allow those in long-term residential care to access direct payments. This disparity in access to personalised support was highlighted during the *Caring for our future* engagement and chimes with the Law Commission’s view that choice and control should not be limited only to people in community settings. Some local authorities have begun to introduce

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[9] Care Quality Commission, “Our statement on the quality of adult social care”, December 2009.

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

Individual Service Funds (ISFs) as a personal budget option for people in residential settings (mainly adults of working age with complex packages) who have some (limited) control over the delivery of their care and support, but progress has been slow.

1.25 Access to quality information and advice is crucial to support people to make informed choices both before and once they need care and support (this is explored in more detail below). This applies to both those receiving care and support from their local council and those funding their own care. However, evidence suggests that there is inadequate provision of information to both state-funded care users and in particular to people funding their own care.[11] Many self-funders do not access local authority information or take up assessments as they receive no support due to their financial position.

1.26 Evidence from the *Caring for our future* engagement, supported by research from the Personal Outcomes Evaluation Tool, showed that people were much more likely to take control of their care and support funding through a direct payment if they had received support with making choices about the care they wanted, and with articulating how that care should help them achieve their goals.[12] Such help might take the form of 'brokerage' or representation. However, the coverage of this type of support is variable across the country – and very often people who are funding their own care and support will not have access to it.

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

1.27 There are well-documented[13] issues associated with the transition between children's services and adult services. One such issue is a gap in provision often described as the 'cliff edge'[14]. An independent report commissioned by the Department of Health referred to the "considerable evidence from research that for most young people with disabilities the process of transition from child to adult services is problematic"[15]. Policy documents and guidance also refer to the issue[16] and individual stories, including those gathered by the Preparing for Adulthood programme,[17] provide an illustration of the importance of the transition process for young people and the benefits of planning and preparation.

Policy objective

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

- *Modernise* the legal basis to reflect the Government's ambitions for personalised adult care and support:
    - o Refocus the law around the person, not the service, by enshrining new statutory principles that place the wellbeing of the individual at the heart of individual decisions about care.

- *Simplify* the law into one single statute for adult social care, supported by clear regulations and a reformed bank of statutory guidance in one place:

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

[12] In Control, *Personal Outcomes Evaluation Tool*, 2011.

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

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

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

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

[17] See: http://www.preparingforadulthood.org.uk/resources/stories

    - Develop a more transparent framework, which simplifies practice for care professionals, reduces burdens, and empowers individuals to better understand their rights and responsibilities.

- *Consolidate* all existing legislation and repeal old statute dating back over 60 years:
    - Incorporate existing powers for local authorities where they fit with the modern service, whilst bringing the provisions up to date and creating a new statutory framework for adult safeguarding.
    - Rationalise and remove unnecessary top-down controls or restrictions to allow services to innovate and meet the changing needs of local populations.

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

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

What policy options have been considered?

Option 1: Do nothing

1.31 This option would mean retaining the existing law relating to adult social care. There are currently over 30 Acts of Parliament dealing with adult social care. The law is also subject to further direction and approval, with the consequence that a statute by itself may not provide the answer to whether a local authority has a power or a duty to provide services. Further to this, the current statute does not provide a statement of fundamental principles on which legislation is based, to aid interpretation in the implementation and operation of the law.

1.32 Doing nothing would mean retaining a complex and confusing legal framework. This option will not support the current and proposed system of care and support, creating further unnecessary burdens on local authorities and people wishing to access care and support services.

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

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

1.34 Specifically, Table 2 below this option entails the introduction of legal provisions intended to:

Table 3: Policy proposals related to consolidation and modernisation of care and support law

Ref	Policy area	Policy proposals	Clauses
Modernisation of the legal framework			
1A	Well-being and preventing, reducing and delaying needs for care and support	• Create a new statutory principle to promote individual wellbeing when taking any step under Part 1 of the Bill. • Introduce a statutory duty on local authorities to take steps (including but not limited to providing or arranging services) intended to prevent, reduce or delay needs for care and support	1, 2
1B	Cooperation and integration with other local organisations	• Place a general requirement on local authorities and relevant partners to cooperate in relation to care and support functions, and clarify local authority duty to cooperate with local service providers. • Create an ability for the local authority or relevant partner to request cooperation in relation to an individual case. • Place a duty on the local authority to promote integration of care and support services with health and other related services.	3, 6, 7

1C	Information and advice on care and support	- Place a duty on local authorities to provide an information and advice service in relation to care and support. - Clarify responsibility for supporting access to independent financial advice to enable people to plan for their care.	4
1D	Promoting diversity and quality in the market of care and support providers	- Place a duty on local authorities to promote a market of diverse and high-quality range of care and support services in the local area, including a focus on sustainability of the market, local authority commissioning practice and workforce conditions.	5
1E	Care and support planning, including personal budgets and direct payments	- Place a duty on local authorities to provide a care and support plan for all those whose needs it will meet. - Require that a personal budget be included in such plans, unless specified otherwise. - Consolidate rights to a direct payment, and include duties to review the care and support plan.	24-27, 30-33
1F	Transition for children to adult care and support	- Provide a duty for local authorities to assess children, young people and young carers in advance of their transition to adult care and support, in order to consider their future needs and support transitional planning. - Require local authorities to continue to provide children's services after the 18th birthday, where adult care and support is not in place.	59-67
Consolidation of existing law			
1G	- charging, financial assessment - entitlements to care and support - exceptions to entitlements - ordinary residence - debt recovery - delayed discharges - mental health aftercare - registers of blind people	Consolidate existing legal provisions and statutory requirements on local authorities – repeal existing law and re-enact effect of legislation, updating language as necessary.	14, 17 18-19 21-23 39-41 70-71 73 74 76

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

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

Costs and benefits of option 1 (do nothing)

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

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

Costs and benefits of option 2 (preferred option)

1.39 We do not expect the proposals outlined in option 2 to give rise to additional recurring costs on local authorities.

1.40 All individual proposals are intended to either consolidate existing legislation (where provisions are to be replaced and their effect re-enacted in the Care Bill) or to codify current local authority practice in the new statute. Some proposals are new to primary legislation, reflecting the fact that statute has failed to keep pace with policy development, but represent established practice which has been required of local authorities by statutory guidance[18]. Table 3 below gives examples of

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[18] "Statutory guidance" is that issued by the Secretary of State under section 7 of the Local Authority Social Services Act 1970

areas in which the law is being updated to capture requirements of statutory guidance, but where we do not expect additional recurring costs. The key pieces of statutory guidance noted are:

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

Table 4: Example of links to existing statutory guidance

Policy area	Policy proposal	Existing requirement
Well-being and preventing needs	Duty to take steps intended to prevent, delay or reduce needs for care and support	*Prioritising Need…* paras 33-40, 112 and 118
Cooperation and integration	Duty to cooperate with relevant partners, and to promote integration with health and related services	*Prioritising Need…*paras 23, 36-37
Information and advice	Duty to establish information and advice service	*Prioritising Need*…paras 11, 36, 45, 80, 82, 104, 111, 143 *Guidance on direct payments*…paras 32-33, 71, 86 *Carers…*para 99
Market-shaping	Duty to promote diversity and quality in the market of care and support providers	*Prioritising Need…* paras 37 and 112-118
Care and support planning	Duty to provide care and support plan for those entitled to care and support	*Prioritising Need*…paras 119-121 and 129-132 *Guidance on direct payments*…paras 97-98 *Carers…*para 94
	Duty to provide written record of assessment for those ineligible for care and support	*Prioritising Need*…para 106
	Duty to provide personal budget for those entitled to care and support (regulations to exclude certain people)	LAC(2009)1: *Transforming adult social care* *Prioritising Need*…paras 119 and 127-128
	Duty to keep care and support plan under review (and power to revise)	*Prioritising Need*…paras 141-151
Transition to adult care and support	Powers to assess children and young people under adult care law in advance of 18th birthday, and duty to continue children's services where adult care is not in place	*Prioritising Need*…paras 24-28 and 135-140

1.41 The following paragraphs consider costs and benefits related to each of the proposals 1A-1G noted in Table 4 above.

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

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

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

1.43 The duty on the Secretary of State (provided for in clause 77(3) of the Bill) is not expected to give rise to new costs or burdens. When making regulations or issuing statutory guidance, the Secretary of State must in any event consider how those instruments will enable local authorities to meet their statutory requirements, and should not require any action which may lead to a contravention of those requirements. This duty gives statutory expression to this principle as it relates to the local authority duty to promote welbeing and through this clarification should provide some small benefits in terms of greater understanding of the new statute, though these are not monetisable.

1B. Cooperation and integration with other local organisations

1.44 The Government is committed to encouraging cooperation, integration and joined-up working between local partners across health and social care, and placed a duty on clinical commissioning groups to promote integration of health services with social care and related services[19]. Clause 3 of the Care Bill places an equivalent duty on local authorities to promote integration of care and support with NHS and related services, to act as a partner provision and further incentivise integration between organisations. Clauses 6-7 place duties on local authorities in relation to ensuring cooperation between departments within the authority, and with other public organisations. It also places a reciprocal duty on those "relevant partners" to cooperate in turn with the local authority, and sets out a non-exhaustive list of other bodies with which local authorities should cooperate, such as providers of services.

1.45 The Bill does not mandate a particular model of integration or cooperation, so benefits are not easy to estimate at individual level.

1.46 We expect that the coherent narrative for integration and partnership working will signal to providers, commissioners and the public that integration will be fundamental to the future of care. Moreover, we expect that taking action in the above-mentioned areas will encourage integration at a number of levels. It will encourage commissioners to source models of care that take their patients through a seamless journey. In turn, this will encourage health and care providers to cooperate across traditional organisational boundaries to offer integrated products.

1.47 Evidence from the Integrated Care Pilots (ICPs) evaluation report found no overall significant changes in the costs of secondary care utilisation. However, for case management sites, there was a net reduction in combined inpatient and outpatient costs (reduced costs for elective admissions and outpatient attendance exceeding increased costs for emergency admissions). The evidence from ICPs shows that integrated care can lead to improved quality of life if well led, well managed and tailored to local circumstances and patient needs.[20]

1.48 However, improvements are not likely to be evident in the short-term. Evidence from the ICPs supports conclusions made by Ovretveit that savings are not likely in the short-term and certainly not inevitable.[21] However, case management approaches used in the pilots could lead to an overall reduction in secondary care costs. The ICP findings also support the findings of Powell Davies and colleagues, in that the most likely improvements following integrated care activities are in healthcare processes.[22] Improvements are less likely to be apparent in patient experience or in reduced costs.

1.49 The duties of cooperation at clauses 6 and 7 are intended to supplement the focus on integration, and mirror similar legal requirements that place a duty to cooperate on certain local public bodies. Such duties are common in public law, and serve as an affirmation of expected practice between partners, without requiring any specific actions or processes to be followed. Consequently, we do not believe that the consolidated duties to cooperate give rise to any new costs or burdens on the local authority and "relevant partners" specified. The cooperation duties do not extend to private sector bodies, such as providers.

1C. Information and advice on care and support

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

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[19] Section 14Z1 of the NHS Act 2006 (inserted by the Health and Social Care Act 2012)

[20] Department of Health, *National evaluation of the DH integrated care pilots*, 2012.

[21] Ovretveit, J., *Does clinical coordination improve quality and save money?,* Health Foundation, 2011.

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

1.51 Independent Age published a report[23] based on data collected by the Care Quality Commission (CQC) in a review of English social services' response to people's 'first contact' for information, advice, help or support carried out between December 2009 and August 2010. 152 English social services authorities took part and it involved around 7,500 detailed "mystery-shopping" phone calls. While all authorities provided information and advice services it found a considerable variation in the quality of the information that was provided from area to area. This indicated that while it could be argued that all local authorities were meeting their duty to provide information and advice, the inconsistency of what was being provided and its quality was an issue.

1.52 During 2009, and in relation to developing personalisation and transforming adult social care the Putting People First (PPF) consortium, including the Association of Directors of Adult Social Care (ADASS) set out a number milestones[24] to assist Councils gauge both direction and required 'speed of travel' in relation to PPF transformation progress. This was supported by a framework of advice to help local authorities with self-improvement[25]. Putting People First Milestone 4 stated '*That citizens have access to information and advice regarding how to identify and access options available in their communities to meet their care and support needs*.'

1.53 Evidence also suggests that the quality of local authorities' approaches to providing online information and advice services can improve outcomes for people.[26] One example of an outcome which is contingent on the quality of advice is the ease with which people are able to navigate the system to access other forms of support, for instance independent financial advice which may help a person to plan for meeting the costs of their care and support.

1.54 As noted above, local authorities are already subject to broad duties to provide information and advice, which can be met through a variety of approaches adapted to local need. This includes information and advice on local care and support services, other community provision, and independent advice and advocacy services, including regulated financial advice. Since the provisions of the Bill are intended to clarify and update these existing duties, rather than to expand their scope or place specific additional requirements on the local authority, on the evidence available, we do not expect the duty in itself to give rise to any significant costs.

1.55 We do know that information and advice currently provided is of variable quality and inconsistent across local authorities. The *Caring for our Future* White Paper therefore set out a range of national and local actions that should be undertaken to support improvements in information and advice services. This included:

- Introduce a new national care and support information portal including a directory of services;
- Improve local authorities' web-based information and advice services;
- Provide additional provision of advice and support to help people arrange care and support;
- Make clearer the duty for local authorities to share information with individuals, carers and families;
- Develop and disseminate best practice models for support and representation services.

1.56 Although the definition of "information and advice" is to be taken to include services such as brokerage and advocacy, the general duty set out in clause 4 of the Bill is not specific as to how local authorities should meet the requirements and which types of service are to be provided. Local authorities should adapt their local information and advice offer to meet the needs of local people, and must ensure that the type and range of information provided is proportionate to those needs. However, the Bill recognises that in specific circumstances, to support the involvement of the person in key care and support processes, the provision of an independent advocate should be required. This provision is considered separately, in section 2C below.

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

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

[24] http://www.adass.org.uk/images/stories/Milestones%20for%20PPF%20-%20Final%209.9.09.pdf

[25] http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/Personalisation_advice/Milestones_Self_Improvement_Letter_to_Directors_16_11_09.pdf

[26] http://www.socitm.net/info/214/socitm_insight/182/better_connected_2013/1

1.57 We do not identify any significant risks associated with the new legal duty regarding market shaping, as this is intended to codify existing practice and provide further guidance for local authorities on the elements that they should consider when seeking to promote and facilitate a diverse and sustainable market, such as considering the workforce and the well-being of those using the services. This duty will clarify existing practice. Over 80% of care and support provision is now provided by the independent sector. There was a large growth in private care homes starting in the 1980s, and the market was further stimulated by the Community Care Reforms in the 1990s. This means that for many years local authorities have been commissioning services from a range of providers.

1.58 There should be no additional resources required by local authorities, but rather a change in approach to improve commissioning. It is for this reason that we have launched the £700,000 Developing Care Markets for Quality and Choice programme. This programme is helping local authorities enhance their capability to shape local markets, using local information to produce Market Positioning Statements.

1.59 There may also be additional costs for some local authorities who do not already have in place measures for market shaping. We do not estimate these to be significant. However, it is for this reason that we have launched the Developing Care Markets for Quality and Choice programme, which is helping local authorities develop their capability to shape local markets.

1E. Care and support planning

1.60 Under this proposal, legislation would set out that everyone eligible for care and support[27] would be provided with a personal budget as part of a care and support plan, giving them a clear allocation of resources so that they can control as much of their care and support as they wish.

1.61 Supported by the proposals on information and advice, these changes in the law, will help to deliver the vital step change required and reduce the scope for variation. A re-designed statute will ensure personalisation is one of the defining features of the care and support system.

1.62 Local authorities are already moving towards a more personalised system in line with the *Vision for Adult Social Care,* which set out an ambition for providing everyone eligible with a personal budget by April 2013. This was underpinned by £520m of funding to develop systems to deliver this. Therefore, this does not represent a new burden on local authorities.

