

<b>Title:</b> Criminal Offence of ill-treatment or wilful neglect <b>IA No:</b> DH 6117  <b>Lead department or agency:</b> Department of Health  <b>Other departments or agencies:</b> Ministry of Justice	<b>Impact Assessment (IA)</b>		
	<b>Date:</b> 27/02/2014		
	<b>Stage:</b> Consultation		
	<b>Source of intervention:</b> Domestic		
	<b>Type of measure:</b> Primary legislation		
<b>Contact for enquiries:</b> Mia Snook (Mia.Snook@dh.gsi.gov.uk)			

<b>Summary: Intervention and Options</b>	<b>RPC Opinion:</b> Not Applicable
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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, Two-Out? Measure qualifies as
-£15m	£NA	£NA	No   NA

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

There is a small but important gap in existing legislation, whereby there are currently specific criminal offences addressing the ill-treatment or wilful neglect of children, adults who lack capacity, and, those subject to the Mental Health Act 1983. There is no specific offence in relation to adults with capacity. The Government has accepted the recommendation of Prof. Don Berwick who chaired the National Advisory Group on the Safety of Patients in England to create a new offence to fill this gap. This means there will be an offence to address conduct by health or social care workers or organisations which results in the ill-treatment or wilful neglect of any service users, not just the groups mentioned above.

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

The policy objective is to establish a criminal offence to operate alongside those that already exist so that any health or social care worker or organisation whose conduct amounts to ill-treatment or wilful neglect can be held to account through analogous criminal proceedings. The intended effect is to close the gap in the current legislation to provide consistency of approach in relation to ill-treatment and wilful neglect. This offence will also send a strong message that poor care will not be tolerated and ensure that wherever ill-treatment or wilful neglect occurs, those responsible will be held to account.

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

Option 1: Do nothing - there would remain a gap in the legislation in relation to the ill-treatment or wilful neglect of persons with full capacity in receipt of health or social care services.

Option 2: Implementation of a new criminal offence of ill-treatment or wilful neglect: the new offence, analogous to similar offences that already exist, is intended to act as a deterrent and, more importantly, provide consistency of approach in respect of conduct that causes ill-treatment or wilful neglect of any service users.

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

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

Signed by the responsible Minister: \_\_\_\_\_ Date: 27 February 2014

# Summary: Analysis & Evidence

# Policy Option 1

Description: Do nothing

## FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2015	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: 0

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	0	0	0

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

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline.

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

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline.

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	0	0

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

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline.

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

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline.

Key assumptions/sensitivities/risks

Discount rate (%) 3.5

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline. Under the do nothing option, there is a risk that in the case of serious failings, providers cannot be fully held to account for their actions.

## BUSINESS ASSESSMENT (Option 1)

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

# Summary: Analysis & Evidence

# Policy Option 2

**Description:** Review and recast the registration requirements so that they are clearer and easier to understand

## FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2015	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: -£15m

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	£2.4m	£2.3m	£15m

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

The main costs are likely to be to the Criminal Justice System and to defendants, both individuals and organisations. With the Mental Capacity Act 2005 as a proxy, we estimate that there may be up to 240 cases a year under the proposed new offence, with an average total CJS cost estimate of £2.2m pa in steady state. In a minority of cases, defendants will be required to fund their own defence costs, estimated to be £400 per case. Penalties may include fines, but these cannot be quantified.

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

The police will incur costs associated with investigation and evidence gathering regarding potential cases of ill-treatment or wilful neglect. These costs are likely to vary significantly so cannot be reliably quantified. Providers may choose to undertake further action to reduce the risk of prosecution under the new offence, and regulators or commissioners may also respond to the new offence by increasing scrutiny of providers. There may also be costs in terms of potential reputational damage.

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	unquantified	unquantified	unquantified

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

It has not been possible to monetise any benefits, because of the nature of those benefits, e.g. the new offence could act as a deterrent which could reasonably be expected to improve quality and safety of services, but this cannot be quantified. However paragraphs 76 - 83 below give further detail of some of the potential benefits.

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

A new offence would ensure that those responsible for the worst failures in care can be held accountable. It could also act as a deterrent, moderating the conduct of individuals who might otherwise be disposed to behave in ways that would constitute an offence. Organisations subject to the offence may also be further encouraged to ensure their management and operational procedures are compliant with safety and quality requirements.

Key assumptions/sensitivities/risks	Discount rate (%)	3.5
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The cost estimates are based on experience under the Mental Capacity Act 2005, but in practice costs may deviate significantly from this. We have made adjustments based on the literature to account for differences in the potential prevalence and reporting of ill-treatment or wilful neglect. In addition, the proposed new offence would target organisations as well as individuals, which could increase costs as it is not possible to identify whether the proxy data includes such cases.

## BUSINESS ASSESSMENT (Option 2)

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

# Evidence Base (for summary sheets)

This is an initial impact assessment which is produced as part of our consultation process. We will be revisiting it in the light of the outcomes of the consultation.

This version of the impact assessment is intended to describe the background to the proposals, to provide detail of the options considered and to identify the key themes of the potential impacts of our preferred option. The figures contained in this impact assessment are our initial estimates based on the figures available. We welcome any additional views and evidence as part of our consultation process.

## Policy Background

1. On 9 June 2010, the then Secretary of State for Health, Andrew Lansley, announced a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire NHS Foundation Trust. The Inquiry was chaired by Robert Francis QC, and built on the work of his earlier independent inquiry into the care provided by the Trust between January 2005 and March 2009.
2. Robert Francis QC published his final report into the events at Mid Staffordshire NHS Foundation Trust in February 2013. Part of the Government's immediate response was to establish a number of specific reviews focussing on issues raised in his report, and Professor Don Berwick was asked to chair an independent review on improving the safety of patients in England.
3. The National Advisory Group on the Safety of Patients in England (the 'National Advisory Group') was established to support Professor Berwick with the review. In its final report<sup>1</sup>, published in August 2013, the National Advisory Group focussed on the importance of achieving a careful balance between culture changes which support openness and transparency, and support staff and organisations to learn from error and improve their practice, with the need to assure accountability to the patient. Automatically looking for someone to blame following an accident or genuine mistake would not support those cultural changes. Nevertheless, the National Advisory Group also accepted that there should be a system in place to deal with those cases where the act or omission is not accidental, but amounts to ill-treatment or wilful neglect.
4. The National Advisory Group recommended the development of a new and specific criminal sanction for those 'found guilty of wilful or reckless neglect or mistreatment of patients'. Their view was that this new offence, analogous to those that already exist, would act as a deterrent and, more importantly, place all potential perpetrators on an equal footing in terms of the sanctions they would face in the event of ill-treatment or wilful neglect.
5. The Government published its full response to the Francis Report<sup>2</sup> on 19 November 2013. This also included responses to the recommendations made by all the specific reviews established in its immediate response. In this, the Government accepted the National Advisory Group's recommendation, and committed to consulting on detailed proposals before legislating on the new offence as soon as Parliamentary time allows.

