

<b>Title:</b> Quality, care providers and the workforce Accompanying IA for the White Paper "Caring for our future: reforming care and support"  <b>IA No:</b> 7063  <b>Lead department or agency:</b> Department of Health  <b>Other departments or agencies:</b>	<b>Impact Assessment (IA)</b>		
	<b>Date:</b> 03/07/2012		
	<b>Stage:</b> Consultation		
	<b>Source of intervention:</b> Domestic		
	<b>Type of measure:</b> Primary legislation		
<b>Contact for enquiries:</b> Caroline Allnutt, Department of Health			

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

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

The quality of care and support is variable between local authority areas and between providers, requiring improvement in the interests of the welfare of individuals, families and carers and to support greater equity. Reasons for this problem include: lack of sufficient numbers of adequately skilled and motivated staff in the care sector, cases of commissioning which focus too much on short-term savings at the expense of wider value for money and the sustainability of the local market, lack of information for users on the quality of available support and for providers on what services are needed locally and a lack of coherent legal framework to promote co-ordination between local agencies on safeguarding.

**What are the policy objectives and the intended effects?**

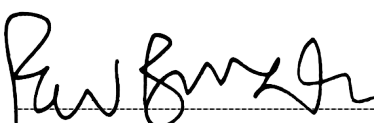
To improve outcomes for users and carers through improved quality of care throughout the country, covering the full range of care services, for all those in need of care and support. This will require a more highly skilled, better led workforce with lower turnover and vacancy rates, more strategic commissioning which incentivises quality and value for money, greater support for local authorities to understand and facilitate their local market, a more joined up approach to safeguarding to protect those in vulnerable circumstances, readily available and transparent information about the quality of care offered by providers, and a stronger role for users and carers in assessing, defining and demanding higher quality.

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

As set out in the White Paper, take forward the following policy proposals: Strengthen system leadership and develop a quality framework; measure quality by piloting clinical audit in social care and extending NICE quality standards; make available provider-level information including user feedback; work with the sector to improve commissioning information and skills; support and enable increased user assessment of services, including training for local Healthwatch organisations; place a market shaping duty on local authorities; support local authorities to understand their local market better; enable development of leaders who can implement joined up approaches across health and care; build workforce capacity to meet future demographic challenges; increase capability and skills for all working in adult social care; clarify through legislation the core membership and responsibilities of Safeguarding Adults Boards (SABs); clarify in legislation that local authorities should have a function to make enquiries about adult protection cases.

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

Does implementation go beyond minimum EU requirements?			No		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	<b>Micro</b> No	<b>&lt; 20</b> No	<b>Small</b> No	<b>Medium</b> No	<b>Large</b> No
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)			<b>Traded:</b>		<b>Non-traded:</b>

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

# Summary: Analysis & Evidence

# Policy Option 1

## Description:

### FULL ECONOMIC ASSESSMENT

Price Base Year 2010	PV Base Year 2012	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate:

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	9	20	172

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

The monetised ongoing costs cover mainly costs to DH and providers for training, audit and data collection (should providers choose to participate) and to statutory agencies in collaborating on safeguarding. The transition costs relate to set-up costs of IT and of initial support from an independent body on market shaping.

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

To the extent that the number of apprenticeships in social care rise faster than under the do nothing option, there will be opportunity costs relating to the training. There are likely to be opportunity costs for the time taken by providers to carry out clinical audits, should they choose to participate. In addition, costs to make improvements to practice resulting from clinical audit, NICE guidelines or better commissioning incurred by commissioners and/or providers have not been monetised.

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

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

Savings to providers from using online recruitment.

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

The benefits comprise mainly welfare gains for care users and carers from improved quality of care, improved safeguarding and improved choice of service innovation.

There are also benefits to employers from improved productivity, including savings from reduced turnover; and benefits to staff in terms of higher rewards.

#### Key assumptions/sensitivities/risks

Discount rate (%) 3.5

Higher quality could potentially lead to increased demand for care and possibly to increased costs of care. Information provision may not be as effective as envisaged. Users may not value quality as highly as other factors eg location. Commissioners and users may have difficult choices between funding higher quality or greater volume of care. There may be little change in provision of services as a result of market shaping. Staff may not see the benefits of upskilling.

### BUSINESS ASSESSMENT (Option 1)

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

## Summary of impact

1. This Impact Assessment provides analysis of the relative costs and benefits of proposals set out in the White Paper “Caring for our future: reforming care and support”. In particular it discusses the impact of proposals set out in Chapters 5 and 6 of the White Paper relating to the following policy areas:
  - Quality
  - Market shaping
  - The care workforce
  - Local safeguarding arrangements
2. This is a consultation stage Impact Assessment. Some of the proposals discussed below will need to be implemented through primary legislation. The Government has announced its intention to publish a draft Care and Support Bill for pre-legislative scrutiny, after which formal introduction to Parliament will follow as soon as possible. Regulatory proposals – by which we mean those that require new legislation – will be subject to a further final stage Impact Assessment when the Care and Support Bill is formally introduced into Parliament.
3. For completeness, we want our stakeholders and Parliament to be clear on the potential costs and benefits for the totality of the White Paper proposals, not just those that require new legislation. Therefore, alongside proposed regulatory measures, this Impact Assessment also sets out the potential costs and benefits of those proposals that do not require new legislation to be implemented. For those non-legislative proposals, we have made clear below where the Government plans to undertake further testing, development and engagement with the sector.
4. For the purposes of this Impact Assessment, we have assumed that proposals that require legislative enactment will be implemented from 2015/16, although this is subject to the passage of legislation through Parliament. Other proposals that do not require enactment through primary legislation may be implemented earlier. This is made clear below.
5. The proposals set out in the White Paper have been developed in the light of publication of two important reports that made recommendations on how to reform care and support. The Law Commission’s report on adult social care recommended bringing together all the different elements of social care law into a single, modern adult social care statute.<sup>1</sup> The Commission on Funding for Care and Support, chaired by Andrew Dilnot, made recommendations for changes to how the cost of care is shared between the individual and the state as a partnership, as well as other important recommendations for the reform of care and support.<sup>2</sup>
6. In September 2011, the Government launched *Caring for our future: shared ambitions for care and support*, a period of focused engagement with people who use care and support, carers, local councils, care providers, and the voluntary sector. The aim of the engagement was to bring together the recommendations from the Law Commission and the Commission on Funding of Care and Support with the Government’s *Vision for Adult Social Care*, and to discuss priorities for reform with stakeholders.
7. This extensive engagement has informed development and appraisal of the proposals set out in the White Paper. Engagement took the form of meetings, conferences, workshops and correspondence. Events were led by members of the care and support community and involved the input of users, carers, local councils, care providers and the voluntary sector. In addition, the Department of Health has also used literature reviews and workshops held with academic experts to inform policy development. This process has enabled us to discuss the effectiveness of a range of policy options and associated costs and benefits.
8. The proposals discussed within this Impact Assessment do not fall within the scope of the Government’s “One-In One-Out” (OIOO) rule which states that “no new primary or secondary UK legislation which imposes costs on business or civil society organisations can be brought in without

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<sup>1</sup> [http://www.justice.gov.uk/lawcommission/docs/lc326\\_adult\\_social\\_care.pdf](http://www.justice.gov.uk/lawcommission/docs/lc326_adult_social_care.pdf)

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

the identification of existing regulation with an equivalent value (in terms of net costs to business) which can be removed.”

9. These proposals do not involve any additional regulatory measures that impose costs on business or civil society. The changes to the law proposed in the White Paper relate to the responsibilities of local authorities and other public sector partners for planning and commissioning of adult social care services and for meeting the needs of their local population.
10. The primary objective of these proposals is to improve outcomes for individuals, enabling people to maintain independence, health and wellbeing. However, we believe that proposals aimed at enhancing diversity of service provision and improving user choice will also offer positive opportunities for independent and civil society organisations. As set out below, responding to the proposals set out in the White Paper may result in additional costs for providers of social care services but we anticipate that they will also open up business opportunities and that providers will choose to participate where they perceive that the benefits of doing so outweigh the costs. Ultimately, it will be for providers of social care to decide on a voluntary basis how they wish to respond.
11. Table 1 below provides a summary of impact for each proposal discussed in this Impact Assessment.

Table 1: Summary of impact

Policy Theme	Proposal	Is legislation required?	Implementation date	Costs fall to	Benefits accrue to
Quality	A: Strengthen system leadership and develop a quality framework	No	2012/13	DH	Councils, providers and care users
	B: Improve the evidence base by piloting clinical audit in social care and extending NICE quality standards	No	2012/13	DH	Care users and providers
	C: Make available provider-level information including user feedback	No	2012/13	DH and providers	Care users and providers
	D: Work with the sector to improve commissioning information and skills, to focus on quality, outcomes and value for money	No	2012/13	DH and providers	Councils
	E: Support and enable increased user assessment of services, including training for local Healthwatch organisations	No	2013/14	DH	Care users
Market Shaping	F: Reinforce in legislation local authorities' role to shape their local market	Yes	2015/16	None	Care users
	G: Support local authorities to understand their local market better	No	2012	DH and councils	Care users
Workforce	H: (i) Establish a Leadership Forum	No	March 2013	DH	Care users
	H: (ii) Align the Health and Social Care Leadership Qualities Frameworks	No	Summer 2012	DH	Care users
	I: (i) Expand the apprenticeship programme for adult social care	No	Ongoing over 5 years	DH	Care users and providers
	I: (ii) Develop an online tool to support recruitment	No	2014	DH and providers	Care users, providers, people considering a career in social care
	I: (iii) Expand the Care Ambassador role	No	Ongoing from 2012	DH, providers and people using Care Ambassadors	Care users and providers
	J: (i) Develop a sector compact	No	2013	DH	Care users
	J: (ii) Develop a Personal Assistant (PA) index	No	2014	DH	Care users
	J: (iii) Support the development of the PA workforce	No	2012	DH	Care users
Safeguarding	K: Clarify through legislation the core membership and responsibilities of Safeguarding Adults Boards	Yes	2015/16	Councils, police and NHS	Care users, communities, councils, police and NHS
	L: Clarify in legislation that local authorities should have a function to make enquiries about adult protection cases	Yes	2015/16	Councils, police and NHS	Care users, communities, councils, police and NHS

12. Table 2 below sets out how we estimate costs will be profiled over a ten year appraisal period. Year 1 of implementation is assumed to be 2012/13.
13. The table shows the costs by the organisation that incurs the expenditure. Where costs are incurred by providers, we expect that some of these costs will at some point be passed on to local authority commissioners and self-funders. Some of the costs shown in the table are opportunity costs rather than new cash costs. As benefits described are generally unmonetised they have not been included in this table.

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

Proposal	Agent	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total	Average annual
<b>Quality</b>													
Transition Cost Total	DH	2.1	1.1	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.3	0.3
Transition Cost Total	Providers	0.0	0.4	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.7	0.2
Recurrent Cost Total	DH	0.1	0.6	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	42.8	4.3
Recurrent Cost Total	Providers	0.0	4.5	6.8	6.8	9.0	9.0	9.0	9.0	9.0	9.0	72.0	7.2
<b>Workforce</b>													
Transition Cost Total	DH	1.6	1.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.1	
Transition Cost Total	Providers												
Recurrent Cost Total	DH	1.0	2.1	2.3	2.2	2.2	1.2	1.2	1.2	1.2	1.2	15.8	1.6
Recurrent Cost Total	Providers	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.2	0.1
<b>Markets</b>													
Transition Cost Total	DH	0.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	
Recurrent Cost Total	Councils	1.1	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	6.1	0.6
<b>Safeguarding</b>													
Recurrent Cost Total	Public sector	0.0	0.0	0.0	8.4	8.4	8.4	8.4	8.4	8.4	8.4	58.8	5.9
<b>Total</b>													
<b>Transition Cost</b>	DH	4.3	2.6	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.1	
<b>Transition Cost</b>	Providers	0.0	0.4	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.7	
<b>Recurring Cost</b>	DH	1.1	2.7	7.6	7.5	7.5	6.5	6.5	6.5	6.5	6.5	58.6	5.9
<b>Recurring Cost</b>	Providers	0.0	4.6	6.9	6.9	9.1	9.1	9.1	9.1	9.1	9.1	73.2	7.3
<b>Recurring Cost</b>	Public sector (inc Councils)	1.1	0.6	0.6	9.0	9.0	9.0	9.0	9.0	9.0	9.0	64.9	6.5
<b>Total Cost</b>		6.5	10.9	16.5	23.3	25.5	24.5	24.5	24.5	24.5	24.5	205.5	
<b>Cost (Discounted)</b>		6.5	10.5	15.4	21.0	22.3	20.7	20.0	19.3	18.6	18.0	172.3	

\*The table shows averages based on unrounded estimates of the costs of proposals.

## Evidence Base (for summary sheets)

This section includes:

- I. Consideration of the problem
- II. Rationale for intervention
- III. Policy objectives and proposals
  - *Quality*
  - *Market Shaping*
  - *The care workforce*
  - *Local safeguarding arrangements*
- IV. Impact of policy proposals
- V. Risks
- VI. Specific impact tests

### I. CONSIDERATION OF THE PROBLEM

#### **Overview**

1. Evidence suggests that the quality, outcomes and user experience related to care and support in England varies widely between local authority areas and between providers, with a corresponding impact on both user satisfaction and general perceptions of care services. There is a need to improve quality in the interests of the welfare of individuals, families and carers and to improve levels of equity across the country.<sup>3</sup>
2. In some areas, local commissioners are not giving providers sufficient encouragement and incentives to improve quality. Recent evidence suggests that there are examples where commissioners are focusing too much on short-term savings rather than seeking to ensure the sustainability of the market or achieve optimum value for money.
3. High quality care needs to be underpinned by a capable, effective and responsive workforce. We know that the current care and support system will need to adapt in the face of increasing and changing demand. This will require an increase in workforce capacity and an empowered, confident and capable workforce to support more integrated and personalised approaches to care. Improving outcomes and user experience will also mean looking beyond traditional social care services with a broader focus on community capacity and early intervention to support independence and prevent or postpone care needs.<sup>4</sup>
4. It is difficult for individuals to judge quality when they choose care unless they receive transparent data to support that choice. Data (including user experience data) is routinely collected by providers but is rarely made available in a format that enables comparisons to inform user choice and commissioning.<sup>5</sup>
5. Improvements to the quality of care should reduce the incidence of abuse. It is not possible to eliminate this risk altogether but rigorous systems are required to reduce the level of abuse and to deal with it when it arises. There needs to be greater incentives and clarity about the way in which public services collaborate and work together to ensure that people in the most vulnerable situations are safe.

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<sup>3</sup> Other important equity issues are discussed in the corresponding Impact Assessment “Assessment, eligibility and portability for care users and carers”.

<sup>4</sup> These themes are explored in more depth in the corresponding White Paper Impact Assessment “Independence, choice and control”.

<sup>5</sup> Proposals to ensure better access to information are discussed in greater detail in the corresponding Impact Assessment “Independence, choice and control” and are closely linked to proposals for improving quality and supporting the development of the care market.