1.63 A snapshot of local authorities that have fully embraced personalisation do not cite increased costs but highlight the benefit of improved outcomes for people needing care and support.[28] However, the provision of personal budgets varies widely, both geographically and by user group. This is exacerbated by personal budgets having no legal basis.

1.64 Perceptions of increased costs can be a barrier to local authorities making progress with personalisation. The IBSEN evaluation found the costs and complexities of implementing individual budgets (where a number of budget streams were brought together from across local and central Government) alongside traditional resource allocation systems and service provision were major challenges. [29] However, it is important to bear in mind not only that these were the experiences of the pilot sites who may have faced difficulties in terms of being early implementers, but also, that the individual budget pilots were dealing with six separate funding streams. Personal budgets involve only one funding stream for adult social care and are therefore much simpler to administer.

1.65 As personal budgets have been in existence since 2008, there is now a wealth of best practice guidance and information sharing on personal budgets for local authorities to access on the Think Local, Act Personal website that should negate these 'early implementer' costs. In a survey conducted in 2008 by LGA and ADASS, it was shown that 19 local authorities (13%) already had

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[27] With the exception of emergency and end of life care, advice and one-off pieces of equipment, etc.

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

[29] Glendenning, C. et al, *Evaluation of the Individual Budgets Pilot programme,* IBSEN, York , 2008.

systems in place for all user groups to receive personal budgets and that 51 (34%) had a system in place only for some people.[30]

1.66 Since the survey was conducted in 2008, there has been wider roll-out of personal budgets. Table 6 below compares the extent to which local authorities have rolled out personal budgets in 2010/11 compared to 2008-09. This suggests that by 2010/11, the start-up costs of personal budgets had been borne by most local authorities.

Table 5: Community based users:

Proportion of community based users receiving self-directed support	**Number of local authorities providing self-directed support to this proportion**	
	2008/09	**2011/12**
5% or less	55	1
10% or less	125	1
20% or less	149	6
30% or less	150	21
40% or less	150	54
50% or less	150	99
60% or less	150	126
70% or less	150	143
100% or less	150	149

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

1.67 Where someone receives a personal budget the evidence base suggests they will accrue benefits. Results from a six-month follow-up undertaken by IBSEN with those offered individual budgets showed that 47% of people who had accepted the individual budget reported that their view of what could be achieved in their lives had changed a lot and 19% reported that it had changed a little. A third of this group reported that their view had not changed at all. Older people were significantly less likely than other user groups to report that the process had changed their view on what could be achieved.[31]

1.68 Using the social care outcome measure “ASCOT”[32], IBSEN found that people in the individual budget group were significantly more likely to report that they felt in control of their daily lives (48%, $p<0.05$) compared with those in the comparison group (41%).

1.69 When looking at each user group individually, IBSEN found that although there were some differences between the individual budget and comparison groups for younger physically disabled people, none of them reached statistical significance. The results suggest that people with learning disabilities in the individual budget group were more likely than those in the comparison group to feel they had control over their daily lives.

1.70 The Audit Commission has also recognised the wider benefits of personal budgets that are not confined to care and support outcomes (for example economic growth, increasing employment opportunities).[33]

1.71 In Control published the National Personal Budget Survey (also known as the Personal Outcomes Evaluation Tool (POET)) in June 2011.[34] This suggests that personal budgets are likely to have generally positive impacts on the lives of all groups of personal budget holders and the people who care for them. The likelihood of people experiencing a positive impact from a personal budget is maximised by a support process that keeps people fully informed, puts people in control of the

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[30] LGA, ADASS, *Putting people first: measuring progress,* 2009.

[31] Please note that proxy interviews were used in 24% of the total cases as some respondents were unable to communicate.

[32] *ASCOT (Adult Social Care Outcomes Toolkit)* http://www.pssru.ac.uk/ascot/

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

[33] Audit Commission, *Financial Management of Personal Budgets*, 2010.

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

personal budget and how it is spent, supports people without undue constraint and bureaucracy, and fully involves carers. Under these conditions, personal budgets can and do work well.

1.72 As with the findings from POET, the NAO commissioned Ipsos Mori to conduct consumer research, published alongside its report on Care Markets.[35] The evidence from this research supports the Government's policy to encourage more people to take their personal budget as a direct payment as this leads to greater choice and control for users as well as greater creativity.

1F. Transition for children to adult care and support

1.73 As noted at paragraph 1.27, there are well-documented issues associated with the transition between children's services and adult services, often the result of a lack of planning and engagement between different departments in the local authority and with the individual concerned, and their family.

1.74 The proposals will place a duty on local authorities to carry out an assessment where it appears that a young person, young carer or the child's carer is likely to have needs for care and support when the child becomes 18, and it would be of significant benefit to the person to do so. This will enable transition planning in advance of the young person's 18th birthday, if they are likely to need care and support as adults. The Bill does not, however, allow for services to be provided to children before their 18th birthday.

1.75 We do not expect any additional cost to local authorities associated with this new duty. Assessments should be carried out to support transition to adult care and support in normal practice, as part of the process of transition between children's and adults' services in the local authority. Children already in receipt of services under the Children Act 1989 will already undergo assessments and reviews as they approach the age of 18 years[36]; this duty is intended to confirm such practice and to allow the local authority to treat assessments undertaken before the 18th birthday for the purposes of adult care and support.

1.76 We do not expect any additional demand for services as a result of the provision because the cohort of people transitioning to adult care and support will remain the same (allowing for nomal fluctuation and demographic changes).

1.77 There should be no additional cost to local authorities to carry out assessments. These are not additional assessments. Local authorities are already under duties to carry out assessments of children and young people under children's legislation, and will also be under a duty to carry out an assessment under adult care and support law on reaching the adult of 18 years. The duty to conduct assessments under adult law in the Care Bill is to allow for earlier assessments, not additional assessments (i.e. conducted ahead of the 18th birthday rather than on or after it), and as such the costs should be the same but would be incurred earlier. It is possible that there will be savings associated with earlier consideration of young people's needs, allowing better planning and improved outcomes for the individual and their family; however such benefits will depend on how the provisions are implemented on a local level (which will be supported by statutory guidance). We are not prescribing the detail of this process, which we expect for many local authorities will not differ significantly from their current processes for communicating with people who request assessment.

1.78 The benefits could not be monetised beyond those set out in the section covering Assessment and Eligibility. The primary benefit is to young people people and their carers being able to better plan their futures and not experiencing gaps in the services they receive.

1G. Consolidation of other matters

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[35] Ipsos Mori, *Users of Social Care Budgets,* July 2011.

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

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

1.80 In the process of consolidation, the language used to describe these provisions is updated or reframed as appropriate to fit within the context of the new statute. Whilst certain improvements are made to the drafting of provisions, and other anomalies rectified, these do not change the fundamental requirements or impact on local authorities. The specific areas covered within proposal 1G are noted in Table 7 below:

Table 6: Areas of legal consolidation

Policy area	Proposals	Replaces existing legislation	Clauses
Charging, financial assessment	• General power to charge for care and support unless prohibited • Duty to carry out financial assessments	• Section 22 National Assistance Act (NAA) 1948 • Section 17 Health and Social Services and Social Security Adjudications Act (HASSASSA) 1983 • Section 8 Carers and Disabled Children Act (CDCA) 2000 • Section 15 Community Care (Delayed Discharges etc.) Act (CCDDA) 2003	14, 17
Entitlements to care and support	• Duty to meet eligible needs for care and support • Power to meet other needs	• Sections 21(1) and 29(1) NAA 1948 • Section 2 Chronically Sick and Disabled Persons Act (CSDPA) 1970 • Section 45 Health Services and Public Health Act (HSPHA) 1968 • Schedule 20 to NHS Act 2006	18, 19
Exceptions to entitlements	• Prohibition on providing services required to be provided by NHS • Prohibition on care and support for those subject to immigration control • Prohibition on providing general housing	• Sections 21(8) and 29(6) NAA 1948 • Section 49 Health and Social Care Act (HSCA) 2001 • Section 21(1A) NAA 1948	21-23
Ordinary residence	• Provisions to "deem" ordinary residence when receiving accommodation in another area • Power to resolve disputes between local authorities and recoup costs • Powers to enable cross-border placements between administrations in the UK.	• Sections 24 and 32 NAA 1948 • Section 56 HSCA 2001	39-41, Schedule 1
Debt recovery	• Power to recover debts from individuals, including where assets transferred to avoid charges.	• Section 45 and 56(1) NAA 1948 • Sections 21-24 HASSASSA 1983	70-71
Delayed discharges	• Provisions to enable notification of discharge from hospital, and reimbursement where delays are the fault of adult social services	• Part 1, CC(DD)A 2003	73, Schedule 3
Mental health aftercare	• Amendments to apply choice of accommodation, additional payments and ordinary residence to mental health aftercare	• Amendments to section 117 Mental Health Act 1983 (not replacing existing legislation)	74, Schedule 4
Registers of blind people	• Duty to hold registers of blind and partially sighted people, and powers to hold additional registers	• Section 29(4)(g) NAA 1948	76
Power to delegate functions	• Power to delegate specified care and support functions to a third party	• Replicates effect of Section 70 Deregulation and Contracting Out Act 1994 (not replacing existing legislation)	78

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

Risks/sensitivities/issues

1.82 The Care Bill re-states and updates existing powers for local authorities and the power for the making of regulations. The detail across a number of themes fall out of scope of the Impact Assessment for this Bill, and this risks issues impacting on implementation of the Bill not being accounted for in this assessment. This impacts on the eligibility criteria, carer assessment and in determining ordinary residence. Impact Assessments will be provided with the regulations, at the appropriate time.

1.83 There are some benefits, for example, associated with giving local authorities the powers to enable better coordination and more proactive, preventative measures. These are not readily quantified, but are not required in order to justify the costs.

1.84 Proposals requiring legislative enactment are assumed to be implemented from 2015/16 with other proposals that do not require enactment through primary legislation may be implemented earlier.

1.85 Work carried forward by local authorities will be in an environment of financial constraint and expenditure across a number of universal responsibilities is profiled into the next Spending Review round and so will be subject to change. Calculations have been based on the base year of 2010/2011 and after the next Spending Review will need revisiting.

Specific Impact Tests

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

One-In Two-Out

1.87 These proposals do not involve any additional regulatory measures that impose costs on business or civil society. The law considered in this Impact Assessment relates to the responsibilities of local authorities and other public sector partners for the planning and commissioning of adult social care services and for meeting the needs of their local population.

1.88 As a result, the proposals discussed within this Impact Assessment do not fall within the scope of the Government's "One-In Two-Out" (OITO) rule which states that "any regulatory measure that is expected to result in a direct net cost to business must be offset by deregulatory measures providing savings to business of at least double that amount."

Wider impact on business

1.89 The primary objective of the proposals set out in the White Paper is to support people who use care and support and their carers to maintain their health, wellbeing and independence for as long as possible. As part of the overall objective of improving quality of care and experience, proposals are also intended to strengthen and enhance the social care market.

1.90 Actions to support personalisation may have positive implications for small businesses in that they could increase the number and range of small and micro providers. The development of personal budgets has led to an increase in the opportunities for micro-providers responding to niche markets as care becomes more personalised.[37]

1.91 The proposal to introduce a market shaping duty on local authorities and support them to understand their local market should help foster increased opportunities for small and micro enterprises. Just like large companies, small firms, who might want to expand or move into a new area, would be able to access more information about the local market. This is a result of the requirement on local authorities to have regard to market sustainability, be aware of current and future demand, and actively consider how service providers might meet that demand. Furthermore, smaller businesses should benefit from better, more strategic relationships between commissioners and all providers. For example, it may be the case that commissioners consider revising procurement arrangements after having completed a market position statement. A local authority may also decide to put in place extra support for small or micro businesses and social enterprises, in order to support the development of a more diverse market and specifically in the local authority requirement to encourage innovation.

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[37] Community Catalysts - http://www.communitycatalysts.co.uk/micro-enterprise-help-for-micro-providers/

Competition

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

Equalities and human rights

1.93 We have not identified any negative impact on human rights as a result of our proposals. Several of the proposals are likely to have positive implications for human rights, in particular proposals to improve the quality and availability of information about the support on offer and proposals to extend and improve personalised care and support to care users and carers.

1.94 The Department of Health published a separate equality analysis to support the *Caring for our future* White Paper and draft Care and Support Bill[38]. This equality analysis covered the areas of consolidation and modernisation of legislation proposed in the draft Bill. Since the Care Bill takes forward the proposals of the draft Care and Support Bill without substantial amendment, we do not anticipate any additional impact on equalities and protected characteristics beyond those identified.

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

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[38] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136452/2900021_Equalities-Assessment_acc2.pdf

2A. ASSESSMENT, ELIGIBILITY AND CONTINUITY OF CARE

Background – case for change

2.1 The current system of assessment and eligibility can be confusing, unfair and unpopular with many care users and carers. Local authorities currently assess users and carers and set their eligibility criteria using guidance issued by the Department of Health.[39] Access to care and support varies across the country, with different authorities setting different thresholds for eligibility and broad variations in how these thresholds are interpreted. Individuals who have the same needs can be eligible for care and support in one part of the country but not eligible in another part. Carers do not yet have the same entitlements to assessment and support as care users (see chapter 8 of this impact assessment, which considers carers).

2.2 This lack of consistency is one of the factors that act to prevent people moving between local authority areas, potentially to take up or remain in work, or be closer to their family. Users and carers primarily find it difficult to move around the country because their care and support is often interrupted until the new local authority carries out an assessment and arranges access to new personal budgets.

Variation in people's ability to access care and support

2.3 Currently, individuals and families who develop a care and support need approach their local authority to have an assessment. If their need is severe enough to meet the local authority's eligibility threshold for access to care and support, and their means are determined as not sufficient to provide it for themselves (as defined by the financial means test), the local authority will provide them with care and support.

2.4 Although assessment and eligibility operate within a broad national framework, local authorities are able to set their own eligibility thresholds in response to local needs and circumstances, resulting in variation in the access to care and support across the country. The system can seem opaque and inconsistent – users and carers do not know from local authority to local authority whether they will be eligible for care and support. There is a lack of clarity around the interdependencies of the carers and community care legislation.

2.5 The Fair Access to Care Services (FACS) framework sets out eligibility criteria against which local authorities assess an individual's need.[40] Local authorities are able to choose where they set their eligibility threshold and therefore the level of need at which they will offer support. This results in variation in the levels of access to care and support offered, as demonstrated in Table 7 below:[41]

Table 7: Local authority eligibility thresholds

FACS threshold for access to care and support	Number of local authorities setting their threshold at that criterion
Critical	3
Substantial	127
Moderate	19
Low	3

2.6 Differences in thresholds applied by local authorities are compounded by considerable variation in the way that they interpret the eligibility criteria set out in the FACS guidance. A recent survey of care managers at different local authorities showed significant differences in their assessment of the eligibility of individual case studies. The study showed for example that a user deemed to have critical needs by a care manager in one local authority was thought to have no needs by a care manager in another local authority.[42]

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

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

[41] Based on data provided by ADASS in autumn 2012.

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

2.7 A 2008 review of eligibility criteria by the Commission for Social Care Inspection (now part of the Care Quality Commission) flagged as two of its top findings:[43]

> *"A lack of clarity and transparency in practice, particularly related to the complexity of the framework, so neither professionals nor people using services are confident of their understanding …"*
>
> *"A lack of fairness in the way criteria are applied, due to variations in professional judgements and different approaches taken by councils."*

2.8 In addition, it is difficult to know what a particular threshold means in practice – meaning therefore that a comparison of thresholds across the country is not useful. The Commission on Funding of Care and Support found that:[44]

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

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

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

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

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

2.12 The 1998 Modernising Social Services White Paper set out as its aim for the new FACS guidance that "Eligibility criteria should inform users about what sorts of people with what kinds of need qualify for what types of service… There has to be a greater level of consistency and fairness in social care."[45] The evidence cited above suggests that this aim has not been fully achieved.