**The evidence base of this impact assessment is structured as follows:**

**Section A:** Definition of the underlying problem and rationale for government intervention

**Section B:** Policy objectives and unintended effects

**Section C:** Description of the options

**Section D:** Costs and Benefits of the options (including specific impacts)

**Section E:** Equality Impact Assessment and summary of specific impact tests

**Section F:** Summary and conclusion

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<sup>1</sup> *A promise to learn – a commitment to act: Improving the Safety of Patients in England*. Published August 2013: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/226703/Berwick\\_Report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf)

<sup>2</sup> *Hard Truths: The Journey to Putting Patients First*, published 19<sup>th</sup> November 2013. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/270368/34658\\_Cm\\_8777\\_Vol\\_1\\_accessible.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf)

## Section A: Definition of the underlying problem and rationale for government intervention

6. There are a range of existing regulatory and legislative mechanisms designed to prevent poor quality care and to hold those responsible to account where it does occur. However, there remains a small but important gap in existing legislation. Currently there are specific criminal offences which address the ill-treatment or wilful neglect of children, of adults who lack capacity, or of those subject to the Mental Health Act 1983, at the hands of those entrusted with their care. However, there is no equivalent specific offence in relation to adults with full capacity.
7. There have been several cases recently where employees have been charged and convicted of ill-treatment and/or wilful neglect of vulnerable people in their care. But these prosecutions have generally been brought under section 44 of the Mental Capacity Act 2005, or section 127 of the Mental Health Act 1983, as the victims either lacked capacity or were subject to the 1983 Act. For example, the prosecutions following the Winterbourne View scandal were brought under s127 of the Mental Health Act 1983. It is currently possible for a situation to arise where two patients, one with capacity and one without, could be subject to ill-treatment or wilful neglect by the same practitioner with the same intent, and yet a prosecution for wilful neglect could only be brought for the individual without mental capacity.
8. Whilst alternative statutory and common law offences do exist, such as common assault, or offences under the Health and Safety at Work Act 1974, it is not certain that they could cover every situation that a specific offence of ill-treatment or wilful neglect would. A new offence is required in order to ensure consistency so that an equivalent criminal offence will apply to those who ill-treat or wilfully neglect patients or service users who have capacity as already applies where the victim lacks capacity.
9. The National Advisory Group recommended the development of a new and specific criminal sanction for those 'found guilty of wilful or reckless neglect or mistreatment of patients'. Their view was that this new offence, analogous to those that already exist, would act as a deterrent and thereby provide equivalent protections to patients where ill-treatment or wilful neglect occurs.
10. The Government has accepted this recommendation, and committed to consulting on detailed proposals for the new offence as soon as possible, prior to legislating as soon as Parliamentary time allows. This Impact Assessment accompanies the Government's consultation document and reflects the proposed approach to the offence outlined in that document.

## Section B: Policy objectives and intended effects

11. The policy objective is to create equity in respect of the criminal sanctions available in the event of a health or social care worker or organisation ill-treating or wilfully neglecting a patient or service user. The intended effect is to close the gap in the current legislation to provide consistency of approach in relation to ill-treatment and wilful neglect. So, for example, it is possible that two service users, one with full capacity and one without, are being subjected to the same type of conduct, by the same person with the same intent, but a prosecution for ill-treatment or wilful neglect could only be brought in respect of the service user without capacity.
12. The stated aim of the recommendation of the National Advisory Group is to put the ill-treatment or wilful neglect of all patients on a par with the offence that already exists in s44 of the Mental Capacity Act 2005. The proposed offence will send a strong message that poor care will not be tolerated and ensure that wherever ill-treatment or wilful neglect occurs, those responsible can be fully held to account.
13. It is important to note that the remit of the National Advisory Group extended only to the NHS. The consultation proposes extending the offence beyond the scope of the recommendation as put forward by Professor Berwick, to include all those in receipt of health and social care services, whether funded/provided by NHS, local authority or privately.

## Section C: Description of the options

### Option 1: Do nothing

14. Under this option the situation would remain as outlined above. There is a risk that different service users facing similar incidences of ill-treatment or wilful neglect would be treated differently by the law. As stated above, whilst alternative statutory and common law offences do exist, such as common assault, or offences under the Health and Safety at Work Act 1974, it is not certain that they could cover every situation that a specific offence of ill-treatment or wilful neglect would. Different penalties would also apply to these alternative offences. For example, the maximum penalty for a breach of section 4 of the 1974 Act (general duties of persons concerned with premises to persons other than their employees) is 2 years imprisonment, whilst breach of section 44 of the Mental Capacity Act 2005 can lead to up to 5 years imprisonment. This means that there wouldn't always be consistency in prosecution and penalties, which would depend on the act and service user concerned. A new offence is required in order to ensure consistency between those who ill-treat or wilfully neglect service users who have capacity and those where the victim lacks capacity; and, to send a clear message that ill-treatment and wilful neglect will not be tolerated, no matter what the position of the service user is.

### Option 2: Introduce a new criminal offence of ill-treatment or wilful neglect

15. The proposed offence would close the current gap in legislation and ensure that where a person ill-treats or wilfully neglects any patient or service user, they can be properly held to account.
16. The consultation document proposes that the offence will apply to all formal health and social care settings, in both the public and private sectors. 'Formal arrangements' cover those situations where a provider (whether individual or organisation) is employed or contracted to provide particular services. These arrangements give rise to a contractual or other formal obligation to provide those services to a reasonable standard, including to any standard agreed with the commissioner/employer. We do not envisage that informal caring arrangements would be within scope of the offence. Our view is that there is a significant and importance difference between formal and informal arrangements, where in the latter case the care provided is usually based on a family relationship or friendship and there is no element of prescribed obligation.
17. The consultation document also proposes that the offence will not capture genuine errors or accidents, which we agree with the National Advisory Group, should be used as learning tools for the individual and/or the organisation to improve service provision in the future.
18. Further, it is proposed that the offence will not be subject to a harm element that focuses on the outcomes for the victim, but would instead focus on the conduct of the provider/practitioner.
19. In our view, this offence does not create any additional burden or liabilities on individuals and providers beyond those that are already expected. The offence will apply in addition to existing legislation, and is being developed as a sanction against unacceptable behaviour of the worst kind. Providers of health and social care services and health and care professionals should never be behaving in a way that amounts to ill-treatment or wilful neglect, but we know that, very occasionally, this does happen, and under this option in cases where they do, the perpetrator can be held to account irrespective of who is the victim of their behaviour.
20. We envisage that the penalties of the proposed offence will mirror those specified in the Mental Capacity Act 2005. For individuals these are, on summary conviction, up to 12 months imprisonment, or a fine of not more than the statutory maximum, or both, or on conviction by indictment, imprisonment for up to 5 years, or a fine, or both.
21. The consultation also confirms the Government's acceptance of the Berwick proposal that the offence should apply to organisations as well as individuals, and proposes a methodology for doing so. In these circumstances, the proposed penalties could include:
  - public reprimand of the organisation, perhaps by the imposition by the court of publicity orders or remedial orders, as already exist in relation to convictions for corporate manslaughter; and