## ***Evidence of poor and variable user satisfaction and perceptions of quality***

6. There is evidence that the quality, outcomes and user experience related to care and support in England varies widely and that experience of care and support compares unfavourably with some peer countries.
7. Recent surveys suggest variable satisfaction levels within England from both those using care and support and those caring for others. For example:
  - A survey of adult care users found that the proportion of people who were either extremely or very satisfied with the care and support they received varied by authority from the 54% at the 10<sup>th</sup> percentile to 67% at 90<sup>th</sup> percentile. The survey also showed that the proportion of people feeling in control of their lives – a key outcome for users – varied from 69% at the 10<sup>th</sup> percentile to 80% at the 90<sup>th</sup> percentile.<sup>6</sup>
  - A survey of adult carers in England found that the proportion of carers who were either extremely or very satisfied with the care and support they and the person they cared for had received over the last 12 months ranged by authority from 42% at the 10<sup>th</sup> percentile to 62% at 90<sup>th</sup> percentile. On the key outcome for care support – carers' quality of life – the proportion of those who rated their quality of life as “good” or better varied from 30% at the 10<sup>th</sup> percentile to 41% at 90<sup>th</sup> percentile.<sup>7</sup>
8. Although the estimates above are subject to confidence intervals, those at the lower end of these ranges are significantly different to those at the upper end. This suggests that the quality of care at the lower end of these ranges should be improved.
9. Data from the National Indicator Set (NIS) for 2010-11<sup>8</sup> also shows wide variation between local authorities and regions in a number of priority areas, which has an impact on outcomes for users. For example:
  - For personalisation, the proportion of people who use care and carers receiving self-directed support varies across authorities from 15% at the 10<sup>th</sup> percentile to 45% at the 90<sup>th</sup> percentile;
  - For re-ablement, the proportion of people over 65 receiving a re-ablement service who were still at home three months after discharge ranged from 72% at the 10<sup>th</sup> percentile to 95% at the 90<sup>th</sup> percentile;
  - The proportion of people with learning disabilities living in settled accommodation varied from 40% at the 10<sup>th</sup> percentile to 80% at the 90<sup>th</sup> percentile;
  - The proportion of people with learning disabilities in paid employment varied from 2% at the 10<sup>th</sup> percentile to 17% at the 90<sup>th</sup> percentile.
10. Once again, at the lower end of these ranges the quality of care provided should be improved.
11. In a survey on perceptions of care services in European countries, out of 29 countries where the survey took place, the UK ranked:<sup>9</sup>
  - 22<sup>nd</sup> for perceived availability of professional care at home;
  - 26<sup>th</sup> for perceived availability of appropriate help and long term care; and
  - 20<sup>th</sup> for overall positive experience of care services.
12. These comparisons will be affected by differences in expectations of individuals in different countries but are nevertheless significant.

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<sup>6</sup> Personal Social Services Adult Social Care Survey, 2010-11.

<sup>7</sup> Personal Social Services Survey of Adult Carers in England, 2009-10.

<sup>8</sup> Information Centre - National Indicator Set 2010-11.

<sup>9</sup> European Commission report, “Health and long-term care in the European Union”, Special Eurobarometer 283/ Wave 67.3 – TNS Opinion & Social, 2007.



## ***The importance of an effective market***

13. The Government's *Vision for Adult Social Care*<sup>10</sup> stated that the diversity and complexity of people's care and support needs are best met by a broad and dynamic range of organisations, able to offer flexible and innovative care to individuals, carers and their families. This ambition has been further supported by the policy direction set out in the *Open Public Services* White Paper, which stated that every public service should be open to a diverse range of providers, so services better meet people's needs and individuals have increased choice and control.<sup>11</sup>
14. 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.
15. 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 everyone 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.<sup>12</sup> 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.<sup>13</sup>
  - 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 83% 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.<sup>14</sup>
  - 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.
16. 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.

## ***Underlying causes of the problem***

17. 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 are discussed in greater detail below and include:
- A. Variation in the quality of care purchased as a result of commissioning strategies
  - B. A lack of information on both the demand and supply side
  - C. Challenges around the recruitment and retention of staff

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<sup>10</sup> Department of Health, *A Vision for Adult Social Care: Capable Communities and Active Citizens*, 2010.

<sup>11</sup> Cabinet Office, *Open Public Services*, 2011.

<sup>12</sup> Evidence given to the Dilnot Commission by charities representing carers.

<sup>13</sup> Further proposals to improve support for carers are discussed in the corresponding Impact Assessment "Assessment, eligibility and portability for care users and carers".

<sup>14</sup> Laing & Buisson, *Domiciliary Care UK Market Report*, 2010 and Laing & Buisson, *Care of Elderly People Market Survey*, 2010.

18. Quality care also means ensuring that people in vulnerable situations are appropriately protected from abuse and neglect. There is therefore a need for improved inter-agency collaboration on safeguarding. This is discussed in Section D below.

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

19. Local authorities have responsibility for ensuring a diversity of quality care and support for their local population. Local authorities continue to commission and purchase care directly for some individuals, but in the future increasing numbers of people will be commissioning their own care (either as a self-funder or via a direct payment or personal budget). Local authorities therefore need to facilitate their local market in the interests of people receiving state support and those funding their own care.

20. Although there are examples of good practice, feedback from the *Caring for our future* engagement suggested that the relationship between commissioners and care providers is not working as well as it should. We consistently heard that local authorities need to improve their understanding of their local market and improve their relationships with all those supplying care services. Discussion focused on the quality of commissioning, where the following themes emerged:

- Providers are concerned that commissioners are focusing too much on price rather than individual outcomes and value for money. During the engagement, some providers specifically raised concerns over commissioners using their purchasing power to drive down prices. Local authorities have a responsibility to deliver value for money for local taxpayers but there were concerns that focusing too much on cost can undermine the potential for innovation and flexibility. There were also examples cited of local authorities too tightly prescribing the care package that an individual should receive. As a result, many felt that the services commissioned were often not the best ones to meet the needs of individuals and carers.
- Feedback suggested that more strategic and integrated commissioning, linking to wider areas such as health and housing services, would offer the opportunity to deliver a greater diversity of better quality services. Many providers said that they were keen to expand their services, but were currently unable to do so because of commissioning practices. Better information would also need to be available, alongside the successful roll-out of personal budgets.

21. The conclusions drawn through the engagement are supported by other existing sources of evidence. For example, 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.<sup>15</sup>

22. The CQC report from December 2009 also found:

- One quarter of local authorities are rated only adequate in terms of giving people choice and control over their care;
- A third of local authorities must do more to care for people with dignity and respect;
- One in six providers is rated only poor or adequate.

23. 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.

24. Evidence suggests the variation highlighted during the engagement is likely to result from a lack of knowledge about the quality of services being commissioned, a lack of resources or skills to improve commissioning strategies and a focus on obtaining the best price rather than the best quality when commissioning services.<sup>16 17</sup> This can mean a focus on short-term savings at the expense of the long-term sustainability of the market, with negative implications for choice, quality and efficiency.

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<sup>15</sup> Care Quality Commission, “Our statement on the quality of adult social care”, December 2009.

<sup>16</sup> BUPA, *A Fair Deal Report*, 2011.

25. Such practices – for example, specifying particular tasks to be carried out in a 10 to 15 minute homecare appointment – risk stripping people of their dignity and jeopardising their human rights. They also risk disempowering care workers. This was highlighted in the Equality and Human Rights Commission’s inquiry into homecare.<sup>18</sup>

#### B. A lack of information on both the demand and supply side

26. It is difficult for commissioners and care users to judge what constitutes quality without sufficient access to transparent data at provider level. Feedback from the *Caring for our future* engagement indicated that a lack of comparable information 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, including how satisfied users and carers were. Anecdotally local authorities report that data (including user experience data) is routinely collected at provider level but is rarely published or made available in a format that enables comparisons to inform choice and commissioning.

27. 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.

28. It is also beneficial for providers of services to have information about what services people want. Poor market signals between the demand and supply side could mean that there are gaps in provision. There were concerns expressed during the engagement that providers have continued to offer the same services and have not diversified in order to better respond to people’s needs. There are also limited opportunities for care users and carers to feed back their experiences and views once they have chosen a service, which means that providers cannot always respond when problems arise.

29. Further proposals for making available high quality accessible information to both commissioners and individuals are also discussed in more detail in the corresponding Impact Assessment “Independence, choice and control”.

#### C. Recruitment and retention of the care workforce

30. Demographic changes mean that future demand for care and support is expected to rise significantly. In parallel, people’s expectations of how public services should be delivered are changing – people expect services to be joined up and organised around their needs, not to be organised around structures.<sup>19</sup>

31. However, to meet these demographic pressures, there is also a need to increase workforce capacity, both paid and unpaid. Care and support is labour intensive and depends a great deal on one-to-one personal care. Skills for Care estimate that the number of jobs in the adult social care sector will need to grow from around 1.6 million in 2010, to 2.8 million in 2025 in order to meet projected demand for social care support.<sup>20</sup> This represents an increase of around 56%. In addition, social care already faces consistent challenges from recruitment and retention of workers, with a vacancy rate of 3.2%, over twice the average for other sectors.<sup>21</sup>

32. High turnover can have adverse implications for employers, employees and care users. For employers, there are high costs associated with frequent recruitment. Skills for Care has estimated

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<sup>17</sup> OFT, *Competition and Commissioning in public services*, 1314, undertaken by PwC, March 2011.

<sup>18</sup> Equalities and Human Rights Commission, *Close to home: an inquiry into older people and human rights in home care*, 2011.

<sup>19</sup> Supporting individuals to prevent or delay care needs and to access integrated, personalised support is discussed in more detail in the corresponding Impact Assessment “Independence, choice and control”.

<sup>20</sup> Skills for Care, *The size and structure of the adult social care sector and workforce in England 2011*, August 2011.

<sup>21</sup> Skills For Care, *The state of the Adult Social Care Workforce in England 2010*, May 2010.

that it costs over £3,000 to recruit and induct a new employee. With a turnover of over 18%, this implies nearly 320,000 posts recruited costing over £1.1 billion per annum. High turnover can mean that employers are not incentivised to invest in training when trained staff are likely to move to other employers or leave the sector. It can be cheaper to employ a member of staff already trained by another employer, than to invest in the training of their own staff.<sup>22</sup> For users and carers, high turnover can have a detrimental effect on their experience of care – it is difficult to build effective working relationships and new staff will be unaware of their particular preferences.

33. Problems with recruitment and retention can directly affect the quality of care offered. A lack of suitable recruits to the sector can compromise quality where employers are pressured to meet demand. A study of the recruitment and retention of a care workforce for older people showed that whilst providers have a clear notion of what they require in a recruit, around four in ten reported occasionally or often having to hire people knowing that they lack the full set of desired attributes. 30% of care homes and over 40% of home care providers surveyed reported that they had to put up with poor staff performance because of recruitment and retention problems “at least sometimes”.<sup>23</sup>
34. As well as addressing capacity issues, there is also a need to develop further workforce capability to drive up the quality of care offered. This will also underpin other initiatives to prevent or delay the need for care, improve quality and achieve personalised, integrated care, as set out in the corresponding Impact Assessment “Independence, choice and control”.
35. Currently the sector invests in its leaders through incremental leadership, largely based around training and qualifications at individual and employer level. However, to meet the challenges facing the sector in coming years it will also be necessary to focus on strategic leadership for transformation, ensuring the sector is able to deliver integrated, personalised services meeting the higher demands of care. This will be required at all levels from front-line and registered managers through to Chief Executives.
36. Research evidence suggests that interactions with, and the characteristics of, the workforce play a large part in the overall quality of care.<sup>24</sup> In terms of workforce characteristics, higher perceived levels of quality by users were associated with:
  - a highly trained workforce;
  - a higher proportion of care workers employed with the provider for over five years;
  - providers who could easily recruit and retain suitable care workers;
  - a higher proportion of workers having guaranteed working hours;
  - higher female wage rate relative to local rates;
  - reasonable travel time allowed between visits.
37. However, adult social care is not currently perceived as an attractive career opportunity and can often be portrayed negatively within the media. Employers and care workers involved in the Longitudinal Care Study pointed to assumptions about care work and the low status of social care in society as wider barriers to applying and remaining in work in the sector.<sup>25</sup> Evidence shows that there is a reliance on a workforce that is largely female, with low qualifications, social and family networks with links to the sector, very locally based and with very specific working time preferences.<sup>26</sup> Provider practices and employment conditions that can appeal beyond this group need to be put in place if the sector is to meet the challenges posed by the growth demands.

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<sup>22</sup> Qureshi, H. and McNay, M., DH Social Care Workforce Research Initiative 2007-2011, Overview and Synthesis.

<sup>23</sup> Rubery et al, *The Recruitment and Retention of a Care Workforce for Older People*, February 2011.

<sup>24</sup> Netten, A., Jones, K. and Sandhu, S., “Provider and Care Workforce Influences in Quality of Home Care Services in England”, *Journal of Aging and Social Policy* 19(3), 2007. Also, COI’s desk-based research.

<sup>25</sup> Social Care Workforce Research Unit, *Caring for our future: shared ambitions for Care and Support, Quality and Workforce Seminar Paper*, King’s College London, <sup>December 2011</sup>.

<sup>26</sup> Rubery et al, *The Recruitment and Retention of a Care Workforce for Older People*, February 2011.

#### D. Need for improved inter-agency collaboration on safeguarding

38. Quality care also means ensuring that people in vulnerable situations are appropriately protected from harm. A care and support system built upon the promotion and protection of people's human rights will lower the risk of people experiencing neglect and abuse.
39. 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%).<sup>27</sup> As the proportion of older people in the population increases, in the future potentially a higher proportion of the population will be at risk.
40. 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'.<sup>28</sup> 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'.
41. 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.<sup>29</sup>
42. 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.
43. *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.<sup>30</sup>
44. 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.
45. 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

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<sup>27</sup> National Centre for Social Research and King's College, *UK study of abuse and neglect of older people: qualitative findings*, August 2007.

<sup>28</sup> 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.

<sup>29</sup> This sums to greater than 100% as some referrals involved multiple locations of alleged abuse.

<sup>30</sup> 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.

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.

46. 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.<sup>31</sup> 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.

## II. **RATIONALE FOR INTERVENTION**

47. Both commissioners and providers are aware that users of services want good quality care, which best meets their outcomes. However, evidence of varying quality and levels of user satisfaction suggests that additional intervention is required if the system is to meet expectations in terms of quality and to reduce disparities in the quality of care and availability of information and advice. During the *Caring for our future* engagement, we heard that there is a lack of common understanding about which parts of the care and support system were responsible for maintaining and improving quality.
48. Specifically, action is required to incentivise commissioners (both local authorities and individuals) to influence and demand higher quality provision, with an increased focus on improving outcomes and value for money rather than short-term costs. The role of local government in facilitating local care markets needs to be clarified in legislation and local authorities should be encouraged to improve their understanding of their local market, to ensure the best outcomes for individuals.
49. Intervention is required to bring about greater transparency and increased access to high quality information. This will empower commissioners (both local authorities and individuals) to make informed choices to maximise their welfare and independence. It will also bring about greater incentives for providers to improve the range and quality of their services. This also includes more and better information being available to the supply side, both in terms of what users want, and their feedback so that providers know where to improve. This could potentially aid further diversification of local markets.
50. Higher quality of care requires an effective workforce. Quality for users is likely to depend not only on the skills and knowledge of the workforce, both paid and unpaid, but also on the capacity of the workforce to meet the needs of each individual it serves. Intervention is therefore required to support employers to improve recruitment and retention rates within the care sector, to ensure that there is sufficient workforce capability and capacity to meet increasing and changing demand. The changes that are necessary cannot be achieved by the large number of varied social care organisations without an initial central steer. Therefore, Government intervention is likely to be required to stimulate and shape the market to enable it to create incentives to support change. This includes the development of new and integrated roles and further development and support for personal assistants (PAs). This will require leadership development at all levels across the sector to deliver integrated, personalised services.
51. Government and public services clearly have a responsibility in ensuring that people in the most vulnerable situations are safe. The consultation on *No Secrets* and the Law Commission's report

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<sup>31</sup> Department of Health, *Safeguarding Adults: Report on the consultation on the review of 'No Secrets'*, 2009.

indicated a common consensus that legislation is needed 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.