2.13 In 2010, Government took the decision to prioritise funding for social care, making available an additional £7.2bn over the four years of the Spending Review. However, despite the fact that this is estimated to provide enough funding for local authorities to maintain access to care and support at current levels, taking into account a programme of efficiency, there is evidence to suggest that some local authorities are restricting eligibility for care and support. For example, a recent budget survey carried out by the Association of Directors of Adult Social Services (ADASS) suggested that 23% of the £1bn reduction in social care funding in 2011/12 was brought about by service reductions rather than efficiencies.[46]

2.14 The number of people receiving services in 2011-12 was 1.5m (down 7 per cent from 2010-11 and down 18 per cent from 2006-07). Of these, 1.2m received community based services (down 8 per cent from 2010-11), 213,000 received residential care (which is less than a 1 per cent change from 2010-11) and 86,000 received nursing care (down 1 per cent from 2010-11). However, these figures are difficult to interpret. The NHS Information Centre notes that feedback from councils

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[43] Commission for Social Care Inspection, *Cutting the cake fairly*, 2008.

[44] *Fairer Care Funding, The Report of the Commission on Funding of Care and Support*, 2011.

[45] Department of Health, *Modernising Social Services White Paper,* 1998.

[46] Association of Directors of Adult Social Services, ADASS Budget Survey, 2011.

suggests that the fall this year is due to a number of reasons which include providing services outside of a formal assessment process and data cleaning.

Underlying causes of the problem

2.15 The lack of clarity and consistency in access to care and support is largely due to local areas having significant flexibility over eligibility and assessment. The FACS statutory guidance on setting eligibility criteria and interpreting each threshold does not impose mandatory duties – this therefore results in local variation in people's access to care. Indeed, current legislation does not allow for mandatory duties.

2.16 Government is clear that some local variation is appropriate within a system that promotes local determination and personalised public services.

2.17 Individual and family circumstances should be taken into account by a local authority in determining the size of a care and support package. For instance, factors such as the care that may be provided by a carer, the accommodation an individual or family lives in, their specific needs and the outcomes they want to achieve, could contribute to variation in the size of a care and support package provided to individuals and families with similar needs.

2.18 Local discretion on other variables such as overall local authority funding, resource allocation and the configuration of local authority markets and services, as well as variation in local needs will also result in variations in care and support packages.

2.19 Finally, it needs to be recognised that within any framework for assessment and eligibility there will always be some differences in outcome given the element of subjectivity or professional judgement that is involved.

2.20 However, users and carers should be able to know whether they will be eligible for care and support and have a sense of the way in which their care and support needs will be assessed no matter where they live in the country. There is a clear distinction to be made between access to care and support where we believe there should be more national consistency in provision, and the size and type of care and support package received which is determined by local decisions and individual circumstance.

2.21 What has emerged is not the locally led system within a nationally consistent framework which was Government's intention, but rather a system with broad variation that can be opaque to users and carers. The view that Government needs to take action to address this was supported during the *Caring for our future* engagement.

Barriers to continuity of care and support

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

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

2.23 There are several barriers to continuity of care in the current system. At present users and carers may face discontinuity of care and support when moving from one local authority area to another until they receive an assessment. Although we do not have a clear view on the numbers of people who do not move local authority area as a result of these barriers, stakeholders, in particular younger disabled adults, carers and their representative organisations, have been heavily critical of the current approach.

2.24 The lack of consistency of eligibility thresholds and the interpretations of those thresholds, the variance in care and support packages and charging arrangements also act as barriers to people moving area. Some of these differences are legitimate as part of a local system, such as the size of care and support package will vary from local authority to local authority depending on local decision-making.

2.25 However, others, such as eligibility thresholds and in particular the current discontinuity of care and support, affect access and can therefore present significant barriers to freedom of movement that need to be addressed. Individuals and families should have greater certainty over their ability to access care and support across the country, to enable them to move more freely between areas.

2.26 There was strong support to introducing a continuity of care process during the *Caring for our future* engagement. This supports the response to consultation by the Law Commission which found that:[47]

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

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

2.28 RADAR summarise the problems well, setting out that:[48]

> *"Currently, disabled people face very severe and unnecessary barriers when moving from one local authority to another. That is because they cannot be certain that they will receive equivalent levels of care and support in a new locality.*
>
> *Even where people are already getting care and support in one authority they will often be unable to start the process of sorting out arrangements in a new location until they have moved, and they then have to negotiate a new care package from scratch. For many disabled people effective and timely social care is the difference between independence and entrapment."*

Rationale for intervention

2.29 Local authorities are responsible for the assessment of need, determination of eligibility and provision of care and support to meet eligible needs. It is the Government's view that local authorities should be able to exercise flexibility in the way in which they meet the needs of their local populations, according to local circumstance. However, evidence suggests that there is currently an unacceptable level of variation in access to care and support affecting care users, those with caring responsibilities and offenders with care needs. This is largely a result of variability in local interpretation of national legislation and guidance. Repeated attempts to bring more national consistency to the system have not had the desired effect.

2.30 Government intervention is therefore required to support greater equality and consistency of access to assessment and provision of support. Without reform through primary legislation, the level of variation will not be reduced and these aims will not be met.

2.31 A report on assessment and eligibility by the Social Care Institute of Excellence (SCIE) set out that:[49]

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

2.32 The Commission on Funding of Care and Support recommended that the Government take action in this area and that in the longer term the future system should have a new, more objective

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[47] The Law Commission, *Adult Social Care Consultation Analysis,* 2011.

[48] RADAR, The Social Care and Portability Bill Information Briefing, 2011.

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

assessment scale, with a simplified and clearer process. Until this is designed and implemented, the Commission recommended the introduction of a national eligibility threshold in the interim. The Commission felt that such changes would benefit both people with care needs and carers.

2.33 Reforming the law to create a clear single statute around assessment and eligibility also provides an opportunity to look again at how these policies interact with the rest of the system, and to ensure that going forward they are designed in such a way to support greater personalisation and self-directed support for care users, families and carers.

2.34 There are currently few incentives to ensure that a local authority provides continuity of care and support if an individual or family moves into their area, or even that they re-assess them promptly to ensure that any discontinuation of care and support is short. In practice, the cost of providing services to new users and carers moving into their local area may act as a disincentive to promptly putting in place a care and support package and there is anecdotal evidence from stakeholders that this may be the case.

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

Policy objective

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

Table 8: Assessment, eligibility and continuity of care:

Policy Theme	Objectives	Policy Proposals
Assessment, eligibility and continuity of care	• Create a more nationally consistent system for eligibility for users and carers which is understandable, transparent and outcome-focused, supports personalisation and prevention and continues to allow local authorities flexibility to reflect individual, family and local circumstance; • Provide continuity of care to users and carers when moving home from one local authority area to another.	A. Establish a national threshold for eligibility for care and support; B. Place a duty on local authorities to meet the needs of care and support for users and their carers who move into their areas, from the day of arrival until they undertake a new assessment.

What policy options have been considered?

Option 1: Do nothing

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

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

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

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

2.38 Under this option, from 2015 Government takes forward the Law Commission recommendations and sets a national minimum eligibility threshold for adult care and support services. This requires new primary legislation with a corresponding impact on local authorities. The Care Bill provides a power to set mandatory eligibility criteria to which local authorities will have to adhere.

2.39 This would ensure that local authorities could not restrict their eligibility for care and support beyond the level set nationally and would bring greater consistency in access to care and support. Councils whose eligibility is currently more restrictive than the new national minimum will widen access to care and support. Councils could choose to be more generous than the national threshold if they wished. However, councils would retain control over how they interpreted the threshold, overall budget setting, the size of individual care and support packages and the configuration of local services.

Costs of preferred option, proposal A

2.40 The Bill provides a power to set the national minimum eligibility threshold for adult social care in regulations. The level at which the eligibility threshold will be set must match the overall resource allocated to adult social care. The Government published a draft of the eligibility regulations during the Bill's passage so that stakeholders had an indication of where the Government intends to set the national threshold. The consultation ended on 29 November 2013 and results are currently being analysed.

2.41 We do not present indicative costings in this Bill impact assessment. Instead, the impact assessment for the eligibility regulations will provide detailed costings of setting the eligibility threshold at the specified level. For local authorities with an eligibility threshold above the new minimum, this will need to consider the cost of additional social care provision and implementation costs including developing and implementing revised assessment processes, staff training, and assessing clients.

Benefits of preferred option, proposal A

2.42 Proposal A would help set out a national minimum offer for access to care and support across the country, which should simplify the system and act to reduce some of the unacceptable variation in access to care and support.

2.43 Further, it should support continuity of care as users and carers will have greater certainty that they will still receive care and support should they move to a different local authority from their own, as all councils would offer care and support at a national threshold.

2.44 There would also be benefits in the form of improvements to wellbeing to individuals and their families from the additional expenditure on provision of care and support with potential small savings to the NHS from this new social care expenditure.

2.45 However, without additional intervention, individuals and families would still face potential discontinuity of care and support when moving to another local authority area. We propose that in addition to Proposal A, we also take forward Proposal B, to place a requirement on local authorities to assess needs in a timely manner and to continue providing people with a package of care and support in the intervening period. This is discussed below. Benefits will be estimated in the Impact Assessment for the regulations, as noted in paragraph 2.41.

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

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

2.47 Under the provisions of the Bill, a duty would be placed on local authorities setting out that they must meet the assessed care and support needs of users and carers (where they are continuing to care for a user who is also moving) who move into their area, until they are able to re-assess them and potentially provide a revised care and support package. This duty would be further defined in guidance but in essence would equate to ensuring that a user, and if appropriate the carer, is able to receive care and support to meet the same assessed needs as in their previous local authority, from the day of arrival in a new local authority area, so that there is no gap in care. The Bill also sets out new duties on the local authorities involved to share information to encourage a smoother transition between local authorities.

Costs of preferred option, proposal B

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

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

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

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

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

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

2.53 The <u>indicative</u> costs associated with Proposal B is set out in table 9 below:

Table 9: Summary of costs of Proposal B (£m)*

(Price base year: 2010/11)

Proposal	Agent	Yr1	Yr2	Yr3	Yr4	Yr5	Yr6	Yr7	Yr8	Yr9	Yr10	Total	Average annual
Continuity of Care- recurring costs	Councils	4.0	9.0	12.2	12.2	12.2	12.2	12.2	12.2	12.2	12.2	110.7	11

Benefits of preferred option, proposal B

2.53 Proposal B will break down the most significant barrier to continuity of care in the current system, which is the risk that an individual or family may lose vital care and support for a period of time until they are re-assessed. This proposal should therefore support individuals and families in being able to move from one local authority to another.

2.54 Proposal B would bring about significant welfare gain by enabling individuals to move closer to family and friends or into more suitable accommodation, which would have benefits in terms of improved outcomes and potential reductions in costs to the state. It would also help both users and carers to move in order to take up or remain in employment, which would bring benefits to the wider economy from increased productivity and potentially a reduction in welfare benefits claimed.

Summary impact of option 2 (proposals A and B)

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

2.56 The Bill sets out the principle of a national minimum eligibility threshold and to place a duty on local authorities to ensure that there is continuity in care and support for people who move areas. In terms of welfare gain, these proposals will widen access to care and support and reduce the uncertainty facing new users and carers, and those already receiving care and support who wish to move area.

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

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

2B. ASSESSMENT AND PROVISION OF SUPPORT FOR CARERS

Background – case for change

3.1 The 2010 Carers Strategy highlighted the crucial role of carers and the importance of a fair and transparent offer to both users and carers.[50] Carers do not yet have the same entitlements to assessment and support as the people they care for.

3.2 Carers' legislation has been introduced as Private Members Bills on an ad hoc basis, reflecting the changing attitudes towards carers over the last 25 years. Under current law, local authorities have a duty to undertake carers' assessments if certain conditions are satisfied. There is a lack of consistency and transparency in relation to how local authorities decide whether and how carers receive support. Local authorities currently have a power rather than an express duty to provide support to meet carers' needs identified through assessment. When exercising this power, local authorities can, but are not required to, apply an eligibility framework and criteria.

Support for carers

3.3 Piecemeal legislation and guidance about carers' assessments has created a process that is confusing, prolonged and overly bureaucratic, both from the perspective of carers and those administering the process. The current processes tend to focus on supporting carers in their caring role and do not necessarily result in the provision of support to improve the health and wellbeing of carers and their quality of life.

3.4 Caring responsibilities can have an adverse impact on the physical and mental health, education and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes. These in turn can affect a carer's effectiveness and lead to the admission of the cared for person to hospital or residential care.

3.5 For example, the Carers, Employment and Services (CES) report by Carers UK and the University of Leeds 2007 found that only a minority (about a quarter) of carers believed they had adequate support from formal services – even though 42% were paying privately for these. Very few were getting carers' breaks or respite services and a large minority felt poorly informed about available support. Among 'new' carers in the CES study, 46% of full-time employees, and 62% of part-time employees felt they did not have adequate support to enable them to work.

3.6 H. Arksey et al found that carers' opinions on the quality and adequacy of support provided by local authorities varied widely, even within the same local authority.[51] Many carers (or care users) were unwilling to accept assistance from their local authority, and there was no evidence of a direct link between the number of hours that carers worked and the level of support received. They found that local authority support was generally not seen as essential to the ability of carers to undertake paid work, partly because it did not easily accommodate work patterns. Whilst local authorities could provide reasonably effective short-term solutions to help carers combine work and care, it was much harder to sustain this support in the longer-term. Services that carers felt would make it easier for them to work and care included childcare for disabled children, longer day centre hours, and practical help with domestic chores.

3.7 It is therefore important that care and support legislation supports families and carers to access timely information and advice and early interventions to enable them to care for as long as they wish and are able to and to have a life of their own alongside caring. The proposals for better access to quality information and advice set out in the paragraphs on *Information and Advice* will support carers as well as care users in this objective.

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

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

3.8 However, as set out above, there are still legislative barriers that can prevent carers from accessing assessment and support, which need to be addressed. Under current legislation, local authorities only have a duty to undertake carers' assessments if certain conditions are satisfied and only have a power not a duty to provide support to meet carers' needs identified through assessment. Carers therefore do not yet have the same entitlements to assessment and support as the people they care for. This Impact Assessment therefore considers the impact of provisions within the Care Bill to address these legislative barriers.

Policy objective

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

Table 10

Policy Theme	Objectives	Policy Proposals
Reforming legislation to provide better support for carers	• Ensure carers have the same rights as users with regard to access to assessments and support.	A. Simplify the legislation in respect of carers' assessments; B. Introduce a new duty on local authorities to meet eligible needs for support.

Summary of options

Option 1: Do nothing

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

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

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

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

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

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

Option 2: Implement the following proposals (preferred option)

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

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

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

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

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

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

Removal of the 'substantial and regular' test.

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

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

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

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

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

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

3.21 This would enable local authorities to offer a carer's assessment to a carer who is paid for some of the care they provide or to a volunteer worker, when the authority believes the relationship is not principally commercial or volunteering. This proposal received a mixed response in the Law

Commission consultation including concerns that this might erode the distinction between a carer and a paid employee and have resource implications. Making this a power rather than a duty would enable local authorities to decide whether to offer an assessment when the caring relationship appears not to be principally a commercial or volunteering arrangement and to control resource implications. It is not envisaged that this power would be used extensively and resource implications would therefore be minimal.

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

3.22 This would support a more unified approach to carers' and users' assessments, which is likely to support better coordination and joint planning, while still enabling carers to be separately assessed from the person they care for if they so wished. The regulations would also allow for the Secretary of State, if he so wished, to require local authorities to have regard to the family's needs as a whole when undertaking either a user's or carer's assessment. Neither of these proposals is likely to have cost implications.

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

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

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

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

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

3.25 We have aimed to identify the potential increase in demand for carer assessments following law reform by looking at the current pattern of assessments in local authorities, using two approaches.