- potentially unlimited fining of the organisation – the size of the fine would be a matter for the courts to decide on a case-by-case basis.
22. In addition, conviction could result in removal of the organisation’s leaders. As part of a programme of work to improve the quality of organisational leaders, the Department of Health is developing proposals to establish a Fit and Proper Persons Test for directors (or equivalents) of organisations registered with the Care Quality Commission. Failure to meet that test could flow from a successful prosecution under the ill-treatment or wilful neglect offence. The impact of this is in a separate IA
23. This impact assessment is based on the proposals as set out in the consultation document and summarised above.

## Section D: Costs and benefits assessment of the options (including specific impacts)

### Potential number of cases

24. Our analysis of the potential number of cases is based on analysis of offences under section 44 of the Mental Capacity Act 2005 (“the 2005 Act”), which sets out that it is an offence for a person to ill-treat or wilfully neglect someone in their care who lacks mental capacity, or whom the offender reasonably believes to lack capacity. This was chosen due to the close connection with the proposed new offence – the stated aim of the National Advisory Group was put the ill-treatment or wilful neglect of NHS patients “on a par with the offence that currently applies to vulnerable people under the Mental Capacity Act”.
25. Modelling carried out at the time for the Impact Assessment accompanying the 2005 Act suggested that approximately 1.2m individuals could potentially lack mental capacity (as defined by the 2005 Act), whilst figures obtained from further analysis of the Criminal Justice Statistics<sup>3</sup> suggest that, over the past three years, there have been between 70 and 85 proceedings brought under section 44 of the 2005 Act each year. This suggests that **up to 0.007% of individuals** covered by the 2005 Act might suffer ill-treatment or wilful neglect as defined in s44 of the 2005 Act and have a case brought to court as a result.
26. We estimate that there could be approximately 10.8m individuals who could potentially be covered by the proposed new offence. This is based on an examination of the numbers of individuals who currently receive care under a formal health or social care setting as set out in the relevant section below. Applying the same 0.007% figure would suggest that there might be up to 765 cases of wilful neglect brought to court per year. As this figure is likely to be *inclusive* of those already covered under the 2005 Act, we exclude these cases as we assume that in the do nothing option, these prosecutions could still be brought under the 2005 Act, and thus there would be no additional cost associated with these cases. This would give an initial estimate that there would be in the region of 700 cases or fewer per year.

### Incidence of ill-treatment or wilful neglect among those with and without capacity

27. However, this is likely to represent an over-estimate of the number of cases, as service users who lack mental capacity may be more vulnerable and so more at risk of suffering ill-treatment or wilful neglect than other service users. If this were to be the case, then it is likely that applying the 0.007% prosecution rate from s44 of the 2005 Act may overestimate the number of cases for the general population.

<sup>3</sup> These numbers may differ from those quoted by the Crown Prosecution Service (CPS) for a number of reasons. Firstly the Criminal Justice Statistics publication (CJS figures) relate to persons for whom these offences were the principle offences for which they were dealt with. When a defendant has been found guilty of two or more offences this is the offence for which the heaviest penalty is imposed. Where the same disposal is imposed for two or more offences, the offence selected is the offence for which the statutory maximum penalty is the most severe. Secondly, the CJS figures are for completed proceedings, whereas the CPS figures are for offences charged and reaching a first hearing in the Magistrates Court. Thus the CPS data relates to the offence that is initially charged, so any changes in charge during the course of proceedings will not be captured. The CJS proceedings data presents the principle offence at the point of completion in either court (i.e. at the end of Magistrates’ Courts proceedings, or the end of Crown Court trial/sentence occasion) – so if the charge changed (e.g. downgraded) between the initial charge and the final outcome, that would be reflected. There is no clear advantage to using either set of figures over the other, however, as the cost analysis for the Criminal Justice System have been compiled based on the CJS figures, we use these estimates to maintain consistency. Further sensitivity testing is undertaken to estimate the costs differences if the (larger) CPS figures are used.

28. The existing academic literature broadly supports the conclusion that those with disabilities (and especially intellectual disabilities, which can be broadly equated with conditions likely to result in the sufferer lacking capacity under the 2005 Act) tend to be more susceptible to crime or abuse than the general population. However, there is much less consensus on what this difference in prevalence or susceptibility might be. Sorensen (2002)<sup>4</sup> summarises the existing literature and cites the following findings:
- Sobsey (1996) conducted a literature review and concluded that people with disabilities are at least 4 times more likely to be victims of crime compared to those without disabilities, with a more realistic figure of between 5 and 10 higher;
  - Murry conducted a study in 1990 of 150 people and found that those with disabilities were at 2 to 10 times greater risk of criminal abuse; and
  - studies of children with disabilities show similar results, in the region of 3.44 to 4.43 higher rates of criminal abuse.
29. Sorensen's review also specifically examined findings for those with intellectual disabilities and found that:
- a study of psychiatrically disabled patients in Los Angeles board-and-care homes found a crime rate of 33%, which was 9.5 times higher than for the general population and,
  - a number of studies examined the link between intellectual or developmental disabilities and sexual assault and found victimisation rates between 6 and 11 times higher than for the general population.
30. In addition:
- a more recent literature review by Horner-Johnson and Drum (2006)<sup>5</sup> cited two studies that examined children and youths with intellectual disabilities and found rates of maltreatment between 3.1 and 7.66 times that found for the general population;
  - a study by the Canadian Centre for Justice Statistics<sup>6</sup> found that individuals who stated that they suffered from mental or behavioural disorders experienced personal victimisation (including violent crimes and theft) at a rate that was more than four times the rate for those without a mental or behavioural disorder; and,
  - Teplin et al (2005)<sup>7</sup> estimates that individuals suffering severe mental illness were 11 times more likely to suffer from violent crime compared to the general population, even after controlling for demographic differences between the two groups.
31. These estimates are so varied due to differences in the populations studied (for example studies of children tend to find less difference in abuse rates), and the use of different definitions of disability and crime or abuse. These differences make it very difficult to generalise these results into an overall estimate of the differing likelihood of abuse between those with and without mental capacity. In addition, these studies tend to have small sample sizes and be studies of very specific groups of individuals. It is not clear how well these results might generalise and be applicable to the specific offence examined in this Impact Assessment.
32. Taking into account these caveats, and purely for the purposes of quantification, we take the midpoint of these estimates as our best estimate of the difference in the likelihood of ill-treatment or wilful neglect between those with mental capacity and those without. This gives a figure that those with capacity might be 6.5 times less likely to suffer ill-treatment or wilful neglect compared to those without, and so our initial estimate of 700 is adjusted downwards accordingly.
33. However, it is also important to take into account a second issue, which is the likelihood that an incidence of ill-treatment or wilful neglect is reported. In his literature review, Sorensen also argued that crimes against those with substantial disabilities are less likely to be reported. If this were to be the case, it would suggest that our estimate of the potential number of cases under the new offence