### **III. POLICY OBJECTIVES AND PROPOSALS**

52. The overarching policy objective is to secure better outcomes and improved experience of care for users and carers. The provision of higher and more consistent quality of care and the supply of an effective workforce will be critical to delivering those objectives and the Government has set out several measures in the White Paper in support of this aim, as listed below.
53. Experts within and outside the Department of Health were consulted as part of the policy proposals formulation presented in these Impact Assessments. 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.
54. As is made clear in discussion below, some of these proposals will be taken forward in legislation via the provisions of the draft Care and Support 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 Impact Assessments relating to the White Paper *Caring for our future* discuss all proposals with significant impact, whether or not they are regulatory in nature. Although proposals have been listed under relevant objectives in the table below, the overall package of proposals should also be seen as interdependent and mutually reinforcing.

Policy Theme	Objectives	Policy Proposals
Quality	<ul style="list-style-type: none"> <li>• Commissioners, providers and the regulator work effectively together with input from users and carers to ensure high levels of user satisfaction and confidence that care providers will strive for excellence and that inadequate care will be dealt with quickly;</li> <li>• Commissioners focus on quality of outcomes and value for money, working in collaboration with care providers and people who use care and support;</li> <li>• Individuals, commissioners and providers will be able to access clear, transparent information about the quality of the care they are buying or providing, including the experience of users and carers. Individuals, families and carers can therefore make informed choices and there are incentives for providers to drive continuous quality improvement;</li> <li>• There is a clearer role for users and carers to feed back and demand higher quality of outcomes and experience.</li> </ul>	<ul style="list-style-type: none"> <li>A. Strengthen system leadership and develop a quality framework;</li> <li>B. Improve the evidence base by piloting clinical audit in social care and extending NICE quality standards;</li> <li>C. Make available provider-level information including user feedback;</li> <li>D. Work with the sector to improve commissioning information and skills, to focus on quality, outcomes and value for money;</li> <li>E. Support and enable increased user assessment of services, including training for local Healthwatch organisations.</li> </ul>
Market shaping	<ul style="list-style-type: none"> <li>• Local authorities facilitate a diverse and vibrant market to deliver a range of high quality, responsive services.</li> </ul>	<ul style="list-style-type: none"> <li>F. Reinforce in legislation local authorities' role to shape their local market;</li> <li>G. Support local authorities to understand their local market better.</li> </ul>
Workforce	<ul style="list-style-type: none"> <li>• The care workforce is led by confident and capable leaders able to lead across integrated services;</li> <li>• Care and support is seen as an attractive career opportunity and the social care workforce has lower turnover and vacancy rates;</li> <li>• The care workforce is highly skilled and capable of meeting increased demand and higher expectations of high quality, personalised and integrated care.</li> </ul>	<ul style="list-style-type: none"> <li>H. Enable development of leaders who can implement whole systems approaches across health and care;</li> <li>I. Build workforce capacity to meet future demographic challenges;</li> <li>J. Increase capability and skills for all working in adult social care.</li> </ul>
Safeguarding	<ul style="list-style-type: none"> <li>• Local organisations understand their role, work together, support each other and share expertise to deliver better safeguarding outcomes for adults in vulnerable situations.</li> </ul>	<ul style="list-style-type: none"> <li>K. Clarify through legislation the core membership and responsibilities of Safeguarding Adults Boards (SABs);</li> <li>L. Clarify in legislation that local authorities should have a function to make enquiries about adult protection cases.</li> </ul>



#### IV. IMPACT OF POLICY PROPOSALS

55. The impact of implementing this package of policy proposals is discussed in further detail below. Each group of policy proposals is assessed against the baseline “do nothing” option.

##### Quality Proposals

###### *Objectives*

- Commissioners, providers and the regulator work effectively together with input from users and carers;
- Commissioning focuses on quality of outcomes and value for money;
- Individuals, commissioners and providers will be able to access clear, transparent information about the quality of the care;
- There is a clearer role for users and carers to feed back and demand higher quality of outcomes and experience.

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

56. There is some agreement and recognition of what good quality looks like in social care. Sector-led improvement and the Adult Social Care Outcomes Framework provide some focus for measuring and improving the quality of care at a national and local authority level. However, there are some gaps identified in the framework for which measures are currently being developed. The Department of Health could also look at mechanisms for providing greater system leadership for care and support.

57. However, given the nature of some of the barriers to improving the quality of care, without further intervention it is likely that at least some of them will remain and that any improvements made will be variable across the country. We have identified gaps in the existing social care quality system architecture that indicate the need for a systematic approach to define quality in social care. A range of interventions are proposed in the White Paper to help address these gaps in the current system and align incentives to deliver quality improvements. Where there is significant impact, this is analysed in detail below.

###### ***Option 2: Implement the following package of policy proposals***

- A. Strengthen system leadership and develop a quality framework;
- B. Measure quality by piloting clinical audit in social care and extending NICE quality standards;
- C. Make available provider-level information including user feedback;
- D. Work with the sector to improve commissioning information and skills, to focus on quality, outcomes and value for money;
- E. Support and enable increased user assessment of services, including training for local Healthwatch organisations.

###### Proposal A: Strengthen system leadership and develop a quality framework

58. Government will work in partnership with the care and support sector to produce a clear and concise quality framework which sets out what high quality care looks like and the roles and responsibilities of different organisations to deliver this. This has been published alongside the White Paper and a further updated version will be published by the end of 2012.

###### *Benefits*

59. Experience from the NHS suggests the following benefits.<sup>32</sup>

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<sup>32</sup> Based on discussions with those working with the National Quality Board.

- The NHS leadership forum for quality – the National Quality Board – has been an important mechanism to ensure key players work together in the interests of higher quality, underpinned by a clear national framework and clarity around roles and responsibilities at all levels.
- A quality framework has been critical in ensuring a common understanding across the system and in implementing change to drive improvements in quality.

60. Professional leadership and co-production, engaging providers, commissioners, regulators and users in finding solutions has been vital to making quality a guiding principle for the NHS and ensuring the NHS Quality Framework gains traction at all levels.

### *Costs*

61. We will explore ways of working with the sector to provide leadership for social care quality. If we were to establish a leadership forum for quality, it might cost around £35,000 per annum for expenses and around £50,000 per annum for the secretariat (0.5 FTE per year). These cost estimates are based on those incurred by a similar body (the National Quality Board) in 2011/12. The costs to the Department and the sector of a co-produced approach to developing a quality framework will depend largely upon what support the sector assigns to this work. The costs are likely to be less than £200,000 in Year 1. This assumes that the resources required would not exceed 2 FTEs for a year and would fall to the Department and the sector. There would also be opportunity costs for the time spent by those attending the forum; these are estimated to be in the region of £15,000 to £25,000. These estimates assume there will be 4 to 5 meetings a year lasting 3 hours each and that the average salaries of those attending meetings will be in the region of £100,000 to £150,000 a year excluding on-costs.

### Proposal B: Improve the evidence base by piloting clinical audit in social care and extending NICE quality standards

62. To help people better understand and recognise high quality care and support, we will commission a voluntary pilot programme to test the application of clinical audit principles in nursing and residential care in 2013 and 2014. The pilot clinical audit will focus on dementia care and will include local support and promotion of clinical audit methods as well as a voluntary nationally developed local care audit. This proposal will improve the information available to providers on the quality of care they offer and give them an incentive to make improvements due to the risk of losing business to better performers who currently charge the same price.

63. The role of the National Institute for Health and Clinical Excellence (NICE) is being expanded into adults' and children's social care. In future, NICE quality standards will establish collaborative, evidence-based guidelines to assist providers and commissioners in securing quality improvements.

64. NICE is currently piloting two joint NHS/social care quality standards, covering the care of people with dementia and the health and wellbeing of looked after children and young people. With support from the Social Care Institute for Excellence (SCIE) and following engagement with stakeholders in March 2012 on the draft scope of the two pilot topics, NICE is aiming to publish the final quality standards in April 2013.

65. From April 2013 onwards, in consultation with the social care sector, care users, their families and carers, NICE will develop a library of quality standards and guidance to improve the quality of social care. Domiciliary care has been formally referred to NICE as a subject for the production of a social care quality standard, drawing on the findings of the Care Quality Commission's current programme of inspections of home care, and the work of the Equality and Human Rights Commission. Work to scope and develop it will commence in April 2013.

### *Benefits*

66. Piloting clinical audit in the care sector will enable us to assess the costs and benefits of this approach and its fit for care and support. Experience from the NHS suggests that clinical audit is a valuable tool in monitoring and improving quality standards and that NICE quality standards will be

key to enabling commissioners, providers, professionals, people who use care and support and carers to understand and recognise what high quality and best practice looks like.

67. It should be noted that evaluating the impact of clinical audit on quality is challenging due to difficulties in accessing reliable data and correctly apportioning causality to clinical audits. A large volume of identified studies did not demonstrate any evidence, primarily because they failed to adhere to the recommended methodology of audit, involving a cycle of measurement, improvement and re-measurement, and thus had no improvement activity to measure.<sup>33</sup>
68. Nevertheless, a study carried out for the Healthcare Quality Improvement Partnership identified a body of evidence from a range of case studies that demonstrated clinical audit is a quality improvement process and can be shown have a favourable impact on healthcare practice and outcomes. There are also financial benefits achieved through clinical audit as it offers potential to reduce costs and make efficiencies at the same time as fulfilling its primary purpose of improving healthcare outcomes.<sup>34</sup>
69. Indicative examples of improved professional practice include better drug prescribing practice<sup>35</sup>, reduction in unnecessary procedures or tests<sup>36</sup> and improved observations for blood transfusion procedures<sup>37</sup>. Indicative examples of improved healthcare outcomes include shorter lengths of stay in hospitals<sup>38</sup>, reduced incidence of pressure ulcers<sup>39</sup> and falls<sup>40</sup>, and reduced infection rates<sup>41</sup>. The study further highlights that benefits from clinical audit will only be derived where it is embedded in practice.

### Costs

70. Based on costs of clinical audit work already undertaken in the NHS, the Health Quality Improvement Partnership – the experts in this area - have provided estimates for the work they would need to undertake (funded by DH) to take this proposal forward. They have estimated that local support and promotion of clinical audit methods will cost around £400,000 in 2012/13 and £400,000 in 2013/14. In addition, £100,000 will be needed to develop a local care audit for use locally on a voluntary basis. We have estimated that to collate and analyse the evidence from the audit and to evaluate the approach would cost no more than £100,000. This is based on what is currently known about the scope of this proposal and a professional judgement by analysts that the amount of time required to conduct this work is unlikely to exceed one FTE researcher (the cost per researcher per year including on-costs are reported to be £100,000 by researchers).
71. The two pilot NHS/social care NICE Standards are already funded but increasing the pace and coverage of social care quality standards might require additional funding. Current estimates for developing new social care quality standards range from £1.5 million per annum for 3 standards a year to £2.6 million for 6 standards a year. There will also be costs associated with implementing guidelines, however since providers and commissioners have a choice whether to follow these guidelines, we can assume they will only do so where they have assessed that it will be cost effective to do so.

### Costs to providers

72. This activity has never been costed in the UK healthcare model. Much of this activity forms part of the general job of a clinician and has never been estimated, as it is seen as integral to their practice along with diagnosing patients or providing medication. The pilot will investigate the costs of the approach in social care.

<sup>33</sup> <http://www.hqip.org.uk/assets/Core-Team/Loughlan-review-HQIP.doc>

<sup>34</sup> *Ibid.*

<sup>35</sup> <http://www.hqip.org.uk/assets/Dev-Team-and-NJR-Uploads/2-Papworth-Hospital-NHS-Trust-Audit.doc>

<sup>36</sup> <http://www.hqip.org.uk/assets/Dev-Team-and-NJR-Uploads/2-Dorset-County-Hospital-Case-study-for-HQIP-June-2010.doc>

<sup>37</sup> <http://www.hqip.org.uk/assets/Core-Team/Loughlan-review-HQIP.doc>

<sup>38</sup> <http://www.hqip.org.uk/assets/Guidance/Royal-Berkshire-Stroke-Audit-Case-Study.pdf>

<sup>39</sup> <http://www.hqip.org.uk/assets/Dev-Team-and-NJR-Uploads/2-Salford-Royal-NHS-Foundation-Trust.doc>

<sup>40</sup> <http://www.hqip.org.uk/assets/Dev-Team-and-NJR-Uploads/2-Hampshire-Partnership.doc>

<sup>41</sup> <http://www.hqip.org.uk/assets/Dev-Team-and-NJR-Uploads/2-South-Tees.doc>

73. Decisions on the type of approach are yet to be taken but given that clinical audit is new to the sector it might seem sensible to adopt a less resource intensive approach in the first instance.
74. To arrive at some illustrative costs to providers of clinical audit we have costed a model of a national audit that samples a subsection of providers and where data are collected for a sample of clients during a fixed period of time. We have also assumed that the pilot audit would take place in care homes.
75. The costs to care home providers who choose to take part in the pilot audit will be made up of two elements:
- overheads related to planning the data collection, data submission, analysis and action planning elements of an audit (management);
  - costs of data collection itself (operational staff).
76. Based on the expert opinion of those working in the clinical audit sector, we estimate that it would take one person 3 days to lead the audit work within a given organisation. If we assume that this work is undertaken by a care home manager at a cost of £35<sup>42</sup> per hour, the total costs per provider would be £840. If this were done across 10% of care homes, there would be a total overhead cost to providers of £1.5 million. There would then be additional work (around 5-6 hours) for team members collecting data. If we assume that this work is undertaken by a care home worker at a cost of £18 per hour<sup>43</sup>, the total data collection costs per provider would be £108. Again, if this were done across 10% of care homes, there would be data collection costs to providers of £0.2 million. Therefore, the total additional costs to providers would be £1.7 million. As these are one-off costs that are relatively small per provider, we assume that they are opportunity costs that are not likely to be passed on to commissioners via higher prices.
77. As a result of the audit, there may be additional costs to make any improvements identified. These have not been costed here, as they will depend on the nature of the audit and what the likely resulting actions would be. There is no estimate available of these costs as a result of clinical audit in the NHS to use for illustration.

#### Proposal C: Make available provider-level information including user feedback

78. Specifically this proposal involves working with the sector to develop information that offers a clear and easily understood comparison between different care providers. The Government's vision is for every registered provider to have a provider quality profile, demonstrating how the provider meets the three key elements of high quality care – effectiveness, user experience and safety. The information available through the provider quality profile will form the basis from which a new, simple and continually updated quality rating can be created.
79. Overall, this proposal addresses one of the key causes of poor quality described above – a lack of information at provider level for both commissioners and users. This approach will support self-funders as well as people supported by their local authority to make informed choices about care and support. It could provide a source of intelligence and feedback for commissioners, care users and local Healthwatch groups.
80. Previous Government work on information and transparency through *Transparency in Outcomes* has focussed on information from a local authority perspective.<sup>44</sup> To make choice meaningful for users, whether publicly funded or self-funders, and drive quality improvement, information is needed at a provider level, as indicated in feedback from the *Caring for our future* engagement.
81. A provider quality profile could therefore assist in the development of a more effective care market, allowing consumers to access detailed information about quality of care, beyond essential CQC standards. This approach will support and empower individuals to choose the care that they

<sup>42</sup> Unit Costs of Health and Social Care 2011 (home care manager).

<sup>43</sup> Unit Costs of Health and Social Care 2011 (home care worker).

<sup>44</sup> Department of Health, *Transparency in outcomes: a framework for quality in adult social care*, March 2011.

purchase through direct payments or with their personal budgets, which will support personalisation of care for users.