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

3.27 The unit cost of a carer's assessment is estimated to be approximately £100, from data gathered by Surrey County Council. (Costs were estimated between £90 and £120 - those at the higher end being conducted by a qualified social worker).

3.28 Activity data (RAP) showed that in the 152 upper tier local authorities, the ratio of carers' assessments to the overall number of service users ranged from a minimum of 6.9% to a maximum of 69.4%. The median was 25.0% and the 90th percentile was 39.3%.[52]

3.29 Our analysis looked at how many additional assessments would be required if those authorities with a proportion lower than the 90th percentile were to increase their proportion of assessments to

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

this level. The analysis showed that the number of assessments would need to rise by 50% to enable all councils to reach the 90th percentile, and the additional cost would be in the region of £23 million.

3.30 An alternative approach is to use data from the PSSRU survey of adult carers 2009/10. Analysis of the survey data from those councils that included data on carers "known by association", showed that 35% of carers did not receive an assessment.[53] This equates to approximately 250,000 carers - providing them with an assessment would represent a 54% increase in assessments and cost approximately £25 million.

3.31 The table below summarises the additional assessment costs estimated using the two approaches:

Table 11: Summary of additional assessment costs

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

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

3.32 The Bill provides a power to set the national minimum threshold for eligible needs for carers in regulations. This threshold will determine which needs are eligible, and therefore may fall within the scope of the new duty to meet needs.

3.33 The Government will announce the level of the national minimum threshold as part of the forthcoming Spending Review which is due to be announced on 26 June. The level at which the eligibility threshold will be set must match the overall resource allocated to adult social care. The Government will publish a draft of the eligibility regulations following the Spending Review statement and during the Bill's passage, so that stakeholders are aware of where the Government intends to set the national threshold.

3.34 This impact assessment presents indicative costings below. The impact assessment for the eligibility regulations will provide detailed costings of setting the eligibility threshold at the specified level when this is published.

3.35 RAP data shows there were over 400,000 carer assessments conducted in 2010/11. Approximately 380,000 carers received services, of whom 189,000 received 'carer specific' services. Our analysis estimates the increase in demand for these support services, arising from the increased demand for assessments discussed above. We also examined the ratio of number of users of services for carers compared to the number of carers' assessments in each authority and estimated additional demand if authorities were to increase their ratio of users of services for carers to carers' assessments to the level of the 90th percentile.

3.36 The average amount spent on 'carer specific' support is assumed to be in the region of £1,000 per carer, over the duration of a caring spell, which is assumed to be between 2 to 3 years.[54] [55] This is informed by the findings of a survey by The Princess Royal Trust for Carers.

3.37 It is anticipated that demand for support for carers would be likely to increase with the adoption of Proposal A due to the rise in assessments, and under Proposal B due to both the rise in assessments and a new duty on local authorities to determine whether a carer's needs are eligible needs, using eligibility criteria, and provide or arrange support to meet eligible needs of carers.

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[53] Survey data limited to the 41 councils that included carers known by association.

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

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

3.38 It is hard to estimate how quickly an increase in assessments and provision of support might occur because it will largely depend on the time it takes local authorities and the voluntary sector to recruit and train additional staff to undertake assessments. It will also depend on other proposals to tackle the challenges associated with identification of carers and access to information and advice set out on the face of the Bill and in the *Information and* Advice section of this Assessment; and the changing attitudes and behaviours of carers themselves.

3.39 Community Care Statistics show a 34% increase in carers assessments between 2005/06 and 2010/11. Even when there was a Performance Indicator in the National Indicator Set on the number of carers assessments (which arguably should have been a driver for increasing the number), growth was modest. Between 2008/09 and 2009/10:

- the number of carers offered an assessment increased by 4%;
- those offered a service (including only information and advice) increased by 9%; and
- those receiving carer specific services remained the same.

3.27 We therefore do not anticipate that an increase in assessment would rise sharply within a short space of time from implementation of new legislation, rather it would be more likely to grow gradually over 3 or 4 years.

3.28 The analysis described above found that the number of assessments would increase by 50%, if local authorities were to match the proportion of assessments to the 90th percentile, or by 54% if all carers 'known by association' were assessed. If the current ratio of assessments to services were applied to the additional assessments, these increases would result in an extra 105,000 to 110,000 carer specific services, costing between £104 million and £112 million. It should be noted that this is likely to be a maximum estimate, as it seems probable that, as a wider group of carers receive assessments, the ratio of assessments to recipients of carer support would be lower for the additional group of carers.

3.29 The analysis examines the ratio of recipients of carer specific support to the number of carer assessments. It looks at how many additional services would be required if those local authorities with a proportion lower than the 90th percentile were to increase their current ratio of support to assessments to this level. Matching the 90th percentile for the ratio of carer specific support to assessments would add 130,000 support services, a 63% increase, and cost approximately £131 million. This estimate is illustrative and may be generous since the new duty may not in practice require that all councils reach the 90th percentile for the ratio of recipients of carer support to carer assessments.

3.30 Table 12 below shows the indicative costs of additional services and associated costs:

Table 12: Indicative costs of additional services

	Arising from a 50-54% increase in assessments	***Matching the 90th percentile***
Carer specific services	105,000-110,00	130,000
Indicative cost	£104 - £112 million	£131 million

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

Cost savings of option 2 (proposals A and B)

3.32 Improved identification of needs and support for carers resulting from option 2 are likely to lead to savings in terms of public expenditure costs avoided. A study by NIHR School for Social Care

Research (Linda Pickard et al)[56] has estimated that the public expenditure costs of working age carers leaving employment as a result of their caring role are £1.3 billion per year in England, comprising:

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

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

3.34 If the provisions in the Bill prevent 20-40% of carers currently in employment from giving up work, based on the study above cost savings to the public purse would be in the region of £260m-£520m per year). Using a central estimate of 30% of carers remaining in employment, this would equate to savings of £390 million per year.

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

3.35 We estimate that implementing these proposals would generate additional assessments at a cost of some £25 million. In addition, demand for support for carers would also increase, both as a consequence of there being more assessments and additionally (independently of the increase of assessments) through a new duty to provide support for carers. Costs arising from these changes are estimated to be in the region of £125 to £150 million. Cost savings arising from public expenditure avoided through improved support to carers to remain in employment are estimated at £390 million.

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

Table 13: Estimated costs associated with increased demand for assessment and support

Proposal	***Year1 2015/16***	***Year2 2016/17***	***Year3 2017/18***	***Year4 2018/19***	***Year5 2019/20***	***Year6 2020/21***	***Year7 2021/22***	***Year8 2022/23***	***Year9 2023/24***	***Year10 2024/25***	***Total***
Support for carers - assessments											
Total recurring costs	15.0	20.0	25.0	25.0	25.0	25.0	25.0	25.0	25.0	25.0	235.0
Support for carers - services											
Total recurring costs	30.0	60.0	90.0	120.0	150.0	150.0	150.0	150.0	150.0	150.0	1200.0
Recurring savings	100.0	178.0	256.0	323.0	390.0	390.0	390.0	390.0	390.0	390.0	3197.0

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

3.38 Following a carer assessment, care and support to meet eligible needs (such as respite care) could be subject to means testing as it is now and we estimate this could potentially reduce the costs of support by some 5%. Local authorities would also retain the power to charge carers for support directly provided to them, although we anticipate that, as now, they would use this power sparingly

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[56] http://blogs.lse.ac.uk/healthandsocialcare/2012/04/25/dr-linda-pickard-public-expenditure-costs-of-carers-leaving-employment/

in recognition of the significant contribution that carers make both in terms of the value of the care they provide and because that care can avoid or delay a user's need for long-term nursing or residential care.[57]

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

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

Benefits of option 2 (proposals A and B)

3.41 The Impact Assessment that accompanied publication of the updated Carers Strategy in November 2010 identified a number of benefits to be gained from strengthening support for carers, particularly in terms of preventing carer burn-out, early interventions that maintain or improve carers' health and greater choice and control for individual carers.[58]

3.42 The PSSRU Survey of Adult Carers 2009/10 was based on 35,000 responses from carers over 18 years of age who were in touch with social services either through having been assessed or reviewed themselves, or named on the file of a care user assessed or reviewed in the previous 12 months. [59] This indicates that most of those receiving carer support, including breaks, were very satisfied:

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

3.43 The Survey of Carers in Households 2009/10, based on just over 2,000 responses, gives an indication of the low proportion of carers in the population who are currently assessed and the potential unmet need for support (though it does not go into the level of support that might be needed):[60]

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

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

- Among working age carers, 26% felt caring had affected their ability to stay in employment, and of these, 39% had left work altogether, 32% had reduced their employment hours and 18% had agreed flexible employment arrangements;
- Around half (52%) of carers said that their health had been affected because of the care they provide (39% of those caring for less than 20 hours and 66% of those caring for 20 or more hours);
- Around two in five carers (42%) said their personal relationships, social life or leisure time had been affected because of the assistance they provided.

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

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

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

[60] NHS Information Centre, *Survey of Carers in Households 2009-10*, 2011

3.45 The independent evaluation of the Carers Strategy Demonstrator Sites published in November 2011 reports potential benefits from improving both assessment and support for carers including:[61]

- Preventing or delaying hospital or residential care admissions for care users;
- Sustaining the caring role;
- Improved health and wellbeing of carers;
- Assisting carers to remain in or return to work;
- Access to peer support networks.

3.46 Particular points to note from the evaluation of the demonstrator sites are:

- Carers valued different ways of accessing support including self-assessment. Assessments focusing on carers identifying their own support needs rather than a range of services offered by the local authority often resulted in low cost solutions and/or support from family and friends.
- Breaks from caring and practical support have the potential to prevent carer burnout and health deterioration and to sustain the caring role. A minority of carers reported that taking a break from caring or practical support had improved how they cared for themselves, their ability to cope and deal with stress and how they felt about life.
- Carers who did not receive a break were more likely to show deterioration in wellbeing scores.
- In three sites, alternative care for the user was offered as well as a personal budget to enable carers to undertake an activity to give them a break from caring. However, few carers took up the offer of paid alternative care because having the flexibility to tailor a break to their choice and time enabled them to arrange replacement care informally with friends and family - and many understandably said they preferred this.
- Positive health and wellbeing outcomes for a substantial numbers of carers can be maintained when carers are facing particular challenges including when the caring role begins, when carers experience strain and when they have intense or long-term caring roles.

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

3.48 The Department of Health values a year of life at perfect health (a quality adjusted life-year or QALY) at £60,000 when being compared to the opportunity cost of health care expenditure, or £25,000 when costs are expressed in financial terms. This estimate is calculated using the societal value of a statistical life estimated to be £1.8 million, based on evidence from the Department for Transport. When health benefits, improved quality-of-life or lives saved are a likely outcome of a policy initiative, quantifying and monetising benefits in this way enables comparisons with costs, to understand whether the likely benefits of a policy will outweigh the costs.

3.49 If a QALY is valued at £60,000 as above, an improvement of 0.071 QALYs per year over 3 years would be worth almost £12,800 over 3 years. Using the same assumption as to the number of additional carers who may receive support (see paragraph 3.28) as a result of the new legal provisions (105,000-110,000 individuals), this gives a basis for estimating benefits which may arise. If all of these additional carers experience a significant improvement in anxiety/depression as a result of support provided by the local authority, benefits would be in the order of £1.34 billion to £1.41 billion per year.

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

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

Table 14: Summary of monetised benefits for carers

Proposal	***Year1 2015/ 16***	***Year2 2016/ 17***	***Year3 2017/ 18***	***Year4 2018/ 19***	***Year5 2019/ 20***	***Year6 2020/ 21***	***Year7 2021/ 22***	***Year8 2022/ 23***	***Year9 2023/ 24***	***Year10 2024/ 25***	***Total***
Carers – benefits of legal reform											
Recurring benefits	344.6	612.6	880.6	1103.3	1340.0	1340.0	1340.0	1340.0	1340.0	1340.0	10988.0
Total benefits (discounted at 1.5%)	339.5	594.6	842.1	1046.1	1243.9	1225.5	1207.4	1189.5	1172.0	1154.6	10,015.1

3.51 These illustrative estimates of the value of the gain from carer support are well in excess of the assumed cost of £1,100 over 3 three years (£100 for an assessment and £1,000 for support). Even if care support had a lower impact, so long as the impact was over 20% of a move from moderate to no anxiety/depression, it would still be cost-effective. This suggests that, although there can be no certainty without robust evidence, the proposed expansion of carer assessments and support is highly likely to be cost-effective. Robust quantitative research on the impact of carer support on carer welfare would be valuable.

Summary of proposals in respect of carers

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

2C. ACCESS TO INDEPENDENT ADVOCACY

Background – case for change

4.1 At present there is no duty on local authorities, beyond that provided by the Mental Health Act 2007 and the Mental Capacity Act 2005, to provide independent advocacy services to support people to have full involvement in care and support processes conducted by the authority – including safeguarding enquiries, assessments of need, care and support planning, and reviews. The availability of independent advocacy is spasmodic and varies across England from authority to authority, dependent on local priorities and decisions[62].

4.2 Practice and evidence suggests that, although the system can be complicated to navigate and understand, the majority of people can be supported appropriately through these processes by local authority care and support staff (social workers, social work assistants etc.), and with support and help from family and friends. Particularly since the introduction and development of personalisation, there is growing evidence that people benefit from independent and peer support to help guide them through the process – enabling them to think and articulate their own needs and the life outcomes they want their care to support them achieve. Increasingly, local authorities are commissioning independent services particularly to support people to develop and put in place their own care and care and support plans.

4.3 For some people, there is a need for the services of an independent advocate to support them to make decisions through the care and support processes[63]. This will, for example, include those who may have particular difficulties in understanding or retaining information or in communicating or articulating their wishes. This will include some people with learning difficulties, autism and those who have mental health and neurological conditions, often multiple conditions that make communications problematic.

Policy objective

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

Summary of options

Option 1: Do nothing

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

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

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[62] Research Report 67: Advocacy in social care for groups protected under equality legislation, Equality and Human Rights Commission 2010
[63] Closer to Home: An inquiry into older people and human rights in home care. Equality and Human Rights Commission 2011

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

4.6 This proposal places a duty on local authorities to provide an independent advocate to assist defined individuals (adults, carers and children in transition and their carers) in their involvement during a safeguarding enquiry, needs or carer's assessment, care and support plan or support plan, and review process.

4.7 This will be confined to advocacy to support a person's *involvement in these specific processes*, and not in relation to the services of an advocate that may be included as a means of meeting any on-going need that may be included in their care and support plan.

4.8 The services of an independent advocate should be available to those without family or friends willing or able to act on their behalf, where the local authority considers that without the assistance of an advocate the adult will experience substantial difficulty in relation to one or more of the following:

i. understanding, retaining, using or weighing the information relevant to the process of assessment, care and support planning or review; or,

ii. expressing or communicating their own views or wishes and feelings.

4.9 This will also need to be available to carers going through the assessment and support planning process, and in the circumstances when a young person or their carer requires an assessment of needs prior or as part of the transitional arrangements to adult care and support.

Costs and benefits of Option 1 (do nothing)

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

Costs and benefits of Option 2 (preferred option)

Costs

During assessment and review

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

Table 15: Additional assessments/reviews arising from funding reform proposals

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

4.12 Of those that are assessed or have a review, we estimate that about 10% of people would not have family or friends willing or able to act on their behalf, and would therefore be eligible for independent advocacy under this Option. This estimate is based on evidence from the experience within IMCA services where individuals are eligible for advocacy support in making key decisions if they do not have family and friends. Advice from those working in the sector supports this estimate.

4.13 Of this group, we have assumed that some people will not take up this service as they will have the capacity to, and want to, advocate for themselves. Advice from experts suggests that the proportion of take up at assessment stage is likely to be high, it has been assumed that 70% of those that are eligible will take up the offer of advocacy. We have also been informed by organisations currently delivering advocacy support that on average this group of users will require 17 hours of advocacy support at a cost of £30 per hour (in 2012-13 prices). Therefore our best estimate is that the additional costs would be around £23m by 2018/19.