<sup>4</sup> [http://www.aspires-relationships.com/ASPIRES/the\\_invisible\\_victims.pdf](http://www.aspires-relationships.com/ASPIRES/the_invisible_victims.pdf)

<sup>5</sup> <http://onlinelibrary.wiley.com/doi/10.1002/mrdd.20097/pdf>

<sup>6</sup> <http://www.statcan.gc.ca/pub/85f0033m/85f0033m2009021-eng.pdf>

<sup>7</sup> <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1389236/>



would need to be adjusted upwards to take into account the higher level of reporting that would occur for those with mental capacity compared to those without.

34. Unfortunately, the existing academic literature on this area is sparse, and so it is difficult to determine what a relevant estimate might be for the difference in reporting. Sorenson, estimates that the rate of reporting is 4.5% for those with disabilities based on an analysis of California’s Adult Protective System data, and compares this to 44% for the US population as a whole based on 1999 National Crime Victimization Survey (NCVS) data. Sorenson also cites two other studies in his paper: Powers, Mooney and Nunno (1990), who examined criminal abuse of residents of institutions and estimated a reporting rate of 15-20% for those with disabilities, and Wilson and Brewer (1992), who examined individuals with severe mental retardation and estimated a figure of 29%. Comparing again against the 44% estimated for the general population, this would suggest that reporting amongst those without disabilities is between 3 and 1.5 times higher.
35. There appears to be a significant difference between Sorenson’s initial estimate and those from the latter two estimates. This difference is likely again to be due to the differences in the types of individuals examined and the definitions used. In this instance, the large jump in estimates suggests that it would be inappropriate to take a mid-point of all three estimates. As Sorenson’s estimate includes individuals with all types of disabilities, whilst the other two specifically concern individuals that would be likely to lack mental capacity or individuals in a care setting, these latter two studies are felt to be of more direct relevance to the question at hand. Thus, we take the mid-point of only these two studies to be our best estimate of the difference in reporting of crimes between those with mental capacity and those without.
36. However, it is important to note here that similar caveats to the above apply, and this estimate is likely to be even more uncertain than those made above due to the small quantity of evidence in this area. Thus the best estimate figure should only be interpreted as the best estimate available to facilitate further quantification of the impacts, rather than a true reflection of the likely difference in reporting rates.
37. Applying this estimate to the figures above would suggest that there would be approximately 240 cases<sup>8</sup> per year under the proposed new offence in the steady state.

### Transition to steady state

38. In addition to our estimate above of the number of potential cases that will arise in the steady state, further analysis of the number of cases brought under section 44 of the Mental Capacity Act 2005 also suggests that there will be a transition period between the offence coming into force and the steady state number of cases.

<b>Number of Defendants proceeded against for ill-treatment or neglect of a person lacking capacity, S44 Mental Capacity Act 2005, England &amp; Wales, 2007-2012<sup>9,10</sup></b>	
<b>2007</b>	5
<b>2008<sup>11</sup></b>	36
<b>2009</b>	47
<b>2010</b>	68
<b>2011</b>	81
<b>2012</b>	85

<sup>8</sup> Our initial estimate of 700 is adjusted downwards by a factor of 6.5, representing the fact that those without mental capacity might be 6.5 times more likely to suffer abuse compared to those with capacity, and then adjusted upwards by a factor of 2.25 to take into account our estimate that those with capacity might be 2.25 times more likely to report a crime compared to those without mental capacity. With rounding, this equates to approximately 240 cases.

<sup>9</sup> The figures given in the table relate to persons for whom these offences were the principal offences for which they were dealt with. When a defendant has been found guilty of two or more offences this is the offence for which the heaviest penalty is imposed. Where the same disposal is imposed for two or more offences, the offence selected is the offence for which the statutory maximum penalty is the most severe.

<sup>10</sup> Every effort is made to ensure that the figures presented are accurate and complete. However, it is important to note that these data have been extracted from large administrative data systems generated by the courts and police forces. As a consequence, care should be taken to ensure data collection processes and their inevitable limitations are taken into account when those data are used.

<sup>11</sup> Excludes data for Cardiff Magistrates’ Court for April, July and August 2008

39. If we allow for a three year transition period to the steady state, in line with the rate of increase in case numbers as was experienced under the 2005 Act (although it is important to note that a number of factors will influence the rate of take up that so no two offences are likely to face the same transitional period), then based on our estimates of there being approximately 1.2m people potentially covered under the Mental Capacity Act versus 10.8m under the proposed new offence, the estimated number of potential cases over the transitional period are as follows:

	Prosecution case rate	Implied number of cases under new offence	Excluding cases already covered under Mental Capacity Act	Adjustments for difference in rates of abuse and reporting	Rounded to nearest 20
Steady state	<b>0.0070%</b>	765	697	241	240
Transitional Year 1	0.0004%	45	40	14	20
Transitional Year 2	0.0030%	324	288	100	100
Transitional Year 3	<b>0.0039%</b>	423	376	130	140