82. The first stage of the quality profile will be provided via the single NHS and Social Care Information Portal at [www.nhs.uk](http://www.nhs.uk) and will contain information such as:
- Basic information about the provider and the care it offers;
  - How the care provider meets CQC essential standards.
83. As we add greater functionality to the quality profile, by April 2013, providers will be able to upload their own information voluntarily to demonstrate the quality of care they provide such as:
- Whether the care provider meets the new NICE quality standards, once developed and other recognised Quality Charter Marks;
  - The views of the users of those services and their families;
  - Feedback and reports from local Healthwatch, if available;
  - Other information about the quality of services, e.g. skills and qualifications of staff.
84. Representatives from the care provider sector (including English Community Care Association (ECCA), Anchor, Barchester, National Care Forum, The Good Care Group) have already identified and signed up to their members voluntarily reporting on six key measures to demonstrate quality care. They have tested these measures more widely in the sector and believe they are measures that providers will be happy to use to demonstrate their reputation in the market and build on information they already have readily available. The Government welcomes the steps taken by care providers to collect and publish a set of quality measures on a voluntary basis as part of a sector led Transparency and Quality Compact.
85. We are exploring with the care sector how these measures can be expanded to include a ‘friends and family test’ which providers can use to gain feedback on user and carer experience of care providers, through a standard, simple and regular survey, or through a simple score system based on personal recommendations. Any such survey would take time to design and secure agreement from the sector on the methodology. Other alternatives would be to see if the sector could agree ways in which existing surveys they carry out could be standardised and/or to restrict information to simple online user ratings or use of a simple score system based on personal recommendations such as a net promoter score.
86. The data set could also be extended to include information that commissioners need for the purposes of monitoring contracts. Providers highlighted during the *Caring for our future* engagement that they currently have to supply different and separate information to the regulator and commissioners, and that different commissioners have differing requirements. There is an opportunity to agree a single data set that meets the differing requirements, reducing the overall burden on providers.
87. Feedback from the *Caring for Our future* engagement and a range of external reports including the recent Equality and Human Rights Commission Report into Homecare have called for greater transparency around the experiences of people using services and have suggested online user feedback websites, along the lines of “trip advisor”.
88. A number of websites facilitating online user ratings of social care services already exist and others are soon to be launched. These websites allow service users and carers to feed back directly to providers and commissioners about good or poor quality practice, and drive improvements to the care provided. The Government welcomes such ventures and will not be looking to develop its own online feedback website for social care. It will however work with existing and emerging websites to ensure appropriate safeguards are in place and will seek to pool comments made by users on external sites into a user feedback area of the provider quality profile from April 2013.

## Benefits

89. The available evidence regarding the impact on quality of healthcare or social care choice policies is relatively thin. However, a review of the existing evidence found that in the US, the public release of information appears to have had little impact on consumer choice.<sup>45</sup> The limited research from the UK echoes these findings. Some later studies suggest that consumers may be becoming more interested in performance data from healthcare organisations.
90. The Department of Health commissioned work from a consortium comprising RAND Europe, The King's Fund and City University to get a better understanding of the factors that drive patients' choices over their elective care provider. This study provides evidence that patients will use information on clinical quality to discriminate between alternative providers, the same is likely to be true for social care.<sup>46</sup>
91. Regardless of the impact on consumer choice, evidence from the health sector<sup>47</sup> and the US<sup>48</sup> suggests the publication of provider-level information can act as an incentive for providers to improve quality. Indeed the publication of star ratings for councils in England by CQC led to improvements measured by increasing numbers of councils gaining higher star ratings over time<sup>49</sup> (although in this case publication of data was also accompanied by targets and there may also have been some negative impacts such as gaming).
92. Imperial College London has recently published independent research that links online patient feedback and objective measures of hospital performance.<sup>50</sup> The research finds the general trend is that where a hospital's overall performance on clinical measures is good, patients seem to rate it highly – and vice versa.
93. This approach will support self-funders as well as people supported by their local authority to make informed choices about care and support. It could provide a source of intelligence and feedback for commissioners and local Healthwatch groups.
94. To realise these benefits fully, development of the provider quality profile will need to be supported by other measures set out in the White Paper, for example proposals on advice and support for those with personal budgets. These are discussed in more detail in the corresponding Impact Assessment "Independence, choice and control".

## Costs

95. This proposal is likely to involve additional costs, both for the Department of Health and for providers who opt to take part.
96. Developing a provider comparison website and having it in place would have an estimated cost of no more than £1 million in the first year. This estimate is based on the cost of £0.6 million suggested by NHS Choices who will provide the website and includes DH estimates of other central costs for overseeing the development and working with providers to develop the approach and content. A provider comparison website in subsequent years (using estimates from NHS Choices) would cost no more than £0.5 million per annum. These costs will fall to DH. Leaving this entirely to the market (not-for-profit or commercial providers) or local authorities to develop portals would cost less centrally but some costs are then likely to fall to local authorities and providers themselves – for example

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<sup>45</sup> Fotaki M., Boyd A., Smith, L. et al, *Patient Choice and the Organisation and Delivery of Health Services: Scoping Review*, National Coordinating Centre for NHS Service Delivery and Organisation Research and Development, December 2005. Available from the NCCSDO website: <http://www.sdo.lshtm.ac.uk/files/project/80-final-report.pdf>

<sup>46</sup> Burge P., Devlin N., Appleby J. et al, *Understanding Patients' Choices at the Point of Referral*, RAND Europe Working paper, December 2005.

<sup>47</sup> Shekelle, P.G. et al, *Does public release of performance results improve the quality of care? A systematic review*, QQUIP, 2008.

<sup>48</sup> Mor, V., "Public reporting of long term care quality: the US experience", *Eurohealth* Volume 16, Number 2, 2010.

<sup>49</sup> Clarkson P. et al, *Has Social Care Performance in England improved? An analysis of performance ratings across social services organisations*, 2009.

<sup>50</sup> Greaves, F. et al, *Associations Between Web-Based Patient Ratings and Objective Measures of Hospital Performance*, 2012.

through registration and the need to respond to online comments. These costs are then likely to be passed on to commissioners via higher prices.

97. To augment their provider quality profile providers, can add a range of other information on a voluntary basis (see paragraph 83 above). The costs per provider of doing this are estimated at between £210 and £525 per year. Based on discussions with the website provider on functionality, we have assumed 6-15 hours are needed per year for each provider to add the information required. We assume that a care home or home care manager completes this task at an hourly rate of £35, based on the PSSRU unit costs report 2011. We estimate that there are around 25,000 registered providers (CQC March 2010). Therefore, the total cost per year if all providers took part is estimated to be between £5 million and £13 million.
98. However, evidence from the experience of NHS Choices with primary care contractors is that it is not likely that all providers will participate at least initially. The participation rate of GP practices was about 50% when the NHS Choices site was first launched in 2008, with the level rising over time to 75% last year. However, participation rates for dentists, pharmacists and opticians are much lower at 26%, 44% and 25% respectively. There may be more incentives for care providers to add information to their provider quality profile than primary care contractors given the competition in the market that exists in many areas, therefore we are assuming that in 2013/14 50% of providers add information, in 2014/15 and 2015/16, 75% of providers add information, rising to 100% in the remaining years.
99. This means estimated costs of:
- between £2.5 million and £6.5 million in 2013/14;
  - between £3.75 million and £9.75 million in 2014/15 and 2015/16;
  - between £5 million and £13 million from 2016/17 onwards.
100. Most (if not all) comparative websites that already exist currently charge providers to add their own information. It is likely that whether or not Government steps in with a national provider quality profile, providers will undertake this activity (potentially on multiple sites) to ensure they can advertise their services and demonstrate reputation in the market. Adding their own information to the provider quality profile may actually save providers time and money they would have expended in other ways to market and advertise their services to attract new customers.
101. The cost of enabling aggregated user feedback on the quality profile will depend on the model adopted, no decisions have yet been taken here. One option might be a formal survey, issues to be explored for example will include how to construct a sampling frame for the survey, how to run the survey and whether it is appropriate to run the survey for small providers.
102. We have looked at the costs of existing user experience surveys, taking the costs of current user surveys reported to the Information Centre by councils and scaling them up to the likely size of a provider level survey and by means of discussions with a council that is currently developing an approach for a provider level survey. We have also looked at the costs of other large-scale surveys of individuals. Based on these costs, we estimate that if the survey of users were to go ahead, the cost at provider level would be around £3 million to £7 million per year/per survey. This assumes that the survey will go to both local authority and self funded clients receiving social care from a care home or domiciliary care provider. The total number of users receiving residential/nursing care or home care at any one time is estimated to be around 850,000 and there are estimated to be around 25,000 establishments providing social care in England. It is not clear at this stage who these costs would fall to directly, this will depend on the model adopted but costs could be borne by one or all of the Department of Health, local authorities, self-funders and providers.
103. There will also be some one-off costs to DH for the development of the survey and approach, which are estimated to be £100,000 to £300,000 in total. As a minimum a feasibility study would need to be commissioned, this has been estimated to cost around £100,000 by researchers. We cannot be sure what further additional work will be needed but is likely to include some or all of question testing, questionnaire development including piloting, consultation with stakeholders and managing the project. For illustrative purposes, we estimate that these could total up to £200,000.

104. An alternative to a formal user survey might be for providers to simply upload results from their existing surveys as additional files onto their quality profile. That activity could be done at the same time as adding other information to the quality profile and is likely to add no more than 5-15 minutes per provider, per year. It has therefore been assumed that this activity would be captured under the costs at paragraph 98 for providers uploading information to augment their quality profile.
105. Other alternatives for enabling aggregated user feedback information at provider level include adding a facility on the quality profile for care users and carers to rate their provider against key aspects of care (eg. dignity, cleanliness) or the use of a net promoter score. These options would have minimal costs for IT development and would not have a cost burden on providers or local authorities.
106. In summary, the cost to providers of augmenting their quality profiles with additional information is estimated to be between £5 million and £13 million per year, based on all providers fully actively taking part. The additional costs of enabling aggregated user feedback could range from nil if a net promoter or existing provider surveys are used, to between £3 million and £7 million per year for a formal provider survey, with the mid-point being £2.5 million. Depending on the option chosen, these costs would fall to one or all of the Department of Health, local authorities, self-funders and providers. Therefore, in total, the cost range for the provider quality profile (assuming all 25,000 actively take part and taking into account the wide range of options for enabling aggregated user feedback) are £5 million to £20 million. Where costs fall to providers, we might assume that these additional costs could be passed on to commissioners via higher prices.

Proposal D: Work with the sector to improve commissioning information and skills, to focus on quality, outcomes and value for money

107. This proposal seeks to improve commissioning. To achieve optimum ownership and traction, this work should be led by and co-produced with the care sector. Specifically it involves:
- giving a strong steer for councils to focus on commissioning for quality, outcomes and value for money;
  - providing best practice examples around commissioning for outcomes; and
  - committing to work with the sector to develop sources to support commissioners.
108. Information and skills deficits in local authorities need to be addressed to enable an increased focus on quality and value for money and to support commissioners to: monitor for quality, access and interpret information and facilitate service user and carer engagement in quality assessments. Action is required to tackle current commissioning practices that restrict care providers' ability to respond to the needs and preferences of care users, for example specifying particular tasks to be carried out in a 10 to 15 minute homecare appointment.
109. This policy proposal will involve work to:
- build on the emerging work from Think Local Act Personal (TLAP) programme, including work in the sector to identify a range of quality metrics and markers at provider level that could be used by commissioners as quality measures in contracting; and
  - encourage sector-led work to develop and disseminate resources (for example model contracts and/or a set of model outcome measures) to help commissioners: learn from good practice; commission on the basis of quality and value for money; and to focus on outcomes not procurement process, informed by quality standards and, where appropriate, lay/user assessments.
110. The Office of Fair Trading (OFT) suggests that commissioners can take a number of steps to ensure that suppliers are correctly incentivised to achieve value for money.<sup>51</sup> Mechanisms such as the introduction of 'quality premiums' (where providers are rewarded for higher quality services) and ongoing rating schemes for providers have the potential to create incentives for service improvement. With greater personalised commissioning in social care, "quality premiums" could be linked to the outcomes in the individual's support plan.

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<sup>51</sup> OFT, "Competition and Commissioning in public services" –1314 March 2011 undertaken by PwC.



111. It should be noted that as more users are supported to take up personal budgets, the traditional commissioning role of local authorities will diminish. Of the 880,000 people receiving community based services on 31 March 2011, 14% were receiving direct payments – an increase from 4% on 31 March 2007.<sup>52</sup> In this context, individuals will effectively act as commissioner and therefore the impact of improving local authorities' role as commissioners will be more limited than would otherwise have been the case.

### *Benefits*

112. The benefits of these measures are to make available evidence and tools to commissioners on good practice. This will enable them to take evidence-based decisions locally on whether and how to make improvements to their commissioning practices. It is possible that further research to evaluate different approaches and practices in commissioning may be needed.

### *Costs*

113. Much of the above is about sharing best practice around commissioning for outcomes and sector led support for commissioners and could be achieved with minimal cost. Depending on how this model is developed, costs are likely to range from £100,000 to £250,000 over two years and would fall to DH. These costs have been estimated by DH based on experience of working on similar projects and would cover staff time of between one and two FTEs over the two years (£70,000 to £150,000) and some additional resources for a review of evidence and events and dissemination (£30,000 to £100,000).

114. If research is needed to evaluate different approaches and practices in commissioning there will be additional costs. The costs of this research will depend on the nature of what is needed which cannot be predicted at this stage. If, for example, the research took one to two researcher years (the cost per researcher per year including on costs are reported to be £100,000 by researchers), the cost would be in the region of £100,000 to £200,000. There will be additional costs to local authorities for implementing best practice and improving commissioning practices. We have not quantified these here and assume that local authorities will only adopt practices which they have assessed will be cost effective for them.

### Proposal E: Support and enable increased user assessment of services, including training for local Healthwatch organisations

115. Specifically this proposal involves funding training for local Healthwatch to play a more active role in the sector and encouraging lay assessments of care services and the use of user feedback and lay assessments in contract management.

116. This proposal also supports measures set out in the White Paper to encourage collaboration on safeguarding and early warning systems, a new duty on local authorities to shape their local care market (Proposal F discussed below) and proposals to improve provision of information and advice (discussed in the corresponding Impact Assessment "Independence, choice and control"). Proposals K and L to strengthen multi-agency safeguarding arrangements are discussed in more detail below.

117. The involvement of Healthwatch will ensure that the information available to commissioners and users is enriched through the outputs of lay assessments, therefore driving up quality. It may also act as an incentive for providers to improve the quality of care they offer.

118. The following measures would be subject to any programme of work led by and co-produced with the sector but could potentially help strengthen user voice and service improvement feedback loops, as well as enhance the information available through the proposed portal of provider information:

- Provide training to local Healthwatch on how they can fulfil their role with respect to social care and how they put in place the necessary safeguards to ensure the rights of care users are preserved before enter and view powers are used. Historically predecessor organisations -

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<sup>52</sup> Information Centre: Adult Social Care Activity Data.

including Patient and Public Involvement (PPI) before Local Involvement Networks (LINKs) – have been more focused on health than care and support. Training could help address this by ensuring that local Healthwatch fully appreciate the unique circumstances of people who use care and support – for example, the need to respect a resident’s decisions to decline a Healthwatch visit to what is in effect their home.

- Where users, carers and the public have concerns about care and support, public facing communications will be used to encourage them to ask their local Healthwatch to consider using their enter and view powers to scrutinise and comment on the standards of care (as LINKs have already done in some areas). In this way, local Healthwatch could be one mechanism for lay involvement in the monitoring of care quality, but other options will also be explored to encourage lay assessments and a greater community role in holding providers to account.

### **Benefits**

119. Quality service improvement is enabled through user and carer feedback. Local Healthwatch are supported to play an active role in care and support as well as health.
120. Local authorities that have invested in training local people through LINKs to undertake lay assessments, such as the Kensington and Chelsea Dignity Champions scheme, are able to benefit from gaining feedback from older people.<sup>53</sup> The “Dignity Champions” carry out assessments of local health and social care services and provide feedback to the LINK. The LINK then produces a report on their findings and makes recommendations for improvements to the service. We would need to monitor the effectiveness of this approach to inform whether they continue in the future.