4.14 At the review stage of the process, advocacy services suggest that take up of advocacy is likely to be lower. It has been assumed that between 25% to 50% will need support at review stage and again based on advice from providers of advocacy that on average they will require 8 hours of advocacy support at a cost of £30 per hour (in 2012-13 prices). Therefore our best estimate is that the additional costs would range from £9m to £18m (mid-point £13m) by 2018/19.

Carers

4.15 Some carers who receive a service – there were 169,000[64] in 2012-13 – are likely to require advocacy support, but the proportion requiring support and the average level of support required is likely to be lower than for users of adult care and support. Based on discussions with carers and advocacy organisations, it has been assumed that 10% of carers receiving a service will require advocacy support, and that on average they will require 5 hours of support at a cost of £30 per hour (in 2012-13 prices). Therefore our best estimate is that the additional costs would be around £3m.

Safeguarding

4.16 In 2012-13, there were 112,000[65] safeguarding referrals. However, we know that some referrals do not constitute a full safeguarding case. Based on discussions with experts in the field, it has been assumed that this accounts for two-thirds of referrals, and we have therefore excluded them. Of the remainder it has been assumed that about two-thirds of people would take up an offer of independent advocacy – about 25,000 people. Based on discussions with those that provide advocacy services the number of sessions required on average per case is assumed to be 22, which includes some time for training and awareness raising. It has been assumed the cost per hour of advocacy is £30 (in 2012-13 prices). Having taken account of demographic growth, this gives an overall cost of £16m in 2015-16. However we know that true safeguarding cases are under reported. If this position were to improve and we assume that there would be an additional 50% of referrals, costs would rise to £26m. Therefore our best estimate is that additional costs would be between £17m and £26m (midpoint £22m).

4.17 We have assumed that take up of advocacy services for assessments, reviews, carers and safeguarding will build up over time. Therefore we have assumed that in the first year 25% of the total costs are incurred, rising to 50% in year 2, 75% in year 3 and 100% in year 4.

4.18 In summary the additional costs of advocacy, and expected numbers of recipients of independent advocates, under option 2 (shown in 2010/11 prices) are:

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[64] Social Services Activity England 2012-13 (provisional) (HSCIC)

[65] Abuse of vulnerable adults in England 2012-13 (provisional) (HSCIC)

Table 16: Costs of advocacy (option 2)

Proposal	***Year1 2015/ 16***	***Year2 2016/ 17***	***Year3 2017/ 18***	***Year4 2018/ 19***	***Year5 2019/ 20***	***Year6 2020/ 21***	***Year7 2021/ 22***	***Year8 2022/ 23***	***Year9 2023/ 24***	***Year10 2024/ 25***	***Total***
Assessments	5.0	14.0	17.0	23.0	23.0	23.0	23.0	23.0	23.0	23.0	196.0
Reviews (mid)	2.0	5.0	10.0	13.0	13.0	13.0	13.0	13.0	13.0	13.0	108.0
Carers	1.0	1.0	2.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	25.0
Safeguarding (mid)	5.0	11.0	16.0	22.0	22.0	22.0	22.0	22.0	22.0	22.0	186.0
Total recurring costs	13.0	31.0	45.0	61.0	61.0	61.0	61.0	61.0	61.0	61.0	516.0

Table 17: Summary of numbers of people receiving advocacy (option 2)

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

Benefits

4.19 The Law Commission's *Adult Social Care* report (May 2011)[66] recognised that "The evidence presented by consultees[67] makes clear that advocacy services play an essential role in assisting people to make and communicate decisions, safeguarding people from abuse and neglect and helping people to enforce their rights, secure access to justice and obtain an effective remedy".

4.20 Independent advocacy can be particularly valuable when the relationship between the person being supported and the social worker has eroded (Featherstone et al, 2012)[68]. In such cases, the advocate can act as an important bridge between both parties and can help to repair damaged relationships.

4.21 The EHRC[69] has shown that "Independent advocacy has a central role to play in promoting people's safety and security without compromising their personal autonomy through supporting decision-making and communication, removing the undue interference of others and in enabling individuals to recognise the strengths and weakness, opportunities and threats of different options available to them".

4.22 SCIE's publication *Prevention in Adult Safeguarding* (May 2011)[70] concludes, "Advocacy can make a significant contribution to prevention of abuse through enabling adults at risk to become more aware of their rights and able to express their concerns".

4.23 Advocacy can help to empower people in these circumstances and working alongside other services, it can also help to identify when harm is occurring and ensure that appropriate action is taken.

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[66] The Law Commission: Adult Social Care (May 2011) pg. 185 paras 12.2 to 12.9 http://lawcommission.justice.gov.uk/docs/lc326_adult_social_care.pdf

[67] Law Commission, Adult Social Care: Consultation Analysis (2011) paras 14.2 to 14.19. http://lawcommission.justice.gov.uk/docs/ASC_Consultation_Analysis_full-version.pdf

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

[69] From Safety Net to Spring Board; EHRC (Feb 2009) http://www.equalityhumanrights.com/uploaded_files/safetynet_springboard.pdf

[70] SCIE's publication *Prevention in Adult Safeguarding* (May 2011) http://www.scie.org.uk/publications/reports/report41/files/report41.pdf

4.24 Some research has been undertaken of the cost effectiveness of advocacy services. These are described below. In interpreting them, we need to bear in mind that the context of the advocacy support being provided in each study is different and is not directly comparable to those services being proposed in this option. However, they do give an indication that advocacy services in some circumstances may be cost effective.

4.25 One study[71] looked at the economic case for advocacy interventions for parents with learning disabilities whose children are going through child protection proceedings. It suggests investing in advocacy for parents with learning disabilities is likely to offset costs in the short term and bring a positive return on investment from a wider public sector perspective. Furthermore, the research findings suggest that there could be additional quality of life improvements to the parent due to reduced anxiety, stress and depression. In addition, there may be some productivity gains from a few parents who seek and find employment as a result of the advocacy intervention, possibly due to an increase in confidence and skills in communicating with professionals. The researchers note that there are limitations to the study and therefore the results should be seen as tentative in nature, but highlight the potential of advocacy services for this group. Advocacy can help to empower people in these circumstances and working alongside other services, it can also help to identify when harm is occurring and ensure that appropriate action is taken.

4.26 Evidence from wider forms of advocacy is beginning to emerge, such as the Scottish Independence Advocacy Alliance advocacy project with Older People in Glasgow. Results from a project to look at the Social Return on Investment have not yet been published, but they have reported early findings[72] indicate that for every £1 invested in older people's advocacy, a social return of investment of £8.00 is returned.

4.27 In addition to the evidence from research studies, descriptive benefits of advocacy services from providers of advocacy support and those reported as a result of the IMCA services are:

- People have improved outcomes and experiences of care and support as advocacy services mean that more people are listened to and are in control of their lives.
- As a result of being able to express their wishes and influence the process of assessment and planning, more people with complex needs receive more appropriate care and support arrangements. Evidence from the introduction of personalisation in the form of personal budgets suggests this would result in improved outcomes for individuals[73].

4.28 Where appropriate advocacy support has not been provided, this can sometimes result in a breakdown of relationships and or the care package. Where relationships break down, the additional time required to resolve and rebuild relationships is longer than if an advocate had been involved from the beginning. Where the care package breaks down, this could result in the use of expensive emergency care provision resulting in higher costs.

4.29 In addition, a Voluntary Organisations Disability Group (VODG) report[74] makes the case for better planning resulting in better value support through a range of case studies.

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

[72] Scottish Independent Advocacy Alliance - the SROI project Pg6/7 http://www.siaa.org.uk/images/siaa_magspring13.pdf

[73] See section 1E of the Care Bill IA for benefits of personalisation via personal budgets.

[74] *Advocacy – a voice for our future: VODG*
www.vodg.org.uk/news/203/111/New-report-shows-that-after-Winterbourne-advocacy-is-a-voice-for-our-future.html

2D. CARE AND SUPPORT FOR PEOPLE IN PRISON

Background – case for change

5.1 At present, a lack of clarity in legislation means that the majority of local authorities do not consider they have a responsibility for the provision of care and support to people in prison. Evidence suggests that uncertainty about responsibilities for assessment and provision with regards to prisoners means that care needs are often not assessed, identified or provided for, both in prison and possibly on return to the community.[75][76][77] If care needs are identified by the prison, they are unlikely to be met by a local authority.

5.2 A Prison Governors Association survey, for example, found that 40% of respondents said prisoners themselves provided social care in their prison. Half of prison governors said care was provided by prison staff who were not part of healthcare services, while just 4% said local authorities provided staff to provide social care.

5.3 Some prisoners may have had care needs before they entered prison. Provision can sometimes be discontinued once an individual enters a prison setting, which may impair rehabilitation and consequently increase the risk of re-offending upon release.

5.4 Some prisoners may develop needs after they enter prison. As for individuals within the community, local authority specialist expertise should be available to undertake assessment and facilitate the provision of care in order to minimise disability, support rehabilitation and ensure satisfactory supported return to the community or transfer, if appropriate, to a residential or nursing home.

5.5 There has been recent criticism of the quality of social care provision in prisons from such bodies as Her Majesty's Chief Inspector of Prisons[78], the Prison Probation Ombudsman prison Independent Monitoring Boards in their annual report to the Secretary of State for Justice, coroners and prisoner advocacy organisations such as the Prison Reform Trust.[79]

5.6 There are considerable risks resulting from the current lack of legal clarity regarding social care provision in prisons:

- Care needs may not be assessed, identified or provided for, which can have negative effects on health and wellbeing outcomes for individuals.
- If prisoners' needs are unmet or inadequately catered for, there is a risk of litigation. Prisoners who have not had their needs appropriately assessed, or been provided with the appropriate aids and adaptations, and or for whom the prison failed to make reasonable physical and regime adjustments have successfully sued the Ministry of Justice for lack of care and there are currently several ongoing cases.
- Similarly, there is a risk that litigation may be initiated by prison officers or other prisoners who undertake care and support activities for which they are inadequately trained.[80]
- In the absence of social care provision in prison, some prison *healthcare* providers give personal care.[81][82] As this should not ordinarily be a healthcare responsibility, this can be a source of local conflict. Moreover, it represents an inappropriate use of healthcare resource.
- Lack of portability for care within the prison system can hamper a prisoner's rehabilitation. A prisoner's journey throughout the prison system is guided in part by their sentence plan,

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[75] The Law Commission, *Adult Social Care,* May 2011

[76] Her Majesty's Chief Inspectorate of Prisons, *Old and Quiet,* 2004

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

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

[79] Prison Reform Trust Press briefings, December 2010

[80] Her Majesty's Chief Inspectorate of Prisons, *Old and Quiet,* 2004

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

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

which addresses their offending behaviour. The lack of clarity regarding responsibilities for social care can be a barrier when attempting to transfer a prisoner to another prison. The receiving prison may claim it is unable to meet this prisoner's needs because the local authority in whose area the prison is situated does not perceive the prisoner's care to be their responsibility. Consequently, some prisoners do not progress satisfactorily through the prison estate as required by their sentence plan. This can increase the length of time spent in prison, increase the risk of re-offending and place an additional burden on criminal justice system resources.

- In some instances, unmet care and support needs may be manifested by poor or disruptive behaviour that can affect other prisoners and compromise control and order in the prison.

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

Policy objective

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

Summary of options

Option 1: Do nothing

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

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

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

Assessment

5.10 Under this option, the Bill clarifies that responsibility for the assessment of prisoners' care and support lies with local authorities. It would also place a duty on prisons to cooperate with local authorities in the undertaking of assessment.

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

Provision of care and support to prisoners

5.12 Under the provisions of the Bill, responsibility for providing prisoners' care and support would rest with prisons up to a specified threshold. Above this threshold, the responsibility for provision of care would rest with the local authority. This threshold would be the same eligibility threshold for people who live in the community and require care and support.

5.13 The Bill clarifies that the local authority in which lies the prison or approved premises where the individual is allocated to will be responsible for assessment and provision of care and support.

Costs and benefits of option 2

Costs

5.14 We estimate that once fully implemented, the additional costs to local authorities as a result of Option 2 will be £8.6 million per year. This comprises the costs of assessment and the costs of providing care. This is based on estimates of the number of people in prison with physical disabilities. Those in the Criminal Justice System with learning difficulties and mental illness may have severe enough problems to meet the eligibility criteria for local authority care when in the community. However, while in prison the majority of social care needs for these people are likely to be met by the prison, such as day care, food preparation and assistance with activities of daily living.

5.15 In the absence of studies on the prevalence of physical disabilities in this prison population, estimates have been made based on needs in the general community. The cost of a social care assessment is based on community care costs. The degree of care and support in prison may be different to that in the community for a person of similar disability. Costs borne by the local authority are likely to be primarily personal care, whilst the prison is likely to provide the majority of domestic care, purposeful activity and social support.

5.16 The costs of older prisoners needing social care are calculated using estimates of the prevalence of disabled older people, the prevalence of people unable to perform at least one activity of daily living and the costs of social care. The costs would include providing all people in prison over 50 with a social care assessment. It is unlikely that all prisoners over a certain age threshold would need an annual assessment. However, this figure is a worst-case scenario until we establish what proportion of prisoners will need repeat assessments and the frequency of these.

Table 17: Prevalence of need and potential costs of social care for people in prison over 50 yrs

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

[1] We expect assessments of prisoners to be less costly than assessments of people in the community since some relevant information, e.g. about informal care, will not be relevant or will already be available.
[2] Based on PSSRU estimate of 2.7m disabled older (65+) people in UK
[3] Based on analysis undertaken in the preparation of Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system

Table 18: Prevalence of need and social care costs for people in prison aged less than 50 yrs

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

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

Table 19: Total Costs

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

5.17 We anticipate that it may take some time before all necessary additional assessments are carried out, therefore we assume that costs are staggered for the first few years of implementation - £6m in Year 1, £7m in Year 2, £8m in Year 3 and then £8.6m thereafter.

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

Benefits

5.19 The clarity provided by the Bill will ensure that the respective responsibilities of prisons and local authorities for the care and support of individual prisoners are clearly set out. This should bring significant welfare gain for people with care and support needs in prisons.

5.20 Greater clarity in guidance on movement across local authority boundaries will make explicit the responsibilities regarding both the assessment and provision of care and support. This should make compliance with the prisoner’s sentence plan simpler and better enable them to address their offending behaviour.

5.21 These changes will ensure continuity of care for people leaving prison, thereby making their transition back to the community easier. Anecdotal evidence from prison governors and others suggests there are also potential benefits in terms of reducing re-offending, through improved planning and partnership working for resettlement.

2E. SAFEGUARDING ADULTS FROM ABUSE AND NEGLECT

Background – case for change

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

Policy objectives

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

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

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

Summary of policy options

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

4.34 As is made clear in discussion below, some of these proposals will be taken forward in legislation via the provisions of the Care Bill. However, many of the proposals discussed below can be taken forward in collaboration with local government and the wider care sector and do not require new legislation to be implemented. For reasons of clarity and completeness, the Safeguarding element of the Impact Assessment of the Care Bill discusses all proposals with significant impact, whether or not they are regulatory in nature. Proposals have been listed under relevant objectives in the table below, although the overall package of proposals should also be seen as interdependent and mutually reinforcing.

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

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

Option 1: Do nothing

4.36 Under a “do nothing” option the statutory No Secrets guidance would still remain extant, requiring local authorities to consider establishing a non-statutory multi-agency management committee for safeguarding and for various agencies concerned to consider whether they should be involved in its work.

4.37 In relation to the work that SABs undertake, under a ‘do nothing’ option No Secrets would again remain extant. This requires local social services authorities to coordinate local policies and procedures for the protection of adults at risk of abuse by establishing local “inter-agency” mechanisms for investigating individual cases. The guidance also suggests that social services authorities should consider establishing a multi-agency management committee as a standing committee of lead officers. These arrangements are only binding on local social services authorities, not other bodies such as NHS organisations and the police, although these bodies do have relevant powers and duties, for example, as to the quality and safety of services, to reduce crime and so on.