#### Underlying analysis on the number of patients:

40. Analysis of the Hospital Episode Statistics (HES) for Admitted Patient Care in England for 2012-13 indicated that there were approximately 17.7m Finished Consultant Episodes (FCEs) recorded. This included ordinary elective cases, non-elective cases, day cases, and maternity but we excluded outpatient and A&E attendances as we judge there to be inherently lower risk of ill-treatment or wilful neglect associated with these scenarios. For similar reasons we have also excluded GP and Dentist visits<sup>12</sup>. Further analysis of these 17.7m FCEs by unique patient identifier suggested that this equated to approximately 8.9m patients in total.
41. In terms of the independent healthcare sector, we examined patient counts for hospital admission only in order to exclude lower risk activities such as short visits to clinics or other outpatient activity (for example, including visits to high street chiropractors). Analysis by Laing & Buisson found that in 2012, private and voluntary hospitals in the UK were admitting 1.64m patients for surgical treatments. While this figure might be over-estimated (since it includes patients from Scotland) or under-estimated (since it excludes patients admitted for non-surgical treatments), no further reliable estimates of independent sector activity could be found.
42. Comparing this 1.64m estimate for total independent sector hospital activity against the estimates in HES, which suggest that approximately 350,000 patients received at least some NHS funded care at an independent hospital, this implies that just under 1.3m patients are privately funded.
43. In total this would suggest that there are approximately 10.2m patients receiving healthcare who could potentially be at risk of ill-treatment or wilful neglect.
44. In terms of the number of individuals in receipt of social care services, the Community Care Statistics on Social Services Activity for England in 2012-13 estimated that the total number of adults receiving services from local authorities was 1.3m.
45. In addition to this, the Personal Social Services Research Unit estimates that there are approximately 300,000 individuals who self-fund their care. This gives an estimate of the total number of adult social care service users at 1.6m. In addition, some children will also be users of social care services, however it has not been possible to estimate these numbers at this stage and the application of the offence to children's social services is considered in the consultation.
46. However, it is highly likely that a significant proportion of individuals in receipt of social care services will also use health services during the year. For example, a study examining the patterns of health and social care use at the end of life carried out by the Nuffield Trust found that, of the 20,000 social care users they sampled, 89.6% also required hospital care during their last year of life. Similarly a study by Bardsley et al (2012) found that 71% of those aged 75 or above and using social care, also

<sup>12</sup> Although all of these potential care settings would be in scope of the new offence, our assumption is that the likelihood of ill-treatment or wilful neglect is likely to be highly correlated with the amount of time spend within the care setting. Thus we judge that it is much less likely for a service user to experience ill-treatment or wilful neglect within a 10 minute GP appointment, compared to a week-long stay in hospital.

required some hospital care. The mid-point between these estimates is 80%, which we use as our best estimate of the degree of overlap.

47. However, it is likely that this degree of overlap will be much lower for younger social care users, although there are no studies to suggest what this might look like. At a minimum, ONS population estimates for 2012 suggest that there were approximately 53.5m people in England compared to the 10.2m health care users estimated above. This gives an average healthcare usage rate of 19% for the population as a whole, which could be applied to the population of younger social care users as a lower bound to the degree of overlap.
48. Analysis of the community care statistics suggest that 67% of those adults in receipt of local authority funded social care services are aged 65 or older, whilst the remaining 33% are aged 18 to 64. For self-funded social care, internal advice from DH suggests that there are very few people of working age who entirely self-fund their care.
49. Applying our estimate that 80% of older (65 or older) social care users and at least 19% of younger (64 or below) social care users also receive hospital care, gives a total estimate of 600,000 additional social care users.
50. In total this therefore suggests a total figure of 10.8m unique users of formal health or care services.

## Investigating bodies

51. The police are likely to be responsible for investigating and charging individuals and/or organisations. This information would then be passed to the Crown Prosecution Service (CPS) for it to assess and commence prosecution proceedings, if there is sufficient evidence and it is in the public interest to do so. Where suspected incidences of ill-treatment or wilful neglect occur, the provider organisation may also choose to carry out their own internal investigation. However, this would remain at the discretion of the provider, as the proposed new offence would not create any obligation for a provider to carry out such an investigation. The costs of such investigations is therefore not considered within this IA.
52. In terms of the costs of the police investigation, and time required to help build the case and evaluate the evidence to assist the CPS in making a decision on whether and who to prosecute, it is not possible to know how much police or other time would be required at this stage and so it is not possible to quantify these potential costs.
53. As an illustration, estimated police costs provided by the Home Office suggest the following hourly police costs, adjusted for inflation. However, there is currently no information about the average amount of time that would be required to investigate such an offence, and this is likely to vary substantially depending on the specific case in question.

	Sergeant or below	Inspector and above
2012/13	£33.30	£56.63
2013/14	£34.07	£57.93
2014/15	£34.72	£59.03

## Justice System

54. Following investigation, some individuals and/or providers may be taken to court for prosecution..
55. Given that the offence under s44 of the 2005 Act is similar to that of the proposed new offence for individuals, we use data on this proxy offence to estimate how a case would progress through the Criminal Justice System<sup>13</sup>. We use data from 2012 on prosecutions and convictions under section 44 of the Mental Capacity Act and information on the maximum penalty of imprisonment of the new offence (Summary – 12 months; Indictment – 5 years and/or a fine), to estimate a weighted cost per case for offenders prosecuted for the proposed ill-treatment or wilful neglect offence.

<sup>13</sup> The Criminal Justice System includes The Crown Prosecution Service (CPS), the Legal Aid Agency, Her Majesty's Courts and Tribunals Service (HMCTS) and HM Prisons and Probation Services.

56. We estimate an upper and lower bound cost per case for the new offence based on CPS costs for guilty pleas and effective trials.
57. Given that the new offence is triable either way, data about the numbers tried under each court from s44 of the 2005 Act was used to estimate the proportion of people tried in the Crown Court and the Magistrates Court for the new offence. Data from 2012 showed that for the ill-treatment or wilful neglect of a person lacking capacity, approximately 22% of cases were tried in the Magistrates Court and 78% in the Crown Court. We assume this will be the same for the proposed ill-treatment or wilful neglect offence. Approximately 12% of those proceeded against are sentenced to immediate custody, with an average custodial sentence length given of 11.9 months.
58. The estimated cost per additional offender prosecuted is approximately between £8,600 and £10,000 in 2012/2013 prices. Each additional case is estimated to cost the CPS between £1,100 and £2,500. HMCTS costs are estimated to be approximately £1,000 per case. Costs to the legal aid agency, HM prison services and probation services have been estimated at approximately £4,200, £1,600 and £700 per case respectively. All costs are in 2012/13 prices and rounded to the nearest £100. These are also summarised in Table 1 below.
59. The estimated Criminal Justice System costs are specific to the offence of ill-treatment or wilful neglect of patients and therefore may not be relevant to other policies. These costs may also be subject to change when the offence details are refined.