### **Costs**

121. We estimate that the initial one-off costs of training local Healthwatch would be in the region of £350,000 to £450,000. This assumes that in each local authority 8-10 people are trained at a cost of £300 per person (this assumes 2 days of training at a cost of £150 per day).<sup>54</sup> There will be ongoing costs of training new assessors as they join and others leave. If we assume 1-2 additional people are trained each year per authority, the ongoing costs are likely to be £50,000 to £100,000. It is difficult to estimate the costs of developing the training as the details of the content has not yet been specified. However, for illustration we estimate that the costs will not exceed £25,000. There will also be opportunity costs for the time that assessors spend on training and carrying out assessments. There may be some small additional costs to monitor the effectiveness of this approach.

### **Summary of benefits of Option 2 (implement Proposals A-E)**

122. Where there is limited evidence on the costs and benefits of proposals we intend to undertake piloting or evaluate existing work. Overall, it is not clear from the evidence currently available what magnitude of improvement in quality will result from these proposals, especially if fees paid to providers remain unchanged.
123. However it should be possible to measure whether any improvements in quality have been achieved using the Adult Social Care Outcomes Framework (although we will not be able to attribute any changes directly to the White Paper proposals).<sup>55</sup> One of the overarching measures in the framework measures social care related quality of care using PSSRU’s ASCOT tool as its basis. The ASCOT tool measures outcomes for individuals using eight domains which include nutrition, control, safety etc.<sup>56</sup>

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<sup>53</sup> <http://www.rbkclink.org/our-work/dignity-champions/>

<sup>54</sup> <http://www.northamptonshire.gov.uk/en/councilservices/business/training/tc/Pages/CostsofTrainingCourses.aspx> and <http://www.actionforadvocacy.org.uk/articleServlet?action=display&article=1924&articletype=38>

<sup>55</sup> Department of Health, *Transparency in Outcomes – a framework for quality in adult social care*, March 2011.

<sup>56</sup> <http://www.pssru.ac.uk/ascot/>

## Summary of costs of Option 2 (implement Proposals A-E)

Table 1

Proposal	Agent	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total	Average annual
<b>A. Leadership and Quality Framework</b>													
Quality Framework and programme of work - Transition Cost	DH	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0
Leadership - Recurrent Cost	DH	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.1	0.1
<b>B. Clinical audit and extension of NICE</b>													
Clinical Audit – Transition Cost	DH	0.5	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.1
Clinical Audit – Transition Cost	Providers	0.0	0.4	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.7	0.2
NICE Recurrent Cost	DH	0.0	0.0	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1	16.4	1.6
<b>C. Publishing Quality information</b>													
Provider Quality Profile Portal – Transition Cost	DH	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.1
Provider Quality Profile Portal – Recurrent Cost	DH	0.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	4.5	0.5
Provider level information – Recurrent Cost	Providers	0.0	4.5	6.8	6.8	9.0	9.0	9.0	9.0	9.0	9.0	72.0	7.2
Provider level information and user feedback – Transition Cost	DH	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0
Provider level user feedback (user survey/ provider supplied/web based) – Recurrent Cost	DH	0.0	0.0	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	20.0	2.0
<b>D. Recognising and rewarding quality</b>													
Transition Cost	DH	0.2	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.0
<b>E. Training for local Healthwatch</b>													
Transition Cost	DH	0.0	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.0
Recurrent Cost	DH	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8	0.1
<b>Total</b>													
Transition Cost Total	DH	2.1	1.1	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.3	0.3
Transition Cost Total	Providers	0.0	0.4	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.7	0.2
Recurrent Cost Total	DH	0.1	0.6	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	42.8	4.3
Recurrent Cost Total	Providers	0.0	4.5	6.8	6.8	9.0	9.0	9.0	9.0	9.0	9.0	72.0	7.2
<b>Costs Grand Total</b>		<b>2.2</b>	<b>6.6</b>	<b>13.5</b>	<b>12.0</b>	<b>14.3</b>	<b>14.3</b>	<b>14.3</b>	<b>14.3</b>	<b>14.3</b>	<b>14.3</b>	<b>119.7</b>	<b>12.0</b>

124. In addition to those set out above, there are some costs that have not been monetised. These are the opportunity costs for the time that Healthwatch assessors spend on training and carrying out assessments and the opportunity costs for the time taken by providers to carry out clinical audits. In addition, costs to make improvements to practice resulting from clinical audit, NICE guidelines or better commissioning practices incurred by commissioners and/or providers have not been included. Better commissioning practices would also produce benefits that are also not quantified in this Impact Assessment.

125. Recent research (Forder 2012) has found that there is a link between higher quality of residential care and higher prices. The difference in prices between higher and lower quality residential care is not great but it is robust: the finding is highly statistically significant. There is likely to be scope for

some providers to improve the quality of their care at no extra cost. Our proposals are about improving quality through strong leadership, sharing good practice, clinical audit and improved commissioning but we would still expect some upward pressure on prices in the sector over a long period.

## **Market Shaping Proposals**

### ***Objective:***

Local authorities facilitate a diverse and vibrant market to deliver a range of high quality, responsive services.

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

126. One of the recommendations made by the Law Commission was that there should be a legal duty on local authorities to shape local services. For the past twenty years, a market has been operating in social care, with the vast majority of provision now provided by the independent sector. It is important that the legal framework within which local authorities work recognises this and actively supports the market to deliver services.

127. Strong evidence emerged from the *Caring for our future* engagement that some local authorities were finding the shift from directly purchasing services themselves to facilitating a wider market, where individuals commissioned their own services, challenging. A recent National Audit Office report cited evidence from local authorities who said that they needed to do more to develop local markets.<sup>57</sup> Only one of the six local authorities visited by the NAO as part of its research had carried out analysis to see what types of care service users would like to see provided in the future, the amount they would be willing to pay, and the likely level of demand. Given that progress in this area is patchy, intervention is required to provide some additional support to local authorities to build their capability in this area.

### ***Option 2: Implement the following policy proposals***

- F. Reinforce in legislation local authorities' role to shape their local market;
- G. Support local authorities to understand their local market better.

#### **Proposal F: Reinforce in legislation local authorities' role to shape their local market**

128. The Government accepts the recommendation of the Law Commission to place a duty on local authorities to shape local care markets and intends to introduce a duty in the forthcoming Care and Support Bill for local authorities to promote the operation in its area of a market in care and support. The Law Commission has said that:

*"The functions of ... market shaping, should be expressed as duties, not merely powers. ... The provision of targeted care through assessment, eligibility and care planning is currently based on duties and would continue to be under our recommended scheme. If we are to see the ... shaping and stimulating the local market for services as of comparable importance in the overall delivery of social care, it is apposite that they, too, should be duties."*<sup>58</sup>

When making commissioning decisions, local authorities will be required to have regard to quality, the local needs of the whole population (not just those eligible for state funded care and support), and the sustainability of the market.

129. This duty will clarify existing practice. Over 80% of social care 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.

<sup>57</sup> National Audit Office, *Oversight of user choice and provider competition in care market*, September 2011.

<sup>58</sup> [http://www.justice.gov.uk/lawcommission/docs/lc326\\_adult\\_social\\_care.pdf](http://www.justice.gov.uk/lawcommission/docs/lc326_adult_social_care.pdf)

## Proposal G: Support local authorities to understand their local market better

130. Although local authorities have been commissioning services for many years, as set out above, there is evidence to suggest that their capability to support an effective care market could be improved.<sup>59</sup> This was also indicated when, during the *Caring for our future* engagement, the Institute of Public Care at Oxford Brookes University carried out independent focus groups with providers and commissioners to discuss how to facilitate more effective markets. The National Market Development Forum (part of *Think Local Act Personal*) is also looking at how to improve operation of the social care market.<sup>60</sup>
131. Local authorities need to adapt to a shift in their role, from directly purchasing care to facilitating a wide range of services to meet the needs of their local population. Local authorities also need to consider questions such as how they can support continuous improvement in quality and innovation, and how they can mitigate against risks to the provision of care and develop sustainable local markets.
132. To support local authorities in doing this, the Government will provide funding for all local authorities in England to access support from an expert body to support them in producing a market position statement. This would act as a statement to the supply side – giving clear information to suppliers of services about the local market and its operation.
133. To do this, we are proposing providing resource to an independent body, which in turn will provide advice and guidance to local authorities on how to develop a better understanding of their market, and build better relationships with their suppliers. This should support local authority strategic commissioning functions, and encourage integration by cutting across social care, health and housing markets. It will compliment the Joint Strategic Needs Assessment (which is in effect a statement of demand) and provide information to health and wellbeing boards.

### *Benefits of Option 2 (Proposals F and G)*

134. A market position statement is a document produced by the local authority capturing, analysing and making available market intelligence from which all parties can benefit. Such a statement can help local authorities to better understand their market, strengthen their relationships with providers, join up thinking across different types of services (for example health and housing) and improve their commissioning capability.
135. Those local authorities who have already developed market position statements have cited a range of benefits – in particular that they:
- provide a robust assessment of the whole market, not just the services which the local authority funds, therefore benefitting those who fund their own care;
  - provide information to providers about how the local authority intends to behave towards the market in the future – hence improving information and signals within the market;
  - bring together the wider role of the local authority, including housing, education, leisure services and health services and challenges local government to consider how they impact and can benefit the social care market; and
  - can form the basis of a more constructive and ongoing dialogue between the local authority, its providers and those using care and support.
136. The benefits of market positioning statements were also highlighted by the National Audit Office in its report *Oversight of User Choice and Provider Competition in Care Markets* (2011).

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<sup>59</sup> For example "Understanding commissioning behaviours: Commissioning and competition in the public sector", March 2011, A report for the OFT by PWC. - <http://www.of.gov.uk/OFTwork/research/strategicresearch/commissioning-competition/>

<sup>60</sup> <http://www.thinklocalactpersonal.org.uk/Browse/commissioning/developing/?parent=8567&child=7959>

## *Costs of Option 2 (Proposals F and G)*

137. As outlined above, this option involves providing resource to an independent body, for one year, to support every local authority to develop a market position statement or further improve their market understanding (if they already have a statement) – should they wish to.
138. To set up the programme, launch the initiative, and provide bespoke support to each local authority, a grant of £720,000 is being made to an independent expert body for this purpose. This is based on the independent body's estimate, agreed by DH, that this will require just under 800 days of work.
139. Those local authorities who want to access this resource will have to commit to undertaking the necessary work to produce and evaluate their own statement. This will require re-focusing existing resources, and engaging with their providers and users. In estimating the opportunity cost incurred by local authorities, we have assumed it will take a local authority analyst one month to undertake the work, plus some senior managers' time. There is therefore an estimated opportunity cost of around £7,000 to £8,000 per local authority. This amounts to around £1 million to £1.2 million for all 152 local authorities in the first year and then £0.5 million to £0.6 million for subsequent years.
140. For market position statements to have lasting value, we would expect local authorities to keep their statement under regular review, and to make changes as necessary (for example should policies change or new intelligence become available). It is important for the MPS to be a living document (rather than a one-off exercise), and used as a catalyst for helping local authorities and providers to build more strategic and productive relationships. As such, we would expect that the direct cost to local authorities of reviewing the document will be low, and should become part of the day-to-day role of commissioners as they respond to the need to facilitate local care markets more effectively. We do not expect that local authorities would require further support from external advisors or the Department of Health to do this.
141. As part of this work, the Department will expect the independent body to produce a final overarching report on progress and evaluate the success of the work programme.

## **Workforce Proposals**

### *Objective:*

- The social care workforce is led by confident and capable leaders able to lead across integrated services;
- Care and support is seen as an attractive career opportunity and the social care workforce has lower turnover and vacancy rates;
- The care workforce is highly skilled and capable of meeting increased demand and higher expectations of high quality, personalised and integrated care.

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

142. Continuing with the status quo is likely to result in an inability to meet the increased demand for care resulting from demographic pressures. This will also be compounded by recruitment and retention challenges. As the workforce moves towards delivering more personalised and integrated services, new job roles and skills will be required to meet increased and changing demand.
143. However, the predominance of smaller providers within the care market makes wholesale strategic change particularly challenging. Without developing leaders capable of leading across integrated services, the sector will not be able to deliver the vision for adult social care.

### ***Option 2: Implement the following package of policy proposals***

- H. Enable development of leaders who can implement whole systems approaches across health and care, by establishing a Leadership Forum and developing a Social Care Leadership Qualities Framework aligned to the existing NHS Leadership Framework;

- I. Build workforce capacity to meet future demographic challenges. This will involve expanding the number of care and support apprenticeships, developing an online tool to support recruitment and expanding the Care Ambassador role;
- J. Increase workforce capability and skills by developing a sector compact and supporting the development of Personal Assistants.

Proposal H: Enable development of leaders who can implement whole systems approaches across health and care

i. Establish a Leadership Forum

144. This proposal entails creating a strategic forum tasked with leading the transformation of leadership at all levels. The Forum will bring together expertise from the best inspirational leaders from the business, statutory and voluntary sectors with leaders from across health, care and housing, including the private and voluntary sectors. In this way, it will provide a clear strategic long-term vision for the transformation and integration of the care and support workforce.
145. The Forum will have clear objectives to be met within a defined timescale and will be accountable to Government for its delivery. It will work with existing bodies such as the NHS Leadership Academy and National Skills Academy for Social Care to make transformation happen. The Forum will be launched by March 2013.

*Benefits*

146. Evidence suggests that leadership is key to delivering change and improvement in care services, particularly when it is predicated on effective partnership working between the state, communities, families and individuals. As well as driving up quality, strong leadership will also facilitate the bringing together of related sectors to ensure clear partnership working, for example with health, housing and leisure.<sup>61</sup> The benefits associated with integrated ways of working are discussed in more detail in the corresponding Impact Assessment “Independence, choice and control”.
147. In due course, developing future leaders able to lead the development of the sector could have the potential for positive impact on market growth with ensuing benefits for people who use services, businesses and taxpayers.

*Costs*

148. In the first year, there will be set-up costs that we estimate to be around £0.5 million to cover the recruitment of Forum members and staff to run the Forum. This is based on the costs of setting up similar councils such as the NHS Equalities Council. We anticipate that there will be up to 40 people attending the Forum on a quarterly basis and that this will incur running costs such as travel and subsistence. Taking the running costs of existing leadership councils such as the NHS Equalities Council, we estimate these could be around £140,000 per year based on quarterly meetings. There will also be opportunity costs, where individuals take time away from undertaking other tasks to input into the Leadership Forum. The work programme will also incur costs – funds will be bid for once projects are identified and business cases developed.
149. The Leadership Forum will be disbanded once its work programmes are complete, we anticipate this may be after 2 years and this will be reviewed.

ii. Align the Health and Social Care Leadership Qualities Frameworks

150. The NHS Leadership Framework sets the standards for outstanding leadership qualities in the health sector.
151. In order to support closer integration across the sectors, we will develop a Social Care Leadership Qualities Framework, aligned with the existing NHS Leadership Framework and using the

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<sup>61</sup> Fauth, R. and Mahdon, M., *Knowledge Review 16: Improving Social and Health Care Services*, SCIE 2007.

same set of leadership behaviours as the NHS Framework, adapted as necessary for adult social care. Together, these two frameworks will describe more effectively the attributes, behaviours and characteristics required to lead the development of high quality integrated care at all levels. To support early momentum of leadership development, the National Skills Academy will publish a Leadership Strategy and aligned Leadership Qualities Framework in summer 2012.