4.38 Doing nothing would therefore mean that the variable range of functions for local multi-agency safeguarding arrangements would continue. Evidence and assumptions about current provision and membership of SABs and associated costs is provided below. This forms a baseline to analysis of the costs and benefits of establishing SABs in legislation.

4.39 Braye et al demonstrate there is considerable variation in the operation of existing non-statutory SABs.[83] Estimates of current ongoing costs are therefore based on assumptions about the activities of an “average” board (for example the number and length of meetings).

4.40 Based on a survey from 2007, around 96% of local areas had a multi-agency adult protection committee, and a further 2% of local areas were planning to establish one imminently.[84] This was based on a survey of 144 local authorities in England and Wales, of which 133 responses were suitable for analysis.

4.41 If the 98% of the 133 authorities who reported having or planning to have a form of non-statutory safeguarding partnership in place were representative of the 152 local authorities with adult safeguarding responsibilities, then approximately 149 of these local authorities would have arrangements in place. If we assume that there is some selection bias in the responses (i.e. those authorities that responded are more likely to have boards in place), then 88% of areas have boards in place (133 out of 152). This would be a conservative estimate as discussions with experts in the field of safeguarding conclude that all areas have some arrangements in place.

4.42 Therefore, for the purpose of this Impact Assessment, we estimate that NHS and local authorities are currently involved in SABs in between 133 and 149 of a possible 152 areas.

4.43 Evidence from a survey of Police Force Areas (PFAs) by the Association of Chief Police Officers (ACPO) and the Home Office, suggests different levels of current safeguarding board attendance or activity among police forces. This found 86 boards in operation in 22 PFAs that responded to this question in the survey. These PFAs contain 91 local authorities. Assuming the same level of activity (around 95%) in the 17 PFAs that did not respond to the survey, this gives an attendance of an additional 58 boards. Therefore the baseline estimate of the number of boards in which police are involved is 144 boards (86 + 58), or approximately 95% of local authorities.

4.44 If we allow for selection bias in survey responses (it is possible that those PFAs that responded to the survey are more likely to be involved in boards), then we can derive a lower bound of SAB police attendance in which no boards are attended amongst the 22 PFAs which did not respond.

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

[84] Penhale, B., Perkins, N., Pinkney, L., Reid, D., Hussein, S. and Manthorpe, J., *Partnerships and Regulation in Adult Protection: Final Report*, Sheffield: Univ. of Sheffield, 2007.

This would imply that police would be represented on 86 of 152 boards, giving a lower bound estimate of involvement in boards of 57%.

4.45 This gives a range for current police involvement in SABs of between 57% and 95%. Home Office estimates suggest the true proportion lies towards the top of this range.

4.46 In 2011, Braye et al. found membership of between 10 and 47 agencies on existing boards. However, given it is not clear what the average number of board members is, or the number of boards with very low or high levels of membership, for the purpose of this analysis we use the mid-point estimate of this range as the best estimate of the average number of members currently on the boards.

4.47 Based on the evidence available we have estimated that:
- the mid-point of the current membership of boards is 29;
- 98% of local authorities have boards currently in place;
- police are represented on 95% of boards.

4.48 For the purpose of costing an "average" board both for current costs and any possible additional costs of options, a number of further assumptions are made regarding the operations of boards. These assumptions are presented in Annex A, as well as the hourly and daily costs of the members of boards.

4.49 There are currently around 80 serious case reviews per year, according to the NHS Information Centre. The cost of a serious case review is estimated to be approximately £48,000.[85] This data is used to inform the baseline costs of existing boards.

Current costs of membership and responsibilities of boards

4.50 The current costs of boards, based on the evidence and assumptions are presented in Table 20 below.

Table 20: Current costs of SABs

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

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

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

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

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

4.53 Under this option, local authorities and other SAB members/local public services partners working collaboratively at a local level, would determine the means by which SABs achieve these goals i.e. the specific functions that SABs should carry out.

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

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

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

Costs of preferred option

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

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

Table 21

Costs of Option 3 (£m, additional to current baseline costs described in Table 8 above)						
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Real costs						
Chair	0.09 – 0.5	0.09 – 0.5	0.09 – 0.5	0.09 – 0.5	0.09 – 0.5	0.09 – 0.5
Administration	0.06 – 0.4	0.06 – 0.4	0.06 – 0.4	0.06 – 0.4	0.06 – 0.4	0.06 – 0.4
Total real costs	0.15 – 0.9	0.15 – 0.9	0.15 – 0.9	0.15 – 0.9	0.15 – 0.9	0.15 – 0.9
Opportunity costs - members						
NHS commissioner member	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2
Local authority member	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2	0.03 – 0.2

Police member	0.11 – 0.9	0.11 – 0.9	0.11 – 0.9	0.11 – 0.9	0.11 – 0.9	0.11 – 0.9
Other Board members	0 – 2	0 – 2	0 – 2	0 – 2	0 – 2	0 - 2
Opportunity costs – responsibilities						
Serious case reviews or equivalent	3	3	3	3	3	3
Total opportunity costs	4-7	4-7	4-7	4-7	4-7	4-7
Total real and opportunity costs	4-8	4-8	4-8	4-8	4-8	4-8
****Numbers rounded so may not tally. The number of decimal places varies in relation to the precision of the estimates**						

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

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

Benefits of preferred option

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

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

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

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

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

4.63 Expert opinion from safeguarding children work cautions against creating "A defensive system that puts so much emphasis on procedures and recording that insufficient attention is given to developing and supporting the expertise to work effectively with children, young people and families".[86] Instead of "doing things right" (i.e. following procedures) the system needs to be focused on doing the right thing (i.e. checking whether children and young people are being helped)." These considerations also support the approach proposed for adult care and support where local agencies are allowed to craft local adult safeguarding priorities in line with local need.

B. Local Authority function to make enquiries

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

Option 1: Do nothing

4.65 In certain circumstances, it is possible to argue that local authorities have an existing legal duty to investigate actual or possible abuse. In particular, section 47 of the NHS and Community Care Act 1980 places a duty on local authorities to carry out an assessment of the need for community care services. In practice, this may require a local authority to conduct safeguarding enquiries, but it does not amount to a comprehensive duty to do so. Moreover, the emphasis of such an enquiry is

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[86] *The Munro Review of Child Protection: Final Report*, Munro, 2011
http://www.education.gov.uk/munroreview/downloads/8875_DfE_Munro_Report_TAGGED.pdf

to investigate the facts and establish the validity of an allegation, rather than to determine the need for specific services to prevent adverse events happening in the first place. Doing nothing therefore presents costs in terms of missing safeguarding needs and having to undertake a response to a safeguarding incident after the event. The current legal framework is also confusing for local authorities and other relevant authorities.

4.66 The NHS Information Centre estimated that there were 94,510 adult referrals in 2010-11.[87] The costs of undertaking adult enquiries are unknown, however Holmes et al (2009) estimate a range of costs for contacts, referrals and initial assessments for children. [88] These are therefore used as an indication of the amount of resource required for adult enquiries.

4.67 Using data collected the authors estimate that:

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

4.68 Using these estimates of referral numbers and the time involved, together with PSSRU estimated unit costs of adult social care workers and team leaders' time[89], we estimate the current cost of enquiries to be approximately £30 million.

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

4.69 This proposal introduces in legislation a function requiring local authorities to make enquiries. Legislations will clarify (but not change) the scope of adults who might be at risk. No additional statutory duties are put on any organisations.

4.70 This approach empowers professionals to take action when they judge necessary. To support professionals in this, guidance could be provided on the factors to be taken into account when conducting enquiries, and the kind of enquiry process that could be used. This does not remove the responsibility of individual health and care organisations for dealing internally with incidents as appropriate.

Costs of preferred option

4.71 A proxy of the current level of safeguarding boards provision is used to estimate the impact on local authorities, as described above. This would lead to an increase of between 2% and 14% in the referral activity[90] at an additional cost of between 600,000 and £4.2 million per year.

Benefits of preferred option

4.72 It is anticipated that introducing a function for local authorities to make enquiries would have the following benefits:

- Improved quality of life for individuals who are able to explore what services they might need to access to improve their situation;
- A reduction in the number of deaths from abuse as a result of consideration by individuals and local authorities of the actions that could be taken to reduce risk.

Costs and benefits of proposals A and B

4.73 In summary, we propose that legislation should:

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[87] The NHS Information Centre, *Abuse of Vulnerable Adults in England 2010-11: Final Report, Experimental Statistics,* 2012.
It should be noted that this data collection is still very new and might be subject to issues around definitions of safeguarding alerts and referrals which vary across councils and impact on data quality.

[88] Holmes, L., Munro, E. and Soper, J., *Calculating the cost and capacity implications for local authorities implementing the Laming (2009) recommendations,* Centre for Child and Family Research, 2010.

[89] http://www.pssru.ac.uk/uc/uc2011contents.htm
Team leader unit cost = £67 per hour (page 155) of client related work;
Adult social worker £53 per hour (page 156) of client related work.

[90] Note this is the range of raising the upper bound of this is the % increase required to raise 88% to 100% (i.e. 100%-88%/88% = 14%).

- Specify that core membership for SABs should comprise the local social services authority, NHS commissioners and the police, with flexible local arrangements for additional appointments of members.
- Set out strategic responsibilities for SABs focussing on outcomes. The primary objective should be to protect adults in vulnerable situations by providing leadership and co-ordination of multi-agency working at local level, reducing the risk of abuse and neglect.
- Confer on local authorities a function enabling them to make enquiries.

4.74 We believe that this approach provides for proportionate risk-based regulation, while ensuring that local boards are able to determine their activities and priorities, based on the needs of the local population.

4.75 A statutory but flexible approach should strengthen the governance of local safeguarding practices and facilitate improvement in weaker areas, without undermining areas where effective partnership working is already in place.

4.76 Requiring SABs to set out a plan for achieving local safeguarding outcomes, and then to report on how successful they were in achieving these outcomes, will support local transparency and accountability, devolving power and financial autonomy to local government and community groups.

4.77 By strengthening the statutory safeguarding arrangements, we expect that there will be a reduction in the number of people subject to abuse and, where abuse does occur, for it to be detected earlier.

4.78 There is evidence to suggest that those who suffer abuse have a lower health-related quality of life, compared to those who do not. A small study from Norway found that women who had suffered threats of and actual physical and psychological abuse had statistically significant lower scores than women in the general population, across all domains of the SF-36, a widely used health-related quality of life measurement tool.[91]

4.79 Another study of older women finds they are significantly more likely to report physical and mental health problems if they have suffered abuse than if they have not.[92]

4.80 Using a systematic review of the prevalence of abuse in general populations[93] it can be estimated that around 6% of people aged 65 and over suffer significant abuse per annum. Using ONS population data[94] this means approximately 480,000 older people are subject to abuse each year. Experimental “Abuse of Vulnerable Adults” data from the Information Centre estimates that there were around 46,000 “completed referrals for abuse” among those aged 65 and over in 2010-11.[95] At a maximum, this equates to 65,000 people, but is likely to be less. Therefore, it is likely that there is a large amount of undetected abuse among older people. In addition, this does not include undetected abuse among adults aged 18 to 65.

4.81 The Department of Health values a year of life at perfect health (a quality adjusted life-year or QALY) at £60,000 when being compared to the opportunity cost of health care expenditure, or £25,000 when costs are expressed in financial terms. This estimate is calculated using the societal value of a statistical life estimated to be £1.8 million, based on evidence from the Department of Transport. When health benefits, improved quality-of-life or lives saved are a likely outcome of a policy initiative, quantifying and monetising benefits in this way enables comparisons with costs, to understand whether the likely benefits of a policy will outweigh the costs.

4.82 The net additional costs of the preferred option is approximately £7m per annum. If between 3 and 5 additional lives were saved per annum as a result of the new arrangements, this would offset the additional costs. Equally as quality-of-life is between 1/5 and 3/5 lower for those who suffer from

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[91] Alsaker, K. et al, “Low health-related quality of life among abused women”, Quality of Life Research 15: 959 – 965, 2006.

[92] Fisher, B. and Reagan, S., “The Extent and Frequency of Abuse in the Lives of Older Women and Their Relationship With Health Outcomes”, The Gerontologist 46: 2 200 – 209, 2005.

[93] Cooper, C. et al, “The prevalence of elder abuse and neglect: a systematic review”, Age and Ageing 37: 151 – 160, 2008.

[94] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-229866

[95] The NHS Information Centre, *Abuse of Vulnerable Adults in England 2010-11: Final Report, Experimental Statistics,* 2012.

abuse, taking people out of abuse would save between 160 and 240 QALYs. Given the potential level of undetected abuse, it seems reasonable to expect more effective safeguarding arrangements to offset these additional costs.

Summary impact

Need for improved inter-agency collaboration on safeguarding

4.83 Abuse is never acceptable but where abuse does take place, it needs to be addressed quickly and effectively. There have been several examples across the health and care system of individual and institutional failures in safeguarding adults in vulnerable situations. Abuse against adults affects a significant proportion of the adult population. A study carried out by the National Centre for Social Research and King's College London reported that 342,400 older people (aged 66+) in the community had been subject to abuse (about 4%).[96] As the proportion of older people in the population increases, in the future potentially a higher proportion of the population will be at risk.

4.84 Abuse can significantly affect other groups. In March 2012, the NHS Information Centre published a provisional report 'Abuse of Vulnerable Adults in England 2010/11'.[97] The data showed that 61% of safeguarding referrals related to people aged 65 and over. 49% of the referrals reported were related to adults who were classified as having a 'physical disability', 23% were for adults classified as client type 'mental health', 20% were for adults classified as client type 'learning disability' and 7% of referrals reported were for 'other vulnerable adults'.

4.85 One of the key challenges around effective safeguarding work is the high number of different organisations and agencies involved. The data from the NHS Information Centre also gives an overview of the range of settings where abuse is found. The majority of referrals cited the adult's own home (41%) or a residential care home (34%) as the location where the alleged abuse took place.[98]

4.86 A strong multi-agency and multi-disciplinary approach is therefore essential, as many agencies potentially hold information about adults in vulnerable situations and they each have different roles in preventing or protecting against abuse and neglect. A theme from many reported cases of abuse is that there can be a lack of effective coordination and cooperation of the different agencies involved in safeguarding. More effective coordination and cooperation between the agencies involved could have prevented, or reduced the impact, of some of the abuse. However, a multi-agency approach can be challenging to coordinate, as it requires a shared sense of objectives across organisations with different sets of priorities, structures, ways or working, personnel, and skills.

4.87 No Secrets is the basis for current adult protection arrangements. As statutory guidance, it is binding on local authorities. *No Secrets* policy guidance requires local authorities with social services responsibilities to lead and coordinate multi-agency involvement in safeguarding adults, and encourages the formation of multi-agency management committees. These arrangements have become non-statutory 'safeguarding adults boards' in most areas. Based on the most recent quantitative study, in 2007 around 96% of local areas had a multi-agency adult protection committee, and a further 2% of local areas were planning to establish one imminently.[99]

4.88 However, beyond the general legal duties for cooperation between local authorities, the police and the NHS, there is no other legislation that makes No Secrets binding on other identified key partner agencies. This represents one way in which the 'patchwork' of adult safeguarding legislation and guidance has created an unclear picture as to the roles and responsibilities of individuals and organisations working in adult safeguarding.

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[96] National Centre for Social Research and King's College, *UK study of abuse and neglect of older people: qualitative findings*, August 2007.
[97] The NHS Information Centre, *Abuse of Vulnerable Adults in England 2010-11: Final Report, Experimental Statistics,* 2012.
It should be noted that this data collection is still very new and might be subject to issues around definitions of safeguarding alerts and referrals which vary across councils and impact on data quality.
[98] This sums to greater than 100% as some referrals involved multiple locations of alleged abuse.
[99] Penhale, B., Perkins, N, Pinkney, L., Reid, D., Hussein, S. and Manthorpe, J., *Partnerships and Regulation in Adult Protection: Final Report,* Sheffield: Univ. of Sheffield, 2007.