*Table 1: Weighted estimated CJS cost per case:*

<b>CJS Agency</b>	<b>Lower bound CJS Cost</b>	<b>Upper bound CJS Cost</b>
HMCTS	£1,000	£1,000
CPS	£1,100	£2,500
Legal Aid	£4,200	£4,200
Prison	£1,600	£1,600
Probation	£700	£700
<b>Weighted cost per case</b>	<b>£8,600</b>	<b>£10,000</b>

60. It is important to note that these cost estimates have been produced using unit costs for different parts of the criminal justice system. Therefore there are some assumptions and caveats that must be noted when applying them. These are further discussed in Annex A.<sup>14</sup>
61. Based on our estimate of there being in the region of 240 cases of ill-treatment or wilful neglect brought per year, this suggests that the total cost to the Criminal Justice System in the steady state is between £2m and £2.4m per year. In the absence of further information, taking the mid-point of these gives a best estimate of £2.2m.
62. Although these costs have been based on the existing data for the Mental Capacity Act 2005, there is a risk that the proposed new offence could potentially differ from this. For example, it is intended that the proposed new offence will apply for organisations as well as individuals. Whilst the 2005 Act can apply to organisations, there is no information on how often it has been so used in practice. This could, therefore, be a source of deviation in costs and is a risk in the analysis.
63. There could also be some one-off familiarisation costs to the police, CPS and judiciary, which we have not been able to quantify.

## **Providers of Health and Social Care Services**

### **Taking action to prevent ill-treatment or wilful neglect**

64. The proposed new offence may incentivise providers to take further action to put in place systems to monitor and ensure that service users are not subject to ill-treatment or wilful neglect in order to avoid a potential prosecution (both on the organisation or on any of their staff). Providers could also face some additional scrutiny from regulators or commissioners.

<sup>14</sup> As the costs for the different agencies may not be based on the same assumptions or methodologies, comparisons of costs across agencies are not robust and should not be made.

65. However, we note that there are already expectations on providers to ensure the quality and safety of the services that they provide. There are a number of legal obligations and other regulatory and voluntary measures to ensure that this happens. The aim of the proposed offence of ill-treatment or wilful neglect is to provide a legal backstop against this in order to ensure that individuals who suffer ill-treatment or wilful neglect have a means to legal redress and those responsible are held to account.
66. Although there is a risk that this new offence may cause some providers or individuals to go above and beyond what is necessary for fear of prosecution, this is felt to be unlikely due to the existing regulation and guidance in this area.

### **Cost of investigation**

67. The mechanism for identifying this offence is likely to be through individual action (e.g. by a service user, their family or friends, or by a healthcare professional) highlighting an issue, or issues being picked up in existing inspection, monitoring or whistleblowing processes already used in the system. Potentially there could be increased monitoring or checks on the provider, however this is expected to be minimal since there is already regulation on providers to ensure that service users are protected from such events.
68. Where a potential offence is identified, this may require significant investigation before a decision to prosecute is reached. These costs would mainly fall on the investigating organisation (discussed above). However, some providers may face costs associated with initial investigation such as staff time to assist the investigation.
69. It is not clear if these costs would constitute additional costs associated with the new offence though, since in many cases we would expect that in the event of a significant patient safety incident or complaint the provider would wish to carry out their own internal investigation regardless.

### **Costs to Defendants**

#### **Private costs of mounting a defence**

70. Where there is sufficient evidence, and it is in the public interest, individuals and/or organisations will be charged and taken to court. As a result they will need to mount a legal defence. It is not possible to know what the defence costs under the new offence will be. The assumptions made in order to quantify the costs of legal aid to the Criminal Justice System (see Annex A) were that 100% of cases in the Crown Court and 50% of cases in the Magistrates would be eligible for legal aid. Although some individuals would be required to make contributions to their legal costs, this is a relatively uncommon occurrence and so is excluded from the analysis. As a result, we only consider legal costs to the 50% of cases that go through the Magistrates Court. As a proxy it is assumed that the defence will incur costs at the rate of legal aid. This is estimated at £400 per case for the Magistrates Court. This cost is used as the assumption for legal costs for defendants.
71. Based on the assumption that there will be in the region of 240 cases per year, and that 22% will be tried in the Magistrates court, this suggests that there are around 26 cases per year where the defendant might be required to pay their own legal costs. This suggests a total cost per year of approximately £10,400.

#### **Costs of penalties**

72. Individuals found guilty of the offence may face the personal cost of a custodial sentence, e.g. loss of earnings. These costs are outside the scope of this Impact Assessment.
73. Individuals and/or organisations may also be required to pay a fine. This is a transfer payment from individuals to the Criminal Justice System and so is excluded from the analysis.

#### **Costs - summary**

74. The costs above are summarised in the table below:

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	
Description of Costs (£'000s)	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total
Investigation Costs											
Criminal Justice System Costs	£190	£930	£1,300	£2,200	£2,200	£2,200	£2,200	£2,200	£2,200	£2,200	£18,000
Private Defence Costs	£1	£4	£6	£11	£11	£11	£11	£11	£11	£11	£85
Personal Cost of Penalties											
<b>Total Cost (undiscounted)</b>	£190	£930	£1,300	£2,200	£2,200	£2,200	£2,200	£2,200	£2,200	£2,200	£18,000
Discount adjustment	1.00	1.04	1.07	1.11	1.15	1.19	1.23	1.27	1.32	1.36	
<b>Total Present Cost (discounted)</b>	£190	£900	£1,200	£2,000	£2,000	£1,900	£1,800	£1,800	£1,700	£1,600	£15,000

NB: Figures may not sum due to rounding

## Risks

75. As discussed above, the costs to the Criminal Justice System of this policy proposal have been based on the experience under s44 of the Mental Capacity Act 2005, with further adjustments to try to reflect the difference in prevalence of ill-treatment or wilful neglect and reporting between the two groups. The key risks to this are as follows:
- As the literature on the difference in prevalence of ill-treatment or wilful neglect and reporting between those likely to have mental capacity and those without is sparse, the estimates we have made are for the purposes of further quantification of costs only. The actual number of cases could deviate from our estimates as a result of this; and,
  - it is intended that the proposed new offence will apply for organisations as well as individuals. Whilst the 2005 Act can apply to organisations, there is no information on how often it has been so used in practice. This could, therefore, be a source of deviation in costs.

## Benefits

76. The proposed new offence will benefit all individuals in receipt of health and adult social care services by ensuring they are equally protected from ill-treatment or wilful neglect and have the same options available to them. It will also ensure that those responsible for the worst failures in care can be held accountable. The associated sanctions may also act as a deterrent, reducing the number of incidents and leading to improved safety and quality of services for all.
77. It is not possible however to quantify the deterrent effect and its beneficial impacts, nor the benefits of increased consistency and better accountability. However, some further discussion is given below.