152. The aligned frameworks will underpin the work of the Leadership Forum described above. It will establish the generic behaviours required to lead the development of quality integrated services across health and social care effectively at all levels of leadership, from front-line managers to Chief Executives. This will strengthen the development of people capable of transformational leadership. It will compliment the work programmes developed by the Forum and the National Skills Academy. The competencies will be used by employers in their workforce development activities including recruitment and Continuous Professional Development, as well as underpinning future training, qualifications and standards for leaders and managers.

### *Benefits*

153. The aligned frameworks will clearly identify the attributes sought from future leaders working at all levels and will underpin transformational leadership development. In due course, this will result in higher quality of services and improved care for users across integrated and personalised services.<sup>62</sup>

### *Costs*

154. The National Skills Academy for Social Care will continue to align the frameworks working closely with the Leadership Forum. The current actual cost is £30,000 and is met through existing budgets. This covers two part-time consultants responsible for development and two workshops to consult with key stakeholders.

### Proposal I: Build workforce capacity to meet future demographic challenges

#### i. Expand the apprenticeship programme for adult social care

155. Building on the success of the apprenticeship programme to date, it is Government's ambition to extend the number of apprenticeship starts by an additional 50,000 by 2017, doubling the number of apprenticeships started in adult social care in 2010/11. Expansion will be across a range of age groups, from young people to the newly retired.

156. In recent years, the Department of Health has supported Skills for Care to run a successful capacity building programme targeting employers, training providers and promoting opportunities to potential apprentices. Funding is provided by the Department for Business, Innovation and Skills (BIS) and the Department for Education (DfE) to cover training costs, while employers pay the salary.

157. In 2008, the Department of Health increased funding to support the expansion of this programme. There were 50,500 new social care apprenticeships started in 2010-11 (an increase of around 38,500 since 2007/08). In 2010/11, the joint Health and Social Care framework represented 11.7% of all apprenticeship starts in England, second only to customer services. However, whilst apprenticeship starts are increasing, there is still a high vacancy rate within the care sector.

158. This growth reinforces the confidence that employers place in apprenticeships. Employers cite employment of apprentices as generating higher overall productivity for their company, making them more competitive in their industry and being more cost effective than hiring skilled staff.<sup>63</sup> The apprenticeship programme is demand-led, apprentices are employed in job roles that are vacant and once they complete their training they can remain in their jobs with the same opportunities for progression as anyone else.

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<sup>62</sup> Other initiatives to remove barriers to further integration of health, care and other public services are discussed in further detail in the corresponding Impact Assessment "Independence, choice and control".

<sup>63</sup> Skills for Care, *Apprenticeship Employer Guide*, 2011.



159. Further support to Skills for Care to extend this programme of capacity building will therefore be necessary to support our ambition to increase the number of starts across all age groups. Whilst other sectors face challenges around demand from employers, adult social care finds it harder to recruit to meet the demand.
160. The approach will include:
- Work with Skills for Care and social care employers to encourage SMEs from across the country to create apprenticeship opportunities for the first time (promoting and making the best of the existing programmes on offer, including the newly announced £1500 incentive for SMEs).
  - The establishment of an Apprenticeships Strategy Board, led by Skills for Care, that includes employers and the National Apprenticeship Service to find new ways to encourage people to take up apprenticeships, and to improve the image of the sector as an attractive career opportunity with clear progression routes for people considering taking up an apprenticeship.
  - Work with the National Apprenticeship Service, Skills for Care and a group of providers to continually drive up the quality of the apprenticeship offer.
  - Creating clear progression routes to Higher Level apprenticeships as an additional route to attract those who could work as care managers, supporting the development of the managers and leaders of the future by seeking opportunities created by the Higher Apprenticeship Fund.
161. Scaling up apprenticeships across different sectors is a priority for Government and funding is made available through the Skills Funding Agency to cover or contribute towards the training costs of apprentices.

### *Benefits*

162. Apprenticeships support each of the three priorities for developing the care workforce: capacity, capability and leadership. They offer a comprehensive training package to improve capability, aid recruitment and retention, and provide career progression from an intermediate apprenticeship through advanced to higher level and beyond if desired, leading to managers and leaders of the future. Skills for Care's Workforce Development Strategy also highlights the importance of apprenticeships as a means of expanding the supply side to build workforce capacity and supporting greater integration and personalisation.
163. The main benefit of increasing the number of apprenticeships is security of supply of care, but additional benefits may also include:
- increased retention of staff and therefore a likely reduction in recruitment costs (anecdotal evidence from employers show they value the programme and that it improves retention);
  - health and wellbeing benefits to individuals who are moved from unemployment into work;<sup>64</sup>
  - business benefits;<sup>65</sup>
  - improved social inclusion through the reduction of unemployment; and
  - the opportunity to increase the diversity of the workforce.
164. A proportion of the apprenticeships will be taken up by NEETs and people who are currently unemployed and claiming Jobseekers Allowance, through the appropriate targeting of the policy. This should generate savings to the Exchequer from reduced joblessness.
165. A report by Hasluck et al on net benefits to employer investment in apprenticeship training concluded the following:

*“Employers are unlikely to incur such costs unless they believe such training will bring benefits to their business (although many respondents did say that they were motivated in part by a sense of*

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<sup>64</sup> There are a number of studies which look at the negative association between health and unemployment. A summary of some of this evidence can be found in a recent BMJ editorial (Dorling 2009: 338:b829) showing worse health, higher risk of mortality and increased health service usage in those who are unemployed for long periods or made redundant.

<sup>65</sup> Skills for Care, *Apprenticeship Employer Guide*, 2011.

“returning something to the community”, a desire to help young people get on in the labour market or a responsibility to contribute to the pool of skills in their industry).”<sup>66</sup>

## Costs

166. Increased capacity building with delivery partners may incur costs to support expanding the programme. Based on current funding of £1 million to Skills for Care, we assume that another £1 million per year will be needed in order to at least double the current number of starts by 2017, based on Skills for Care’s achievements to date with similar funding.
167. The number of apprenticeships in adult social care has been rising in recent years and very sharply in the last year for which data are available. This is due to Skills for Care’s capacity building and the responsiveness of employers to the benefits they perceive apprenticeships to provide as outlined above. The objective of the measures proposed is to sustain and accelerate the increase in numbers of apprenticeships in social care. The impact of the measures needs to be assessed in relation to the difference in future numbers of apprenticeships in social care with and without the measures proposed, that is the difference between the ‘do nothing’ option and the proposed option.
168. If the measures proposed generate in time an additional 50,000 apprenticeships per year over and above the increase that would occur without these measures (the counterfactual), there would be training costs to Government, which vary depending on the apprenticeship framework being funded. Whether the numbers of apprenticeships will in practice rise by 50,000 per year above the counterfactual will depend on the willingness of social care employers to employ the additional apprentices and their success in attracting apprentices.
169. Where these training costs fall to public sector agencies, they are opportunity costs which do not require increased budgets. Public funds for apprenticeships in the social care sector will not be available for apprenticeships in other sectors. Where these costs fall to employers they may in practice be shared with the apprentices since apprentices are generally paid £2.50 per hour rather than at least the general national minimum wage rate for their age. Employers and apprentices who are prepared to meet the training costs would do so in the expectation of future benefits.
- ii. Develop an online tool to support recruitment with links to clear and integrated career pathways linked to defined qualifications
170. This proposal links to the information portal discussed in the corresponding Impact Assessment “Independence, choice and control”. As a central resource for the sector, the online tool will provide links to jobs in the sector as well as offering information about working in care and support, including examples of clear, integrated and flexible career pathways linked to defined qualifications. This could be used widely both within the sector for workforce planning and Continuous Professional Development, and also as a careers resource for people interested in entering the sector.
171. During the *Caring for our future* engagement, it was highlighted that “the workforce needs a proper career structure with good training, pay and prospects”.<sup>67</sup> It is envisaged that the online tool will become a one-stop portal for people looking for jobs, more information about career pathways, volunteering opportunities, or for care ambassadors to attend events.
172. An article in Personnel Today supports the use of online recruitment as a way of cutting costs for employers.<sup>68</sup> The article highlights a survey by *Employment Review* which found that making greater use of online recruitment was the most effective way of improving recruitment while cutting costs. Three-quarters of organisations (74%) said they were now doing this.

<sup>66</sup> Hasluck C., Hogarth T., Baldauf B. and Briscoe G., *The Net Benefits to Employer Investment in Apprenticeship Training*, University of Warwick Institute for Employment Research, November 2009.

<sup>67</sup> Beresford, P. and Andrews, A., *Caring for our Future: What Service Users Say*, Centre for Citizen Participation: Brunel University, 2011.

<sup>68</sup> *Recruitment methods: costs and effectiveness*, Personnel Today (20 February 2007). Retrieved 4 January 2012 from: <http://www.personneltoday.com/articles/2007/02/20/39302/recruitment-methods-costs-and-effectiveness.html>

173. Demonstrating career pathways could incentivise both long term and step-on/step-off careers within the sector and beyond in health, housing and leisure. It will promote the varied opportunities provided by integrated working across adult social care and other sectors, therefore reaching a larger audience. This would offer a joined up approach towards targeting different labour pools and growing supply to social care jobs. The main benefit is security of supply of care.

#### Costs

174. A scoping study will be necessary in the first year to recommend the relevant approach and business model for the sector. Costs will include a project manager, project support and business analysts for approximately 6 months to research existing provision and current good practice both in the UK and internationally as well as sector requirements, and to provide an option appraisal to aid decision making. It may also cover the creation of tender documents for the development of the tool. It is estimated this will cost around £250,000. Development costs will then become clearer as a result of this study but it is estimated this will not exceed £1 million in Year 2, and maintenance costs from Year 3 on an annual basis will not exceed £250,000. The development and maintenance of the tool will require detailed knowledge of the sector and various job roles and services and will therefore be put out to tender and developed in partnership with the sector.

#### iii. Expand the Care Ambassador role

175. Care Ambassadors are people who already work in the sector, in a wide variety of roles, who occasionally take time out to promote a positive image of the sector to people interested in learning more. Skills for Care co-ordinate the current scheme which has been running for a number of years, making links between employers, local communities and developing useful resources to be used by care ambassadors. There is an opportunity to expand the scheme - developing good practice, ensuring availability across the country and involving high profile care ambassadors to raise the profile of the sector.

176. Skills for Care state there are currently around 1,300 Care Ambassadors nationally, although to date provision has been varied in different areas of the country.<sup>69</sup> Target audiences for expansion could include young people through education settings, the National Citizens Service, careers fairs, people who are unemployed or NEET through work with Job Centre Plus and people reaching retirement age through the University of the Third Age or other similar schemes.

177. The development and expansion of the Care Ambassador scheme is one of the key actions identified in the care sector's Recruitment and Retention Strategy Implementation Plan to be led by Skills for Care, through an employer steering group with representation across England and a broad range of care and support organisations.<sup>70</sup> There has been unanimous support from the employers on the steering group to move forward with the project.

178. There are significant links to be realised between the role of the Care Ambassador and other Government employment initiatives including the National Citizens Service, sector-based work academies, the Work Programme and all of the other initiatives that form the Youth Contract. Care Ambassadors have a critical role to play in promoting the benefits of a social care career to potential recruits and to intermediaries providing careers/employment support. They also have the potential to take on new and complementary roles such as mentoring new recruits to ease their transition into employment and make them more likely to stay and progress in work.

179. Whilst co-ordinated centrally, the scheme is flexible to meet local need. For example, some areas may wish to increase the number of young people in the workforce, other communities may need to recruit more men and so on, thus supporting capable communities and representation across the workforce.

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<sup>69</sup> Skills for Care, *Adult social care workforce recruitment and retention strategy*, 2011.

<sup>70</sup> Skills for Care, *Recruitment and Retention Strategy Implementation Plan*, 2011.

## Benefits

180. The main benefit is security of supply to care and support jobs by targeting different areas of the labour market. The use of role models will help people to see care and support as a sector within which people can progress through long-term, varied, challenging but rewarding careers. Care Ambassadors can promote new roles, technologies and integrated working, which will help to overcome traditional stereotypes. Links can be made with the online tool to support recruitment to advertise Care Ambassador's services. The scheme offers opportunities for personal development to Care Ambassadors through the development of new skills.
181. Further research could help evaluate the cost effectiveness of this option.

## Costs

182. Costs for expanding the Care Ambassador role would include co-ordinating and developing materials, training, advice, outreach services and networks for example to be provided by Skills for Care. It is estimated these costs would be around £800,000 in Year 1 and would also cover one national programme manager and six regional project managers. Following the refresh, we estimate recurrent costs of £0.25 million per year from Year 2 to maintain this delivery team. This will involve ongoing programme and project management and administrative support and continued development of effective materials to support the Care Ambassadors in their role. It will also involve maximising opportunities to link with other initiatives such as the DWP Work Programme, Sector Based Work Academies and the National Citizens Service.
183. Supply will also need to be agreed in the development of the programme – for example Care Ambassadors would agree with their employers how many events they would attend per month, and local areas could work together to ensure enough Care Ambassadors were recruited from a range of local employers to meet demand.
184. In order to address backfill costs to employers, Skills for Care is piloting a payment and partnering policy. A Care Ambassador's time would be charged at £15 per hour and organisations using their services can choose to either pay this cost, or offer something in return such as complimentary room hire or refreshments for example. Costs incurred would be commensurate with the benefits achieved by the organisation. For example, if 1,300 Care Ambassadors undertook 7 hours per year (we assume 1 day) at a cost of £15 per hour, this would cost £136,000 per year from Year 2.

## Proposal J: Increase capability and skills for all working in adult social care

### i. Develop a sector compact

185. The Government will work with care providers, care users and carers to develop a care and support sector compact to encourage behavioural and skills development, including:
- A clear statement of what is expected of someone working in adult social care with a core focus on the standards expected when interacting with care users and carers. This could be the refreshed code of practice for social care workers.
  - A skills pledge developed by the sector to demonstrate a clear baseline level of skills that employers sign up to (similar to Investors in People). There could be opportunities to make access to the Workforce Development Fund (WDF) – funded by Department of Health and administered by Skills for Care to support access to training - dependent upon being a signatory. Links could be made with the national minimum training standards currently being developed.
186. The compact will be developed collaboratively and published by the end of 2013. To inform the development and progress of the sector compact we will explore whether there will be a need for a regular survey to measure the performance of the workforce in terms of meeting the outcomes and needs of people who use services. This will inform the ability of the workforce to deliver personalised, integrated care services.

187. Sign-up to the sector compact will be voluntary. It will be co-developed with the sector including people who use services, employers and the workforce, to ensure long-standing and comprehensive buy-in and a shared focus on quality and personalisation. The skills pledge will seek to address the gap in training and skills development at Level 2 and for managers. There are opportunities to make links with the development of a Personal Assistant index (discussed below) and new training standards and code of conduct for care assistants outlined in the White Paper.
188. As part of this process, we would encourage ADASS and care providers to identify the appropriate proportion of available resource to support training and development as part of the commissioning process. This sets a framework for agreement between employees and employer to improve skills, competencies and behaviours.

### *Benefits*

189. Benefits will be achieved in due course and will depend on take-up. The compact will give clarity to employers and employees about what is expected of them. It will create new ways to support care users taking control and making informed decisions about the care they purchase, based on quality as well as cost. Successful implementation alongside Proposal C for making information on quality available will encourage employers to invest in training in order to reap the benefits of being recognised as a high quality care provider by the people purchasing care.
190. A skills pledge raises employer ambition and investment in skills by providing a means to address specific skills and issues, with the aim of raising skill levels and making better use of existing skills. This is supported by the UK Commission for Employment and Skills who are promoting the development of employer-led skills pledges in various sectors.
191. The Health and Social Care Act 2012 provides for the introduction of a voluntary registration for social care workers. This will ensure greater transparency and understanding of what people using services can expect from the people supporting them.
192. Further research could help evaluate the cost effectiveness of this option.