4.89 The Law Commission endorsed the findings of the Commission for Social Care Inspection (the predecessor organisation to CQC), that 'the existing legal framework for adult protection is neither systematic nor coordinated, reflecting the sporadic development of safeguarding policy over the last 25 years.' Instead, there is a wider range of law, including general community care legislation and guidance, the Mental Health Act 1983, the Mental Capacity Act 2005, the Safeguarding Vulnerable Groups Act 2006, the inherent jurisdiction of the High Court and the civil and criminal justice system.

4.90 In the Report on the Consultation on the Review of No Secrets, 68% of the respondents to the question 'do we need new legislation' supported the need for new legislation.[100] 92% of respondents who replied to the question 'should Safeguarding Boards be placed on a statutory footing' wanted statutory safeguarding boards. In the report, the need for new legislation and statutory safeguarding adults boards was reinforced by examples from respondents - for instance:

- current arrangements meant that adult safeguarding was given low prioritisation and agencies were not cooperating effectively;
- staff were not attending safeguarding meetings or were fielding junior staff who could not make decisions;
- organisations were not sharing information and working in silos; and
- agencies were shifting responsibility to other agencies, or were not contributing towards the cost of the safeguarding system.

Key Assumptions/Sensitivities/Risks

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

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

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

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

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[100] Department of Health, *Safeguarding Adults: Report on the consultation on the review of 'No Secrets'*, 2009.

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

Estimated unit costs of those involved in safeguarding boards

(As discussed above there is evidence of a range of safeguarding arrangements in local areas, so the unit costs and associated staff grades are intended to represent an average.[101])

- NHS costs per day – provider and commissioner – Agenda for Change Band 8b[102], estimated at around £390 per day.
- Local authority member estimated at £311 per day.
- Cost of chair – assumed to be equivalent cost to a Director of Adult Social Services, estimated at £747 per day.
- The cost per hour of a senior police officer (including on-costs) is estimated to be £60.15. This is an uprated calculation of the cost of police time, estimated in 2008 using the ASHE (Annualised Survey of Hours and Earnings) and CIPFA (Chartered Institute of Public Finance and Accounting). This estimate is widely used in Impact Assessments of policies with impacts on the police. This hourly rate is equivalent to approximately £480 per day.
- Administration for the board is undertaken by a third of a whole-time equivalent administrative member of staff, estimated salary per annum including on-costs is £45,000. So cost of staff for admin of the board is £15,000. Additional non-workforce administrative costs of £5000 are added.
- An estimate of £160 per day is used for the cost of other agencies represented on the boards.
- Travel and subsistence is estimated at around 5% of the running costs of the boards.

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

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

[102] http://www.nhscareers.nhs.uk/details/default.aspx?id=766

2F. IMPLEMENTATION OF LEGAL REFORM

Background – case for change

7.1 As noted in the first section of this impact assessment (paragraphs 1.1 to 1.27), the legal framework for adult care and support is in need of major reform.

7.2 The section outlines specific issues, costs and savings arising from implementation of a new legal framework.

Policy objective

7.3 As previously discussed in earlier sections.

Summary of options

Option 1: Do nothing

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

Benefits

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

Option 2: Consolidation and reform of the law

7.6 As outlined above, the legal framework for adult social care consists of a patchwork of legislation, which makes interpretation and application of the law complex and time consuming. Consolidation and simplification would be best achieved by establishing a unified statute for care and support.

7.7 The intended effect of reform is to create a clear, cohesive, modern and accessible scheme for adult social care, which sets out the responsibilities of Local Authorities and the rights of individuals.

7.8 These aims will be achieved by addressing a number of shortcomings of the existing law relating to adult social care, which have given rise to the problems identified earlier. Through this impact assessment, we are assessing the impact of changes to the adult social care statute per se; as set out in the Care Bill that takes forward a number of policy initiatives. Further details of the policy proposals are set out in the preceding sections 1 through 15 of this impact assessment.

Benefits

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

Everyday activities of social workers

7.10 We assume that simplifying the law will reduce the administrative burden on social workers, as they will spend less time interpreting legal issues.

7.11 There is little data that expressly covers the time spent by social workers considering legal issues, but research does indicate that they currently spend a great deal of time on administrative work and less time on face-to-face contact with care users. In fact, a 2009 UNISON survey indicated that 73% of the social workers that were surveyed felt that that they had either “insufficient” or “very insufficient” time available to spend with care users.

7.12 In addition, evidence in literature also suggests that social workers are generally lacking in legal knowledge and that they do not devote much of their time to legal matters.103 The Law Commission highlighted one survey that suggests that many social workers do not use the law at all in practice. It reports that law has a “low profile in daily practice” and that there is a lack of “overt use of the law to inform practice.” This results in a dependency on policy and procedure rather than professional discretion.[104] Some researchers have suggested that this lack of legal knowledge, along with the uncertainty created by the complexity of the law, may cause more defensive administrative practices in response to the threat of litigation.[105]

7.13 The Law Commission concluded that this lack of legal knowledge results in delays to processes. Evidence suggests that these delays may be due to a social worker’s lack of knowledge of potential alternative solutions, or may be the result of social workers lacking the confidence in their knowledge to assert themselves when consulting with other professionals.[106]

7.14 The Law Commission acknowledged that it would be artificial to single out particular elements in social workers’ daily tasks, rather it proposed that a certain percentage of time spent on that task will henceforth be saved as a result of a reformed legal framework. Therefore, the Commission attempted to quantify the savings in social workers’ daily tasks by making a global estimate of the sort of overall time savings brought about by a clearer and simpler legal structure. Its assumptions were tested through consultation and, although no written responses dealt with the accuracy or otherwise of this approach, in consultation meetings with social workers and social worker managers, it was broadly accepted as reasonable.

7.15 Acknowledging that it is comparatively crude, the Law Commission assumed that social workers will save between 20 and 45 minutes a week on average and that this equates to between 0.68% and 1.54% of their time annually.[107] The Law Commission believes that the time savings for frontline social workers might be towards the bottom of this range, whereas it might be higher for more senior managers. This will produce savings to Local Authorities of between £7.6 million and £17.1 million per year. As set out in Table 22 below, our mid-point best estimate of these savings is £12.4 million.

Table 22: every day activities of social workers

	Low	Best	High
Number of full-time equivalent (FTE) social workers working in adult social care		**21,240**[108]	
Average total salary to employer (including on costs)		**£52,363**[109]	
Time savings	**0.68%**	**1.111%**	**1.54%**
Annual savings	**£7,562,893**	**£12,345,310**	**£17,127,728**

Complaints

7.16 It is reasonable to assume that a more modern legal structure will reduce the number of complaints, and therefore the cost to Local Authorities to investigate them, and the Law

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[103] Law Commission, *Adult Social Care Law Reform Impact Assessment,* 2011

[104] Braye, S. et al., “Beyond the Classroom: Learning Social Work Law in Practice”, *Journal of Social Work 332, 330,* 2007.

[105] Postle, K., ‘Between the Idea and the Reality: ambiguities and tension in care managers’ work”*, British Journal of Social Work* 335, 2002.

[106] McDonald, A. et al., “Barriers to Retaining and Using Professional Knowledge in Local Authority Social Work Practice with Adults in the UK”, *British Journal of Social Work 1370, 1379,* 2002*.*

[107] Law Commission, *Adult Social Care Law Reform Impact Assessment,* 2011.

[108] Skills for Care, *We gather information about the social care sector: the state of adult social care workforce in England,* 2010.

[109] This is the average salary of social workers in 2010/11 plus direct overhead costs – PSSRU, *Unit Costs of Health and Social Care,* 2011

Commission agrees with this.[110] It is not expected that the reduction in complaints will occur as a result of a significant difference in the decisions made about service provision in the new system, but rather, because there will be fewer mistakes. Clearer and simpler law will mean that better decisions are made with fewer mistakes, which will in turn result in fewer complaints.

7.17 According to estimates from the National Audit Office, in 2006/07, adult social care complaints cost Local Authorities in England approximately £14.4 million (at 2010/11 prices).[111] This figure relates to the internal costs to Local Authorities of dealing with complaints, excluding the costs of complaints to the LGO.

7.18 The reduction in complaints is likely to be modest. Reductions are most likely to occur in relation to complaints about inaccurate advice, lack of information or expenses/costs. Such complaints account for approximately 21% of complaints to Local Authorities.[112] Based on this figure, the Law Commission assumed a saving of between 5%-15% of complaints with a best estimate of 10%. This would result in savings of between £0.7 million and £2.2 million per year, based on the calculated 2010/11 figures. As set out in table 2 in Annex 1 below, our mid-point best estimate of these savings is £1.45 million.

7.19 In addition to the costs to Local Authorities, there are also costs of complaints to the LGO. The Law Commission noted that in 2009/10 the LGO considered 836 complaints relating to adult social care and estimated that almost £0.5 million was spent investigating these complaints.

7.20 The Law Commission estimated that there will also be reductions to the number of complaints that the LGO receives. This is likely to be a smaller reduction than the one seen to Local Authorities, as it is likely that complaints involving mistaken decisions are resolved earlier in the complaints process when the local authority is still investigating it. The Law Commission estimated that there would be a reduction of between 2.5%-7.5%. Based on this, the saving to the LGO would be between £0.01 million and £0.04 million per year (see table 22 below).

7.21 The total annual savings relating to complaints would be between £0.71 million and £2.24 million per year – mid-point best estimate £1.475 million – comprising £1.45 million to Local Authorities and £0.025 million to the LGO. Local authority complaints processes are often lengthy, with a number of escalation stages and individuals do not always submit their complaints immediately after an incident has occurred. As a result, we assume that these savings will not start to be realised until 2016/17, assuming the provisions of the reformed law come into effect in 2015/16.

Table 23: Savings from fewer complaints

	Low	Best	High
Reduction in complaints to local authorities	**5%**	**10%**	**15%**
Spending on complaints by local authorities in England		**£14,000,000**[113]	
Savings to local authorities	**£720,000**	**£1,440,000**	**£2,160,000**
Reduction in complaints to the LGO	**2.5%**	**5%**	**7.5%**
Spending on complaints by LGO		**£539,816**	
Savings to the LGO	**£12,495**	**£26,991**	**£40,486**
Annual savings	**£733,495**	**£1,466,991**	**£2,200,486**

Litigation

7.22 We believe that simplifying the law will lead to a reduction in the level of litigation that Local Authorities face, as fewer mistakes will be made as a result of misinterpretation. This will result in savings to Local Authorities of the direct costs of litigation (including counsel's fees and court costs) together with savings in legal advisors' time.

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[110] *Ibid*

[111] National Audit Office, *Feeding Back? Learning from Complaints Handling in Health and Social Care,* 2008. This figure has been calculated using the GDP deflator of 2.71%.

[112] *Ibid*

[113] National Audit Office, *Feeding Back? Learning from Complaints Handling in Health and Social Care,* 2008. This figure has been calculated using the GDP deflator of 2.71%.

7.23 In its consultation Impact Assessment, the Law Commission suggested that between 30% and 40% of the time spent by lawyers working on adult social care would be saved by simpler law.[114] Few comments were received to support or refute this, although one local authority did contest it, on the basis that most of its work was on safeguarding and Court of Protection work, rather than mainstream adult social care.

7.24 In order to make a more accurate assumption, the Law Commission conducted research on the social care workload of the higher courts to establish the proportion of issues litigated that would not have been litigated if the system that it proposed was introduced. This was a small-scale study, which took account of social care cases in the Court of Appeal and Administrative Court for the year from July 2009. There were twelve adult social care cases in this period and it was concluded that in eight of them their proposals for law reform would have made no difference. Of the remaining four, one would not have been litigated at all, and it was estimated that a third of the issues in the other three cases would not have to be litigated.[115] This gives a figure of 16.67%.

7.25 The Law Commission therefore revised its original assumption and suggested that between 10% and 20% - best estimate 15% - of the time spent by lawyers working on adult social care would be saved by simpler law, although this is assumed to be a modest estimate. However, the Commission did note that this potentially underestimates the savings, as where litigation would still have been necessary consolidation and clearer provisions would have made the process quicker.

7.26 Based on the Law Commission's estimates, this would result in savings of between £0.8 million and £1.7 million per year for Local Authorities. As set out in table NN in Annex 1 below, our mid-point best estimate of these savings is £1.25 million.

7.27 It is estimated that around £3.8 million per year is spent on the direct costs of litigation, which includes counsel's fees, court costs and other disbursement, and time spent by non-legal staff on the litigation.[116] Assuming that litigation is reduced by between 10% and 20%, the savings would be between £0.4 million and £0.8 million per year. As set out in table 4 in Annex 1 below, our mid-point best estimate of these savings is £0.6 million.

7.28 As the litigation process is lengthy and it takes a long time for cases to be referred to court, we assume that the savings in relation to reduced litigation will not start to be realised until 2016/17, assuming provisions of the reformed law come into effect in 2015/16.

7.29 A recent report by Counsel and Care found that one of the top three issues that older people, their families and carers contacted Counsel and Care's advice service about in 2010 was concerns about being given incorrect and often illegal advice by their council.[117] It has also been suggested that social workers' lack of confidence in applying the law can result in delays to the assessment and care planning processes.[118] Similarly, a lack of legal knowledge can lead to an over-reliance on limited statutory powers or local authority policies, meaning that individuals do not always get the most appropriate support to meet their needs.

7.30 Creating a clearer and simpler statute with clearer and simpler practice guidance will mean that fewer mistakes are made and will prevent wrong advice being given. This will not only result in fewer complaints and less litigation, as outlined above, but will also improve the outcomes and experiences of care users, carers and their families.

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[114] Law Commission, *Adult Social Care: A Consultation Paper,* 2010

[115] Law Commission, *Adult Social Care Law Reform Impact Assessment,* 2011.

[116] *Ibid.*

[117] Bernard, C., *Care Concerns 2010: "No Help Here"*, 2011

[118] Law Commission, *Adult Social Care Law Reform Impact Assessment,* 2011

Table 24: savings from less lawyers' time required (in England)

	Low	Best	High
Number of FTE lawyers working on adult social care		**182**[119]	
Median salary (excluding on-costs)		**£45,400**[120]	
Time savings	**10%**	**15%**	**20%**
Annual savings	**£823,280**		**£1,652,560**

Table 25: savings from lower litigation costs (in England and Wales)

	Low	Best	High
Costs met by public funds		**£2,480,000**[121]	
Costs agreed and met by opponents		**£746,000**[122]	
Social workers		**£570,000**[123]	
Time savings	**10%**	**15%**	**20%**
Annual savings	**£379,600**	**£569,400**	**£759,200**

Costs

7.31 There will be some transitional costs resulting from the changes to the legal framework and these relate, in the main, to the training of social workers.

7.32 It will be necessary to train existing social workers in the new law. The Law Commission suggested that there would be a requirement of four days of training per adult social worker in the first year and a further two days in the second year.[124] From then onwards, normal continuing training requirements would fulfil any ongoing need.

7.33 Assuming that an external trainer conducted the training and that Local Authorities used their own premises and therefore incurred no costs for venue hire, the total cost for training would be between £4.2 million and £8.5 million over the two years. Broken down, this would mean costs to Local Authorities of between £2.8 million and £5.7 million in the first year and between £1.4 million and £2.8 million in the second (see Table 25 below). As set out in table 25 below, we have used midpoint best estimates of £4.25 million in the first year and £2.1 million in the second. These costs would be reduced considerably if the training were to be conducted in-house.