### Deterring ill-treatment and wilful neglect

78. Although it is difficult to determine the extent to which the proposed new offence might act as a deterrent against poor quality care, an illustrative example is provided below that demonstrates that even very minimal improvements to the quality of care can have large social benefits.
79. This is achieved by calculating the impact of a small change in health outcomes using the EQ-5D framework for calculating health states<sup>15</sup>. This framework asks individuals to rate their health from 1 to 3 in five different domains, including the experience of pain, mobility and anxiety. A score of 1 means the individual has no problems whereas a response of 3 indicates serious or severe problems. These scores can then be turned into a health state by assigning values to each of the possible combination of scores and converted into a Quality Adjusted Life Year (QALY)<sup>16</sup> by also considering the duration of the health state. Based on this methodology, any move away from perfect health in any of the five domains leads to a reduction in an individual's health state of at least 0.155 points. Thus if one service user is able to avoid one month's worth of less than perfect health due to poor quality care, there would be a 0.013 QALY gain.
80. Applying this figure to the approximately 10.8m patients receiving health or social care services estimated above, if 0.05% of individuals (approx. 5,400 individuals) saw the minimal improvement to the quality of care as described above, this would lead to a total QALY gain of 70. Based on a

<sup>15</sup> As developed by the EuroQol Group. Please see Appendix 4 of the supplementary Green Book guidance for more information. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/191503/policy\\_appraisal\\_and\\_health.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/191503/policy_appraisal_and_health.pdf)

<sup>16</sup> The QALY approach weights life years (saved or lost) by the quality of life experienced in those years. Years of good health are more desirable than years of poor health. A value of 1 is equivalent to one additional year of perfect health. Please see Appendix 4 of the supplementary Green Book guidance for more information. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/191503/policy\\_appraisal\\_and\\_health.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/191503/policy_appraisal_and_health.pdf)

societal willingness to pay £60,000 per QALY, the total societal value of this modest change in health outcomes would be approximately £4.2m.

81. It is not known whether the proposed new offence could offer a sufficient deterrent effect to generate a health gain of this scale. The legislation already in this area could be argued to already provide sufficient deterrent against such behaviour, however on the other hand the increased publicity associated with the new offence and knowledge that it provides universal coverage against all instances of ill-treatment or wilful neglect may be useful in terms of making individuals more aware of their actions. The prevention of more significant health impacts via ill-treatment for a smaller number of individuals could similarly produce significant benefits for society.

### Ensuring consistency of approach and improved accountability

82. The proposed offence will ensure that all health and social care service users benefit from consistency of approach and access to the same legal mechanism in order to hold those responsible for ill treatment or wilful neglect of service users to account. It is difficult to quantify the value of this benefit although it is likely to be substantial. For those affected by poor care, the on-going effects of the damage caused and sense of injustice can be substantial and will often lead individuals to expend considerable time and effort in seeking justice. For example, in the case of Mid-Staffordshire NHS Foundation Trust, campaigning by families for justice has been on-going since 2007. In the case of the Hillsborough disaster, campaigning has lasted over 20 years since the incident. While it is not possible to quantify the exact value affected individuals place on achieving justice, these examples give an indication of the magnitude of feeling that might be involved in where a case of ill-treatment or wilful neglect has caused serious harm or death.
83. For the general public and those not directly affected by the failings, there may still be a feeling of injustice associated with the perception that those guilty of inflicting harm on patients or service users are not appropriately punished. While it would be difficult to derive a total value for this benefit and it would be likely to represent a relatively modest amount per individual, the cumulative effect across society as a whole could potentially be very large. As there are approximately 44m adults in England and Wales, this suggests that for the societal benefits of improved accountability to outweigh potential costs of the proposal, the average willingness to pay for increased accountability would only need to be £0.06p to generate a total gain to society of £2.64m that would outweigh the estimated average annual cost of the proposal.

### One In Two Out Status

84. The proposed policy is to create a legal backstop against ill-treatment or wilful neglect of service users. The offence is addressing criminal behaviour and should not be considered as regulatory. It is not expected to create any additional requirements or burdens for providers. Only non-compliant providers or individuals are expected to be impacted. As such, it is considered to be out of scope of One In Two Out.

### Value for Money

85. The below table shows the profile of the net present value of identified impacts over a 10 year period. All figures are based on assumptions and should be treated as such, however this represents our best understanding of the likely impacts:

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	
Description of Costs (£'000s)	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total
Investigation Costs	UNQUANTIFIED										
Criminal Justice System Costs	£190	£930	£1,300	£2,200	£2,200	£2,200	£2,200	£2,200	£2,200	£2,200	£18,000
Private Defence Costs	£1	£4	£6	£11	£11	£11	£11	£11	£11	£11	£85
Personal Cost of Penalties	UNQUANTIFIED										
<b>Total Cost (undiscounted)</b>	£190	£930	£1,300	£2,200	£2,200	£2,200	£2,200	£2,200	£2,200	£2,200	£18,000
Discount adjustment	1.00	1.04	1.07	1.11	1.15	1.19	1.23	1.27	1.32	1.36	
<b>Total Present Cost (discounted)</b>	£190	£900	£1,200	£2,000	£2,000	£1,900	£1,800	£1,800	£1,700	£1,600	£15,000
<b>Description of benefits</b>											
Detering ill-treatment or wilful neglect	UNQUANTIFIED										
Ensuring consistency and increased accountability	UNQUANTIFIED										
<b>Total Benefits</b>	UNQUANTIFIED										
<b>Net Present Value</b>	-£190	-£900	-£1,200	-£2,000	-£2,000	-£1,900	-£1,800	-£1,800	-£1,700	-£1,600	-£15,000

NB: Figures may not sum due to rounding

86. The costs estimates are based on past experience under s44 of the 2005 Act, scaled up based on an estimate of the number of potential users of health and social care services per year and adjusted based on our best estimate of the difference in prevalence of ill-treatment or wilful neglect, and the difference in potential rates of reporting of crimes. As no centralised figures exist for the number of health and social care users, this estimate has been constructed using a number of different sources. The difference in prevalence and reporting rates have been constructed based on evidence from a number of studies examining this or similar issues, however, as discussed above, it is not clear how applicable these estimates might be to the specific circumstance examined here.
87. Given these assumptions they are sensitivity tested below under scenarios:
- if cases of ill-treatment or wilful neglect were 4.5 times more likely to be reported by those with mental capacity compared to those without capacity rather (twice the current estimate of 2.25), we would expect the number of cases, and thus the annual cost of the proposal, to double. The NPV over 10 years would be -£30m;
  - if the prevalence of ill-treatment or wilful neglect among those with mental capacity was 3.25 times less than for those without capacity (half the 6.5 times currently estimated), we would similarly expect the number of cases, and thus the annual cost of the proposal, to double. The NPV over 10 years would be -£30m;
  - if the effect of a lower prevalence rate of ill-treatment or wilful neglect among those with mental capacity were exactly outweighed by the higher rate of reporting, our initial estimate of there being up to 700 cases of ill-treatment or wilful neglect would be valid. The annual cost of the proposal in the steady state would be approximately £6.6m, and the NPV over 10 years would be -£45m;
  - if half of all cases involved the prosecution of an individual and an organisation, AND if this were to double legal costs, the average legal cost per case would be 1.5 times higher than currently estimated. Thus the NPV over 10 years would be -£23m;
  - if there were double the number of cases currently being brought under the Mental Capacity Act than currently estimated (see footnote 3 – in 2012 CPS estimates of the number of cases was 155 compared to 85 from the CJS), under our estimation methodology this would also double the number of estimated cases of the new offence. Thus the NPV over 10 years would be -£30m.
88. The net present value is negative as it only includes the quantifiable identified costs. There will be additional costs which have not been possible to quantify at this stage. In addition, it has not been possible to quantify the benefits of this policy to offset against the costs. It is intended that the proposed new offence will ensure that health and social care workers or organisations that subject patients or service users to ill-treatment or wilful neglect can be held to account and subject to equivalent criminal sanctions.