### *Costs*

193. The costs to employers of the sector compact will be dependent on how ambitious the minimum levels set out in the skills pledge are. The Workforce Development Fund (WDF) - funded by Department of Health and administered by Skills for Care to support access to training – makes available to the sector £13 million per year to offer support with training costs. In 2009/10, the WDF benefitted almost 75,000 individuals, out of a 1.6 million workforce, 70% of which had no relevant or recorded qualifications. It benefitted over 5,000 organisations out of 46,000 providing adult social care. This could be used to support the skills pledge if access to the WDF becomes dependent on being a signatory of the skills pledge. The prime objective of the training is to make workers more effective at their jobs. This could feed higher pay but should be off-set by higher productivity and increased efficiency.
194. Costs to Department of Health are estimated at £300,000 to develop the compact in partnership with the sector. This will cover project management and engagement through workshops for example. There will also be costs involved in developing and conducting a user-satisfaction survey. Based on the cost of the NHS Workforce Survey, we have assumed these one-off costs to be £0.7 million but estimate they will not be more than £1 million.

#### ii. Develop a Personal Assistant index to inform user's choice and control

195. As more people have access to a personal budget, we anticipate that the demand for Personal Assistants (PAs) to deliver tailored, personalised support will increase significantly. According to Skills for Care's comparative estimates for personal budgets and similar models of self-directed

support, the number of PAs and similar types of staff jobs will increase consistently over the coming years from 251,000 in 2010, 421,000 in 2015, 628,000 in 2020 and up to 812,000 in 2025.<sup>71</sup>

196. We propose scoping the possible development of a PA information "index". This will facilitate easier access to available PAs for people with care needs. It will also provide a clear and transparent comparison of the services available from individual PAs, including information on the PA's experience and qualifications as well as feedback from people who have employed them. The scoping exercise will explore with direct employers and personal assistants what information will be most useful. The aim is to build a single set of information capable of meeting the needs of users, providers, commissioners and the regulator.
197. The issue of how personal employers can get in touch with PAs and make judgements about their ability to meet their individual needs was raised as part of the development of "Working for Personalised Care: a Framework for Supporting Personal Assistants Working in Adult Social Care".<sup>72</sup> A survey undertaken by ADASS to examine how local authorities are supporting employers to manage direct employer responsibilities found significant variation in the availability of PA support services.<sup>73</sup> The PA index could address this variation through the development of a national system based on best practice to allow employers to determine which PAs can meet their needs.

### Benefits

198. Essex Coalition for Disabled People has outlined the types of support that enable people who use services to exercise choice and control.<sup>74</sup> These include independent information, advice and guidance, peer support, practical services and support such as payroll, help with recruitment and take up of CRB checks and training, including guidance on how to manage staff and to provide practical training for PAs.
199. As part of the engagement process, the Joseph Rowntree Foundation reinforced the importance of making available good information about services on offer.<sup>75</sup> It pointed out that older people have no way of knowing what their care worker can do for them and that such information would remove uncertainty. Research suggests that older people and those with mental health conditions are less likely to take up direct payments.
200. A PA index will help to address this. It will provide the information and support, including user feedback, which employers need to develop the confidence to employ their own staff, and to exercise choice and control over their relationships. It will provide incentives to improve services based on quality. It could also provide greater understanding of the diversity of PAs and support workers, and raise awareness of the potential roles they can play. Linked to the sector compact, it could help to realise high quality user-led services and to increase person-centred care and advance the ability to shape a market built upon quality, not cost.
201. A PA index would also begin to shape available opportunities for career development and retention for PAs and other support workers.
202. Together the PA index and sector compact could help to emphasise the importance of training in driving up quality and supporting workers in their job roles and provide additional incentives for PAs to improve their skills and experience. Skills for Care research suggests that a fifth of those who had difficulties recruiting PAs ascribed this to the lack of career development and training opportunities available, while the most frequent reason given by PAs who stated that they were likely to leave PA work in future was that they are looking for training or career development opportunities.<sup>76</sup>

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<sup>71</sup> Skills for Care, *The state of the social care workforce*, 2010.

<sup>72</sup> Department of Health, *Working for personalised care – A framework for supporting personal assistants working in adult social care*, 2011.

<sup>73</sup> ADASS, *The Invisible Workforce – Developing PAs in the Adult Social Care Workforce*, May 2011.

<sup>74</sup> <http://www.ecdp.org.uk/>

<sup>75</sup> Joseph Rowntree Foundation: *How could we improve the quality of care and how could we develop the future workforce to do this?*, March 2012.

<sup>76</sup> Skills for Care (IFF Research), *Employment aspects of and workforce implications of Direct Payments*, 2008.

## Costs

203. Scoping work will be required to determine the requirements for the index. This will be undertaken working closely with the sector via focus groups and working with user-led groups. It is important that the PA index meets the needs of people employing PAs in the broadest sense in order to improve confidence and therefore equalities will be an important feature of the scoping exercise. Costs for scoping would include project management for approximately 6 months and is estimated to be no more than £250,000. This would enable further understanding of the most effective model and the potential costs and benefits involved.

### iii. Support the development of the PA workforce

204. We propose extending access to the Workforce Development Fund (WDF) - funded by Department of Health and administered by Skills for Care to support access to training - to PAs. We will also promote the existence of the WDF to personal employers who may not be aware of the funding available for their PAs. Feedback from the *Caring for our future* engagement identified a need for “proper, nationally available training for personal assistants”. It also suggested that some workers find it difficult to adapt to the “more flexible way of delivering support to disabled people”.<sup>77</sup>

205. Evidence suggests that existing care workers are often reluctant to transfer to the PA role.<sup>78</sup> Concerns have been raised over continuity of employment; difficulties of work scheduling; risk of over involvement; lack of back up in difficult situations; and uncertainty over how to access training, qualifications and support as reasons why. Commissioners have also identified a lack of routine information for workforce planning.

206. The characteristics of the PA workforce mean that it is often difficult for micro-employers to find resources for back-fill when PAs take time out for training and development. Support through the WDF will help with this problem and could also incentivise use of on the PA index as PAs will then be able to demonstrate relevant training and qualifications.

## Benefits

207. As care and support becomes increasingly personalised and the number of direct employers requiring tailored support increases, the PA workforce will have a key role to play. This proposal supports that workforce to deliver integrated and personalised services to meet the needs and preferences of the people using services.

## Costs

208. A percentage of the WDF funding will be directed to the PA workforce to support their development. There will be no further costs attached to this option.

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<sup>77</sup> Beresford, P. and Andrews, A., *Caring for our Future: What Service Users Say*, Centre for Citizen Participation: Brunel University, 2011.

<sup>78</sup> Rubery, J. et al, *The Recruitment and Retention of a Care Workforce for Older People: Final Report to DH*, 2011.

## Summary of costs of Option 2 (implement Proposals H-J)

Table 2

Proposal	Agent	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
<b>Establishment of Leadership Forum</b>											
Transition Cost	DH	0.50									
Recurrent Cost	DH	0.00	0.14	0.14							
<b>Align Leadership Qualities Frameworks</b>											
Transition Cost	DH		0.03								
<b>Expand Apprenticeships</b>											
HIJ Recurrent Cost	DH	1.00	1.00	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00
<b>Online tool to support recruitment</b>											
Transition Cost	DH	0.25	1.00								
Recurrent Cost	DH			0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25
Recurrent Savings	Providers	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
<b>Expand Care Ambassador role</b>											
Transition Cost	DH	0.80									
Recurrent Cost	DH		0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25
Recurrent Cost	Providers		0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14
<b>Develop sector compact</b>											
Transition Cost	DH		0.30								
Recurrent Cost	DH		0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70
<b>Develop a PA Index</b>											
Transition Cost	DH		0.25								
<b>Total</b>											
Transition Cost Total	DH	1.55	1.58								
Recurrent Cost Total	DH	1.00	2.09	2.34	2.20	2.20	1.20	1.20	1.20	1.20	1.20
Recurrent Cost Total	Providers		0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14
<b>Costs Grand Total</b>		2.55	3.81	2.48	2.34	2.34	1.34	1.34	1.34	1.34	1.34

209. These measures to improve the capacity and capability of the care and support workforce, particularly the proposal to expand apprenticeships in social care, may have an impact on wages in the care sector. The short-term impact may well differ from the longer-term impact.

210. In the short-term, the subsidies from central Government will help care providers employing apprentices to achieve a full complement of staff at a lower wage bill than in the absence of apprenticeships. This is partly because apprentices receive wages of £2.50 per hour and partly because of the reduction in any existing upward pressure on wages from the reduction in unfilled vacancies.

211. The medium to long-term impact on wages is more complex. If, as intended, many apprentices choose to remain in the sector after their apprenticeships, this would reduce any upward pressure on wages since there would be more people interested to work in the sector and fewer unfilled vacancies. More generally, however, people with higher qualifications are usually, other factors equal, more productive and better paid than people with lower qualifications. Improvements in the skills and qualifications of the workforce are relevant to the achievement of higher quality care. They also have the potential to promote economic growth, raising national output, income and expenditure.

212. It is likely that if the qualifications of social care staff rise, there will be an increase in productivity in the sector and it is possible that there will be an upward pressure in wages in the sector. This would not occur rapidly - staff do not receive an immediate pay rise on obtaining an NVQ Level 2 for example - but could occur over a long period. It would also be dependent on changes in the levels of skill in the wider economy. If these increased at a similar or higher rate than the social care workforce, there would likely be no upward pressure on wages.



213. Even if there is an increase in wages, this need not necessarily mean an increase in costs and prices in the sector. First, if a rise in the proportion of staff with qualifications reduced staff turnover, this would yield some savings to providers. Second, if the expected increase in productivity meant that the same volume of output could be produced with fewer staff, (that is if the rise in wages was matched by a fall in staff numbers, keeping wage costs constant), rising wages would not result in the cost per unit of social care output rising. In practice, however, it seems more likely that much of the productivity gain would lead to improved quality of care, a key objective of the reforms, rather than lower staffing ratios.

## **Safeguarding Proposals**

### *Objective:*

Local organisations understand their role, work together, support each other and share expertise to deliver better safeguarding outcomes for adults in vulnerable situations.

214. Analysis of the following proposals is set out below:

- K. Clarify through legislation the core membership, roles and responsibilities of Safeguarding Adults Boards (SABs);
- L. Clarify in legislation that local authorities should have a function to make enquiries about adult protection cases.

215. We also intend to use the opportunity of pre-legislative scrutiny on the draft Care and Support Bill to consult specifically on whether a new power should be created for local authorities to access a person who may be at risk of abuse or neglect, in cases where the local authority may not be able otherwise to carry out a safeguarding enquiry. This consultation will seek to improve the limited evidence base for the potential costs and benefits of a power of access.

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

216. Three options have been considered to take forward this proposal: Firstly, to do nothing; secondly to specify an exhaustive list of members and responsibilities in legislation; or thirdly to take a less prescriptive approach which specifies core membership with additional flexible local appointments and high-level strategic responsibilities. The third option is the preferred option. Analysis of all three options is provided below.

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

217. 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.

218. 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.

219. 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.

220. Braye et al demonstrate there is considerable variation in the operation of existing non-statutory SABs.<sup>79</sup> 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).
221. 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.<sup>80</sup> This was based on a survey of 144 local authorities in England and Wales, of which 133 responses were suitable for analysis.
222. 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.
223. 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.
224. 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.**
225. 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. This would imply that police would be represented on 86 of 152 boards, giving a lower bound estimate of involvement in boards of 57%.
226. 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.
227. In 2011, Braye et al. found membership of between 10 and 47 agencies on existing boards.<sup>81</sup> 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.
228. 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.
229. 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.

<sup>79</sup> 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.

<sup>80</sup> 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.

<sup>81</sup> 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.

These assumptions are presented in Annex A, as well as the hourly and daily costs of the members of boards.

230. 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.<sup>82</sup> This data is used to inform the baseline costs of existing boards.

*Current costs of membership and responsibilities of boards*

231. The current costs of boards, based on the evidence and assumptions set out above and in Annex A, are presented in the table below.

Table 3

Estimate of baseline costs of SABs (£m, minimum and maximum costs based on 88% and 98% of local authorities having boards respectively)						
	Year					
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
<b>Real costs</b>						
Chair	4	4	4	4	4	4
Administration	3	3	3	3	3	3
<b>Total real costs</b>	<b>7</b>	<b>7</b>	<b>7</b>	<b>7</b>	<b>7</b>	<b>7</b>
<b>Opportunity costs - members</b>						
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
<b>Opportunity costs - responsibilities</b>						
Serious case reviews or equivalent	4	4	4	4	4	4
<b>Total opportunity costs</b>	<b>22 - 25</b>	<b>22 - 25</b>	<b>22 - 25</b>	<b>22 - 25</b>	<b>22 - 25</b>	<b>22 - 25</b>
<b>Total real and opportunity costs</b>	<b>29 - 33</b>	<b>29 - 33</b>	<b>29 - 33</b>	<b>29 - 33</b>	<b>29 - 33</b>	<b>29 - 33</b>
<b>**Numbers rounded so may not tally</b>						

Option 2: Specify an exhaustive list of members and functions for the SABs in primary legislation or regulations

232. The original *No Secrets* guidance specified a long list of agencies that could be identified as possibly involved in a multi-agency framework. Under this option the legislation could specify that all these agencies (listed at Annex A), or equivalent, are represented on every SAB.

233. Under this option, the detailed board functions set down in the report of the Law Commission would be set out in statute. These functions are:

- To keep under review the procedures and practices of public bodies which relate to safeguarding adults;
- To give information or advice or make proposals to any public body on the exercise of functions which relate to safeguarding adults;
- To improve the skills and knowledge of professionals who have responsibilities relating to safeguarding adults; and
- To produce a report every two years on the exercise of the board's functions.

<sup>82</sup> 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.

234. The Law Commission also suggested that Government be given a regulation-making power to add to this list of functions.

#### Costs of Option 2

235. Making boards statutory will lead to an increase in the number of boards to 100% of local authorities (currently estimated at between 88% and 98%). Specifying a list of members would prescribe a minimum of around 23 agencies to be represented on boards. As set out above, the current maximum number of agencies represented on boards is 47 and it is likely that boards with 47 representatives will have these prescribed members already. Therefore, the range of membership will be between 23 and 47. This would raise the estimated mid-point of membership of boards from 29 to 35.

236. The additional costs of Option 2 are estimated to be between £8 million and £12 million per year, the mid-point estimate is therefore £10 million.

Table 4

Costs of Option 2 (additional to current baseline costs described in Table 3 above)						
(£m)	Year					
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
<b>Real costs</b>						
Chair	0.09 – 0.5	0.08 – 0.5	0.08 – 0.5	0.07 – 0.5	0.07 – 0.5	0.07 – 0.5
Administration	0.06 – 0.4	0.05 – 0.4	0.05 – 0.3	0.05 – 0.3	0.05 – 0.3	0.05 – 0.3
<b>Total real costs</b>	<b>0.15 – 0.9</b>	<b>0.13 – 0.9</b>	<b>0.13 – 0.8</b>	<b>0.12 – 0.8</b>	<b>0.12 – 0.8</b>	<b>0.12 – 0.8</b>
<b>Opportunity costs - members</b>						
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
NHS provider 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	0.02 – 0.1	0.02 – 0.1	0.02 – 0.1	0.02 – 0.1
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	4 – 6	4 – 6	4 – 6	4 – 6	4 – 6	4 – 6
<b>Opportunity costs - responsibilities</b>						
Serious case reviews or equivalent	3	3	3	3	3	3
<b>Total opportunity costs</b>	<b>8 – 11</b>	<b>8 – 11</b>	<b>8 – 11</b>	<b>8 – 11</b>	<b>8 – 11</b>	<b>8 – 11</b>
<b>Total real and opportunity costs</b>	<b>8 – 12</b>	<b>8 – 12</b>	<b>8 – 12</b>	<b>8 – 12</b>	<b>8 – 12</b>	<b>8 – 12</b>

**\*\*Numbers rounded so may not tally**

237. Given the need for local professional judgement and flexibility, we think Option 2 is too prescriptive. We have also discussed the Law Commission's proposals for Board functions with our Safeguarding Advisory Board, which is a forum of key safeguarding stakeholders from the social care sector. Their view is that statutory SABs should also function at a higher, strategic level, as a set of strategic responsibilities, and specifically focus on outcomes.