Table 26: costs of training social workers (in England)

	Low	Best	High
Number of qualified social workers (headcount) working in adult social care		**23545**[125]	
Number of days training (year 1)		**4**[126]	
Number of days training (year 2)		**2**	
Costs of trainer (per day)[127]	**£600**	**£900**	**£1,200**
Training costs (year 1)	**£2,825,400**	**£4,238,100**	**£5,650,800**
Training costs (year 2)	**£1,412,700**	**£2,119,050**	**£2,825,400**
Total training costs	**£4,238,100**	**£6,357,150**	**£8,476,200**

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

[120] Law Commission, *Adult Social Care Law Reform Impact Assessment,* 2011.

[121] *Ibid.*

[122] Legal Services Commission, *Statistical Information 2009-10,* 2010

[123] Law Commission, *Adult Social Care Law Reform Impact Assessment,* 2011

[124] *Ibid.*

[125] Skills for Care, *We gather information about the social care sector: the state of adult social care workforce in England*, 2010.

[126] Law Commission, *Adult Social Care Law Reform Impact Assessment,* 2011

[127] Assumes that there will be approximately 20 social workers per training session.

7.34 The opportunity costs of social workers' time whilst completing this training would be £25.1 million in the first year and £12.5 million in the second (see Table 27 below).

Table 27: opportunity costs of training social workers (in England)

Number of qualified social workers (headcount) working in adult social care	23,545
Hourly cost of social workers	£38[128]
Number of days training (year 1)	4
Number of days training (year 2)	2
Opportunity costs (year 1)	£25,051,880
Opportunity costs (year 2)	£12,525,940
Total opportunity costs	£37,577,820

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

7.36 There will be some additional opportunity costs associated with the training of other local authority staff, such as those who work in call centres. This training would only be required on a one-off basis and it is reasonable to assume that it could be provided in-house by a social worker. Although it has not been possible to make accurate calculations for the costs of this training, we estimate that it will cost between £1 million and £2.5 million. We have used a mid-point best estimate of £1.75 million. Our assumptions and calculations are set out in Table 28 below.

Table 28: opportunity costs of training other local authority staff (in England)

	Low	Best	High
Hourly cost of social worker (trainer)		**£38**	
Hourly cost of those being trained		**£20**[129]	
Number of staff per session		**25**	
Number of hours per session		**3**	
Number of sessions per local authority	**4**	**7**	**10**
Cost per local authority	**£6,456**	**£11,298**	**£16,140**
Total training costs	**£981,312**	**£1,717,296**	**£2,453,280**

7.37 It is not expected that there will be any ongoing costs from law reform.

Key assumptions/sensitivities/risks

Key assumptions

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

- In 2009/10, there were 21,240 social workers working in adult social care in England who would be affected by our proposals. We have assumed that these numbers will remain constant over the next five years.
- In 2010/11, the total average cost to a local authority of one social worker is £52,363 and that includes the mean basic salary and on-costs.

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[128] PSSRU, *Unit Costs of Health and Social Care,* 2011.

[129] Assumes that the average salary of those being trained is £15,000.

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

Sensitivities

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

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

Risks

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

- The number of social workers who require training. There is also some uncertainty about the extent of training that social workers will require on the reformed law.
- The transitional costs as in-house training may attract additional costs.
- The extent of the reduction in time spent by social workers on legislative matters.
- The number of complaints and the amount of litigation that will be avoided, as well as the savings to Local Authorities from a reduction in complaints about adult social care.

Specific Impacts

One-In Two-Out

7.41 The proposals for reform of the law set out in this Impact Assessment do not fall within the scope of the Government's "One-In Two-Out" (OITO) rule which states that "any regulatory measure that is expected to result in a direct net cost to business must be offset by deregulatory measures providing savings to business of at least double that amount."

7.42 These proposals do not involve any additional regulatory measures which impose costs on business or civil society and therefore are considered out of scope of this rule. The proposed reforms to the law which will undergo pre-legislative scrutiny relate to the responsibilities of Local Authorities and other public sector partners for planning and commissioning of adult social care services and for meeting the needs of their local population.

Equality

7.43 Our overarching aim in reforming the law on adult social care is to establish a clear, coherent and effective system for adult social care in England. This will help to clarify the rights of care users and carers.

7.44 In reforming the adult social care statute, we will also look to remove discriminatory and outdated language, such as the definition of a disabled person under section 29 of the National Assistance Act 1948.

7.45 As part of its review of the adult social care statute, the Law Commission consulted with a wide range of care user and carers, including older people, people with learning disabilities, deafblind adults, people with physical disabilities, alcohol misusers, and people with mental health problems. The Law Commission also participated in several events with representative organisations and user-led organisations.

7.46 Further information regarding impacts on equalities is provided in the corresponding equality and rights analysis.

Health and well-being

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

Human rights

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

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

Justice system

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

Equality analysis

Title: Care Bill (Part 1)

This equality analysis sits alongside the Impact Assessment for Care and Support Legal Reform (May 2013). Both the Impact Assessment and Equality Analysis cover the majority of provisions set within the Care Bill. This includes the general responsibilities of local authorities (including provision of information), assessment and eligibility provisions, direct payments, and safeguarding.

Issues not covered as they are subject to separate Impact Assessments and Equality Analyses are:

- Funding reform of Care and Support
- Deferred Payments
- Market Oversight

What are the intended outcomes of this work?

Creation of a single, modern statute for social care for the first time; the introduction of a national eligibility threshold in social care for the first time to eradicate unfair postcode lottery; to enable reform of funding system, in line with recommendations of the Commission on Funding Reform.

Who will be affected?

People who use care and support, carers and their families.

Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment. For more information, see the current DH Transparency Plan.*

What evidence have you considered?

The Department has drawn on a wide array of sources to develop the Bill, number of which factored in equalities. Some of these include:

- The Law Commission Report into adult social care;
- Caring For Our Future: reforming care and support – equality analysis
- Consultation responses to the draft Care and Support Bill
- Consultation events to support the development of the draft Bill
- Outcomes of Social Care for Adults (interim findings, 2011)
- Care for older people: projected expenditure to 2022 on social care and continuing health care for England's older population (Nuffield Trust)
- Disability policy and practice – applying the social model of disability (Barnes and Mercer, 2004)
- Laing & Buisson, Care of Elderly People Market Survey, 2012/13
- Audit Commission reports, *Improving Value For Money in Adult Social Care*, June 2011 and its earlier report *Management of personal budgets*
- In Control, *Personal Outcomes Evaluation Tool*
- Models of Multi-agency Services for Transition to Adult Services for Disabled Young People and Those with Complex Health Needs: Impact and costs (SPRU, 2010)
- National evaluation of the DH integrated care pilots
- Evaluation of the Individual Budgets Pilot programme
- Putting people first: measuring progress, 2009
- Ipsos Mori, Users of Social Care Budgets, July 2011
- PSSRU, Survey of Fair Access to Care Services (FACS) assessment criteria among local authorities in England, 2012.

- Commission for Social Care Inspection, Cutting the cake fairly, 2008.
- Fairer Care Funding, The Report of the Commission on Funding of Care and Support, 2011.
- Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own, June 2008 and Recognised, valued and supported: next steps for the Carers Strategy, November 2010.
- Arksey, H. et al, *Carers' aspirations and decisions around work and retirement,* Department for Work and Pensions, Research Report 290, 2005.

Disability

The Bill is designed to help overturn traditional approaches to disability, and implement a social model approach. This is underpinned by approaches which seek to place greater power in the hands of all service users, including disabled people. This is exemplified in setting out rights for everyone to have a personal budget, as well as consolidating the law around disabled people being able to access direct payments. This will give people greater control over the services they use.

In addition, the Bill places a duty on local authorities to ensure that in the future adults who use social care services (including disabled people) will have control over their day to day life.

Sex

The most relevant aspect to gender equality is around the provisions in the Bill for carers. As the last UK census outlines, there are approximately 6 million carers in the UK, and the vast majority of these are women. The Bill for the first time sets out a number of rights for carers for the first time, placing a series of duties on local authorities to meet a carer's needs for support. This should have a significant benefit for a large number of women.

Race

No evidence suggests that there will be inequitable impact on race.

One aspect of the Bill which we have aligned with language barriers is that of Information and Advice. The Bill places a duty upon Local Authorities to provide Information and Advice to service users in the 'appropriate' format, to ensure accessibility. Guidance will set out that this may also include needing to ensure this information is provided in different languages.

Age

The Bill includes a number of provisions that benefit various age ranges, and have been demanded by a number of groups including Age UK.

The Bill will benefit older age ranges as they are the group who predominantly require both domiciliary and residential care. As the Bill seeks to improve both levels of access, and improve how services are provided, this is the group that will benefit mostly as a result of the policy measures.

However, it is not only older people who will benefit as a result of the Bill. In addition disabled adults aged 18-65 will benefit from improved services.

Furthermore children who are approaching adulthood will benefit from new transition provisions, which will allow adult social care services to assess these children. This will help smooth the transition for disabled children into adulthood.

Gender reassignment (including transgender)

No inequitable impacts upon people who have undergone gender reassignment, nor transgender people, have been identified.

Sexual orientation

No inequitable impacts relating to sexual orientation have been identified.

Religion or belief

No inequitable impacts have been identified.

Pregnancy and maternity

No inequitable impacts upon pregnancy and maternity have been identified.

Carers

The Care Bill for the first time enshrines rights for carers in legislation. This includes a duty upon local authorities to provide support for carers.

Other identified groups

No other identified groups.

Engagement and involvement

Was this work subject to the requirements of the cross-government Code of Practice on Consultation?
Yes

How have you engaged stakeholders in gathering evidence or testing the evidence available?

The draft Bill and supporting documents (including impact assessments and equality analyses) were made available on the DH website and a dedicated website.

The introduction to the draft Bill explained the legislative proposals, the consultation process and how to respond, and the clauses are written in plain English. We produced an EasyRead version of the draft Bill itself, as well as fact sheets and Q&A. All documents were available to download or purchase from The Stationary Office.

On publication, we wrote to stakeholder organisations encouraging them to respond. To raise awareness and encourage debate, the Department used Twitter to summarise the care and support clauses and provide updates on the engagement process.

Comments were invited by 19 October 2012 either by email, post or via the dedicated website which invited responses to individual clauses and to a series of thematic questions. Over 1,000 written comments were received from a total of 433 unique respondents, including 246 organisations and 187 individuals.

The consultation process included extensive engagement activity to facilitate meaningful discussion and dialogue with identified stakeholder groups and to encourage those who use care and support, their carers and families and health and social care professionals to contribute their views. Where possible, we made use of existing events, meetings and networks.

Due to the nature of Social Care, and its interface with traditionally disempowered groups (older people; disabled people; carers) it was considered that a large degree of engagement with such groups to generate a robust evidence base was essential. Hence qualitative evidence with these groups was generated through this consultation, which was underpinned by an easy read version of the Bill.

Pre-legislative scrutiny, which was conducted by a joint committee, provided further opportunity to engage and understand potential impacts as a wide number of witnesses gave evidence on the Bill.

How have you engaged stakeholders in testing the policy or programme proposals?

We have engaged with stakeholders around policy design on all policy aspects. We have done this through a number of events, as well as through formal consultation and ongoing engagement. Through these mechanisms stakeholders have been able to provide feedback and suggestions as to how policy should be designed.
We will continue to engage with a broad range of stakeholders to further test and gather feedback around how best to implement the policies set out in the Bill. Again, we will do this through a number of formal and informal mechanisms.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

The table below sets out the groups that were engaged in specific engagement events in 2012. The specific date is set in the right hand column.

These were in effect sessions to generate rich qualitative evidence and data. A note was taken at each meeting, and these notes fed in directly to the development of the Bill.

Action on Elder Abuse	9 August
Action on Elder Abuse conference	10 October
Ambassadors' Forum	11 October
Association of Directors of Adult Social Services (ADASS) and Local Government Association	13 September
ADASS Executive	13 September
Care and Support Alliance	25 July 10 September 18 September 17 October
Care and Support Transformation Group	19 July
Care Quality Commission	17 September
Carers in Hertfordshire	27 September
English Community Care Association	8 August
Health and Social Care Partnership and Carers UK	14 September
Henry Spink Foundation	2 October
Law Commission	1 October
Lincolnshire County Council	5 October
Local Government Association	7 August
London ADASS regional branch meeting	12 October
Luton Older People's Partnership Board	18 October
Mencap	21 September
National Care Forum	8 August
National Conference on Adult Services	22-24 October
National Housing Federation	11 October
No Recourse to Public Funds network	19 October
Regional Action West Midlands/Regional Voices Birmingham	16 October
Regional Safeguarding Adults Leads event (Yorkshire and the Humber)	26 September
Right to Control Advisory Group	14 October
Royal College of Nursing	11 October

Royal National Institute for the Blind	23 October
Safeguarding Advisory Group	25 September
Sense	12 October
Skills for Care Board Meeting	27 September
Skills for Care Employer Forum	4 September
Society of Local Authority Chief Executives	4 October
Standing Commission on Carers	3 October
Standing Commission on Carers Cross-Government Programme Board	16 October
Surrey Care Association annual conference	9 October
Think Local Act Personal	26 September
Think Local Act Personal Co-Production Group	24 September
Voluntary Organisations Disability Group	20 September
Voluntary sector joint learning event (London)	11 September
Voluntary sector joint learning event (Sheffield)	1 October

Summary of Analysis

The evidence considered in the development of the Bill, as well as the extensive consultation and engagement work, has pointed to very substantial positive impacts of this Bill, for a range of groups who have traditionally been disempowered.

The greatest benefits will be derived by older people requiring care; disabled adults; and carers.

One possible negative impact we have identified is around the provision of information about care and support by local authorities. This will need to be provided in appropriate formats and in the language required by local people. The duty placed upon local authorities is to provide information that is sufficient for its local population.

The evidence suggests that the Bill will eradicate the current differential impact that exists due to the inconsistency of eligibility threshold across the country. This is part of the rationale for the Bill.

Eliminate discrimination, harassment and victimisation

Through the Bill adult safeguarding boards are being strengthened. This will contribute to the prevention of discrimination, harassment and victimisation by tightening procedures to detect harm done to adults in need of care and support.

There is a general duty of well-being on local authorities. This strengthens the local authority's role and responsibility to ensure that adults receiving social care are protected from all forms of abuse and neglect.

Advance equality of opportunity

The Bill seeks to treat all groups equally. We believe it does this, and does not feature any discriminatory aspect.

The services that the Bill addresses are bound by the existing Equality Duty. Care and Support services must therefore have due regard to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

We believe there is equal opportunity for all those with care needs to receive care and support.

Promote good relations between groups

Not directly applicable. The Bill deals with the rights of individuals. However, a knock-on effect of better services, better outcomes, and better equality of access to services should be to improve community cohesion.

What is the overall impact?

The overall impact will be to increase equality of access to services, both in socio-economic and geographical/regional terms. By increasing this equality, and thus driving up levels of service provision, there should be improved outcomes across the board. Furthermore, these outcomes should improve across all groups.

Addressing the impact on equalities

Most notable areas of addressing current impacts on equalities:

- Rights and provisions for carers, which will have greatest benefits for women;
- Improved access to services, and strengthened offer around social care services, will have greatest benefits for older people and disabled adults.

Action planning for improvement

We do not believe there are any gaps around equalities that we have not identified or considered over the previous 18 months, as the Bill has been developed. On this basis we do not believe or propose to develop an action plan. We will however monitor on an ongoing basis the impacts on different groups of the policies contained within the Bill, and how they are implemented from 2015.

Please give an outline of your next steps based on the challenges and opportunities you have identified:

- The Bill aims to mitigate any negative impacts around lack of accessibility due to language barriers by requiring local authorities to provide information that is ‘accessible’ to the local population.
- The Department of Health will strengthen this by providing guidance to local authorities to ensure that information is provided in appropriate formats and languages, which will enable accessibility to services.

For the record

Name of person who carried out this assessment: Edward Scully

Date assessment completed: 19 April 2013

Name of responsible Director/Director General: Shaun Gallagher

Date assessment was signed: 7 May 2013