#### Option 3: Specify core membership with additional flexible local appointments of members and confer strategic responsibilities on SABs (preferred option)

238. This option would involve specifying in legislation a core membership for SABs of local social services authorities, NHS commissioners and the police, in line with the Law Commission's recommendations, with an additional power for the SAB to add to the membership as required by the local situation. **This is the preferred policy option** for membership.

239. 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.
240. Under this option, agencies 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.
241. 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.
242. 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.

### *Benefits of Option 3*

243. 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.
244. 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.
245. 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.
246. 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".<sup>83</sup> 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.

### *Costs of Option 3*

247. 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-

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<sup>83</sup> *The Munro Review of Child Protection: Final Report*, Munro, 2011  
[http://www.education.gov.uk/munroreview/downloads/8875\\_DfE\\_Munro\\_Report\\_TAGGED.pdf](http://www.education.gov.uk/munroreview/downloads/8875_DfE_Munro_Report_TAGGED.pdf)

point estimate of the number of members the same. The estimated additional costs of Option 3 are between £4 million and £8 million per year, therefore the mid-point estimate is £6 million per year.

248. 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 5

Costs of Option 3 (additional to current baseline costs described in Table 3 above)						
(£m)	Year					
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
<b>Real costs</b>						
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
<b>Total real costs</b>	<b>0.15 – 0.9</b>	<b>0.15 – 0.9</b>	<b>0.15 – 0.9</b>	<b>0.15 – 0.9</b>	<b>0.15 – 0.9</b>	<b>0.15 – 0.9</b>
<b>Opportunity costs - members</b>						
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
<b>Opportunity costs – responsibilities</b>						
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
<b>Total real and opportunity costs</b>	<b>4 – 8</b>	<b>4 – 8</b>	<b>4 – 8</b>	<b>4 – 8</b>	<b>4 – 8</b>	<b>4 – 8</b>
<b>**Numbers rounded so may not tally</b>						

249. 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.

250. 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 3 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.

**Proposal L: Local Authority function to make enquiries**

251. 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

252. 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 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.

253. The NHS Information Centre estimated that there were 94,510 adult referrals in 2010-11.<sup>84</sup> 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.<sup>85</sup> These are therefore used as an indication of the amount of resource required for adult enquiries.
254. 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.
255. 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<sup>86</sup>, we estimate the current cost of enquiries to be approximately £30 million.

#### Option 2: Confer a local authority function to make enquiries

256. This proposal introduces in legislation a function enabling 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 other organisations.
257. 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.

#### *Benefits of Option 2*

258. 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;
  - If the net additional cost of this proposal is approximately £2.4 million per year, this is equivalent to saving approximately 1 – 2 statistical lives per year (see below for more information on DH valuation of statistical life).

#### *Additional costs of Option 2 to introduce a local authority function to make enquiries*

259. 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<sup>87</sup> at an additional cost of between 600,000 and £4.2 million per year.

<sup>84</sup> 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.

<sup>85</sup> 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.

<sup>86</sup> <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.

<sup>87</sup> 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%).

## **Overall benefits of Proposals K and L**

260. In summary, we propose that legislation should:
- 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.
261. 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.
262. 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.
263. 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.
264. 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.
265. 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.<sup>88</sup>
266. 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.<sup>89</sup>
267. Using a systematic review of the prevalence of abuse in general populations<sup>90</sup> it can be estimated that around 6% of people aged 65 and over suffer significant abuse per annum. Using ONS population data<sup>91</sup> 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.<sup>92</sup> 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.
268. 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.

<sup>88</sup> Alsaker, K. et al, “Low health-related quality of life among abused women”, *Quality of Life Research* 15: 959 – 965, 2006.

<sup>89</sup> 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.

<sup>90</sup> Cooper, C. et al, “The prevalence of elder abuse and neglect: a systematic review”, *Age and Ageing* 37: 151 – 160, 2008.

<sup>91</sup> <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-229866>

<sup>92</sup> The NHS Information Centre, *Abuse of Vulnerable Adults in England 2010-11: Final Report, Experimental Statistics*, 2012.



269. The net additional costs of the preferred option are between £4 million and £6 million 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 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.

## V. RISKS

### *Quality Proposals*

270. Proposals A to E rely on voluntary participation to achieve their objectives and there is therefore a risk that their effect may not be as significant as hoped, should local authorities and providers not respond as intended.

- The provider quality profile including online user feedback from service users through a “trip advisor style model” is reliant on a critical mass of providers adding information and care users giving feedback to enable people to be able to make the necessary comparisons on quality of care to inform choice and drive quality.
- People less familiar with the use of new technologies or without access to the internet may not be able to benefit from the provider quality profile and online user feedback. However, we anticipate that this risk will be mitigated by proposals set out in the corresponding Impact Assessment “Independence, choice and control” to require local authorities to fulfil a duty to provide information and advice to their local population.
- There is a risk that local Healthwatch may not be able to recruit enough volunteers to play an active role in the sector so there may be little take of the proposed training. However, people already volunteer in this way through existing Local Involvement Networks. As local Healthwatch take over responsibilities from LINks we expect many of those volunteers will continue their good work and hope the increased profile of the local Healthwatch alongside the recent publicity given to issues around quality in social care will incentivise more people to become involved.
- Given the resource implications set out for providers, it may be difficult to recruit care providers to take part in a pilot of clinical audit in social care without paying them to do so. This risk may be offset by other incentives in place for providers to become involved. These include being able to use the clinical audit results to market their service through the provider quality profile and benefits to the organisation itself in terms of being able to demonstrate that their service is effective (and cost-effective); providing opportunities for training and education; supporting providers to quality issues systematically and explicitly, providing reliable information to confirm the quality of services and highlight areas for improvement; and enabling their workforce to demonstrate competence in key areas of care.

271. More generally, mitigation of these risks relies on clearly articulating the incentives and support for the different players to take part in the various proposals in order to encourage maximum participation. A common understanding of what high quality care looks like and the roles and responsibilities of organisations at all levels in the system to achieve that is key.

272. Publishing an enhanced quality framework for social care aims to address this issue but there is a risk that it will not gain the traction that it needs in the sector to make a difference. Likewise there is a risk that any resources and best practice around commissioning for outcomes, quality and value for money are not used by providers and commissioners. This risk is mitigated through developing the quality framework and the commissioning support with full involvement of the care sector and ensuring it is owned and taken forward at the highest level through our plans for strengthening leadership for quality in care and support.

## ***Market Shaping Proposals***

273. We do not identify any significant risks associated with the new legal duty regarding market shaping, as this is codifying existing practice and providing further guidance for local authorities on the elements that they should consider when seeking to promote and facilitate the market. However, there is a risk that local authorities do not have the capabilities and expertise to carry out this new duty effectively. It is for this reason that we intend to provide support by rolling out a programme to help local authorities develop market position statements.
274. In terms of our market position statement work programme, the Government has allocated sufficient funds to support all local authorities, so there is no risk that local authorities will not be able to access funding. Our intention is that there will also be sufficient capacity to ensure that all local authorities can access support within the year, so they are not delayed in progressing with this work.
275. The market position statement work will be lead by an independent organisation and will require co-ordination across different local authorities. As such, there is a risk of co-ordination failures. To mitigate against this we have involved the Association of Directors of Adult Social Services (ADASS) at an early stage in the planning of the programme and intend to involve the regional ADASS tiers in order to effectively scope and deliver the work. A steering group will be set up to guide the work, and the Department will also monitor and evaluate the progress being made throughout. We are also planning to have an initiation programme with a launch event, co-ordinated by the steering group to explain the rationale for the work and briefing materials will be prepared so that all local authorities are informed about the work.
276. Finally, there is a risk that we will not be able to evaluate the full benefits and impacts of this programme of work, given that local authorities will be free to develop their own statements and engagement strategies with their local markets. To mitigate against this, we have stipulated that there must be a full review and evaluation of the project, at the mid-point and end of the work. At these points, there will be a statistical summary of activities and an analysis of the quality of the market position statements produced by the different local authorities. The Department of Health would welcome suggestions for further developments to the programme to the steering group.

## ***Workforce Proposals***

277. As with Proposals A to E, the success of Proposals H, I and J aimed at strengthening workforce leadership, capacity and capability will rely upon participation from the care sector and in particular employers. We plan to mitigate this risk by engaging with the sector in the further development of policy options, promoting the benefits and information widely and using targeted and ambitious communications to demonstrate the opportunities offered by the sector for people considering taking up a career in adult social care.
278. The online tool to support recruitment and PA index may not be as effective for people less familiar with the use of new technologies or without access to the internet. This will be overcome by working with employers, local authorities and user-led groups to provide support locally and promoting this support widely.

## ***Safeguarding Proposals***

279. 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. Reports would also need to demonstrate the effective use of financial resources allocated for safeguarding activity. 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.

## **VI. SPECIFIC IMPACT TESTS**

### ***One-In One-Out***

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

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

### ***Wider impact on business***

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

283. Proposal A to take forward a quality framework, Proposal D to work with the sector to improve commissioning information and skills and Proposal E to strengthen user voice will provide transparency to both commissioners and providers and ensure that services are matched to needs and can be provided more efficiently.

284. Proposal B to pilot clinical audit may potentially create some burden on providers. Although participation will be voluntary, there may be a disproportionate impact on small firms arising from the staff time required to undertake audit. However, such a burden may well be outweighed by the benefit to providers in terms of them being able to benchmark their practice against a key area of service and ultimately improve their practice and marketability. The clinical audit pilot will help us understand the extent of burden placed on providers to take forward audit and the levels to which that can be off-set in terms of greater efficiency, better outcomes and improving marketability.

285. Clinical audit is already extensively used to good effect in the NHS. The length of time required and the skills and experience of those undertaking the audits varies. For some clinical audit projects, data collection, analysis and action plans can be carried out in a matter of hours, while others may take several months. Any audits designed for use in the care sector will be developed in consultation with the sector to ensure they are fit for purpose and achievable within the resources available. Whilst undertaking the clinical audit process involves some time and resource commitment, reviewing practice in this way can help to ensure better use of resources and therefore increase efficiency. There may be similar issues linked to adhering to NICE guidelines that again will be voluntary.

286. There is potential for Proposal C - making available provider-level information - to have some impact on the ability of smaller providers to enter the market. The provider quality profile could favour larger care provider organisations with greater financial capacity to publish information items. The exact content of the profile will be worked up with involvement of a range of provider organisations to help ensure smaller providers are not disadvantaged.

287. A large proportion of the content of the quality profile will be generated from existing data with no input from providers themselves. Providers will be asked on a voluntary basis to submit some information to help them build their reputations in the market, including basic details about the care provider; whether they meet NICE standards once available; and how they meet key metrics. These metrics have been identified and voluntarily agreed by provider representative organisations - they are based on information providers already collect or have easy access to.

288. In terms of burdens placed on providers, it may well be that one national portal for the information with a nationally identified dataset (as proposed) may end up being less burdensome on providers than them expecting to meet the information requirements (and costs) of many different comparison websites. Providers would have a choice whether or not to pay fees to join but as the scheme grows in size and popularity, it will prove advantageous for providers to be included. DH will work closely with the sector in designing the collection system (where possible getting data through existing collections such as those made by CQC and Skills for Care) and the way the data is presented to minimise the impact on small businesses. The Government's preferred approach is to adopt a voluntary approach working with providers. Only in the event that this fails to deliver the intended outcomes will the Government then consider moves towards a more mandatory approach, again engaging with the sector.
289. In the future there may also be some element of voluntary provider activity to enable aggregated user feedback (perhaps derived from a survey around some key questions) to appear on the scorecard. It is likely that providers will only choose to participate in gathering this user feedback if they think it is cost effective to do so. We will engage with the sector on the best way of achieving this with minimal burden.
290. A significant number of care providers are 'micro-providers' (less than 10 employees), and would therefore have an exemption from new areas of regulations. If, in the future, the Department identified the need for mandatory data collection for all providers, we would need to work with BIS to seek an exemption so we can also apply any new data collection regulations to micro-providers.
291. Proposals F and G 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 have more information about the local market and therefore would be able to make more informed investment decisions. Furthermore, smaller businesses should benefit from better, more strategic relationships between commissioners and 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.
292. The expansion of apprenticeships in the care sector, under Proposal I, does not represent a burden to business since take-up is voluntary and demand-led. SMEs can benefit from the introduction of wage grants to assist them in recruiting their first apprentice, and all businesses can benefit from support with training costs, the size of which depends upon the age of the candidate and the size of the employer.
293. The online tool to support recruitment, also under Proposal I, will provide links to other websites advertising jobs and will not incur costs on business itself. In addition to offering a careers resource for people interested in entering the sector, it will offer opportunities to business as a resource to support workforce planning and Continuous Professional Development.
294. In taking forward the development of a social care sector compact under Proposal J, it is possible that the cost of meeting this skills level would be easier to absorb within larger providers. We will work with the provider sector to ensure an appropriate and proportionate approach is taken. If access to the Workforce Development Fund is made dependent on being a signatory, then small firms will continue to benefit from access to funding for training. This is especially the case for personal employers and the PA workforce. The PA index, also under Proposal J, will be voluntary. We anticipate that PAs will choose to sign up to the index where they perceive the benefits of doing so to outweigh any costs.

### **Competition**

295. Overall, Proposal C to make provider level information on quality available will have positive implications for competition by giving users more relevant information and therefore empowering user choice. However, if small firms are exempt from the proposal or if it is not possible for them to take part in all aspects of the proposal it may limit their competitiveness, as users will not be able to

access the same range of information for these providers as others. As set out above, we will work with provider organisations to ensure an appropriate approach is taken which does not put smaller providers at a disadvantage.

296. Proposals F and G should also have a positive impact on competition. These proposals should enable more suppliers to enter the market due to increased intelligence about the intentions of local authorities and the local market. This should encourage new entrants to the market and increase the levels of competition.

297. Proposal I to improve workforce capacity and specifically to develop a central online recruitment tool offers the ability to provide additional information about skills to the public and to potential recruits. This skills transparency should support additional competition for high quality staff and improvements in the way in which skills, competencies and learning can be used as a catalyst for improvements in the labour market.

### ***Other impacts***

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

## **ANNEX A - Current costs of boards and assumptions regarding the current and additional costs of boards**

### **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 in the tables below will be lower in future years.

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.<sup>93</sup>)

- NHS costs per day – provider and commissioner – Agenda for Change Band 8b<sup>94</sup>, 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.
- 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.

### **List of agencies that could be specified under Proposal K, Option 2 (based on suggestions for membership of multi-agency partnerships in existing *No Secrets* statutory guidance):**

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<sup>93</sup> 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))

<sup>94</sup> <http://www.nhscareers.nhs.uk/details/default.aspx?id=766>

- Commissioners of health and social care services (2 members)
- Providers of sheltered and support housing (1)
- Regulators of services (1)
- The police and other relevant law enforcement agencies (including the Crown Prosecution Service) (2)
- Voluntary and private sector agencies (2)
- Other local authority departments e.g. housing and education (2)
- Probation departments (2)
- Jobcentre Plus and other benefits agencies (1)
- Carer support groups (2)
- User groups and user-led services (2)
- Advocacy and advisory services (2)
- Community safety partnerships (1)
- Services meeting the needs of specific groups experiencing violence (1)
- Agencies offering legal advice and representation (2)