## Section E: Equality Impact Assessment and summary of specific impact tests

### Equality Impact Assessment and the Public Sector Equality Duty

89. This policy proposal is subject to the Public Sector Equality Duty (PSED) set out in s149 of the Equality Act 2010 (“the 2010 Act”). As such the Department of Health is required, in the development of the new offence, to consider the potential impacts of the proposals on affected groups who share any of the protected characteristics covered by the PSED. In particular, due regard must be given to the need to:
- eliminate discrimination, harassment, victimisation and any other conduct prohibited by the 2010 Act;
  - advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and



- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
90. The protected characteristics covered by the PSED are: age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; marriage and civil partnership; and, sexual orientation.
91. In parallel with the consultation, we are conducting an initial screening exercise which seeks to identify the scope of those who may be affected and whether the proposed policy may have equality impacts for affected persons who share a protected characteristic. We are also using the consultation exercise to obtain the views of stakeholders on possible impacts to inform the screening exercise. The consultation document asks a specific question on these issues, and we will use responses to help us develop both the initial screening and, if appropriate, a full Equality Impact Assessment.

### Competition

In any affected market, would the proposal:

- Directly limit the number or range of suppliers?

No. The proposals do not involve the award of exclusive rights to supply services, procurement will not be from a single supplier or restricted group of suppliers.

- Indirectly limit the number or range of suppliers?

No, this offence is not a significant barrier to exit from or entry into the market.

- Limit the ability of suppliers to compete?

This offence will apply to providers of health care or adult social care as well as all appointed individuals providing the services. All will face the same level of liability.

- Reduce suppliers' incentives to compete vigorously?

The proposal does not exempt suppliers from general competition law.

### Small and Micro Business Assessment

- How does the proposal affect small businesses, their customers or competitors?

The offence would apply to providers of formal health and adult social care services of all sizes and the impacts are as described above. The proposed new offence addresses criminal behaviour and is not considered to be regulatory. No provider would be expected to take any additional action as a direct result of the proposal, over and above the arrangements that should already be in place to ensure the criminal behaviour established by the offence does not occur.

### Legal Aid/Justice Impact

The following have been considered in the main impact assessment above and will be considered further in a full Justice Impact Test:

- Will the proposals create new civil sanctions, fixed penalties or civil orders with criminal sanctions or creating or amending criminal offences? **Yes**
- Any impact on HM Courts services or on Tribunals services through the creation of or an increase in application cases? **Yes**
- Create a new right of appeal or route to judicial review? Enforcement mechanisms for civil debts, civil sanctions or criminal penalties? **Yes**
- Amendment of Court and/or tribunal rules? **No**
- Amendment of sentencing or penalty guidelines? **No**
- Any impact (increase or reduction on costs) on Legal Aid fund? (criminal, civil and family, asylum) **Yes**
- Any increase in the number of offenders being committed to custody (including on remand) or probation? **Yes**

- Any increase in the length of custodial sentences? Will proposals create a new custodial sentence? **Yes**
- Any impact of the proposals on probation services? **Yes**

### Sustainable Development

The proposals are not expected to have a wider impact on sustainable development. There will be no impact on climate change, waste management, air quality, landscape appearance, habitat, wildlife, levels of noise exposure or water pollution, abstraction or exposure to flood.

### Health Impact

- Do the proposals have a significant effect on human health by virtue of their effects on certain determinants of health, or a significant demand on health service? (primary care, community services, hospital care, need for medicines, accident or emergency services, social services, health protection and preparedness response).

The potential impacts on health have been considered above in the cost benefit analysis of this Impact assessment. As indicated, there may be a positive impact in that the deterrent effect of a new criminal offence may result in improvements in the quality and safety of service provision.

There are no expected health risks in association with, diet, lifestyle, tobacco and alcohol consumption, psycho-social environment, housing conditions, accidents and safety, pollution, exposure to chemicals, infection, geophysical and economic factors, as a result of the proposals.

### Rural Proofing

- Rural proofing is a commitment by Government to ensure domestic policies take account of rural circumstances and needs. It is a mandatory part of the policy process, which means as policies are developed, policy makers should: consider whether their policy is likely to have a different impact in rural areas because of particular circumstances or needs, make proper assessment of those impacts, if they're likely to be significant, adjust the policy where appropriate, with solutions to meet rural needs and circumstances.

The proposals will not lead to potentially different impacts for rural areas or people.

### Wider impacts

The main purpose of the policy is to establish a criminal offence to operate alongside those that already exist so that any health or social care worker or organisation whose conduct amounts to ill-treatment or wilful neglect can be held to account through analogous criminal proceedings.

### Economic impacts

As far as is possible, the costs and benefits of the proposals on businesses have been considered in the main cost benefit analysis of this impact assessments, see Section D above.

### Environmental impacts and sustainable development

The proposals have not identified any wider effects on environmental issues including on carbon and greenhouse gas emissions.

### Social impacts

No impact has been identified in relation to rural issues. The costs to the Criminal Justice System are outlined as above.

## Section F: Summary and conclusion

92. Based on the above impact assessment, the preferred option is Option 2: Implementation of a new criminal offence of ill-treatment or wilful neglect. The new offence would be analogous to similar offences that already exist, would act as a deterrent and, more importantly, would ensure that any

health or social care worker or organisation whose conduct results in patients or service users suffering ill-treatment or wilful neglect can be held equally to account.

93. The main costs of the proposal are the costs to the police of investigating and gathering evidence, costs to the Criminal Justice System of bringing prosecutions, and any private legal costs to individuals and organisations of mounting a defence. There is uncertainty about the potential size of these impacts, however cost assumptions have been developed in discussions with MoJ based on experience under s44 of the Mental Capacity Act 2005. The main benefits of the proposal are to improve accountability for those responsible for poor care, and to potentially deter ill-treatment or wilful neglect from occurring. It has not been possible to quantify these benefits, however initial analysis suggests that these benefits could be substantial even under very modest assumptions. As a result it is expected that the benefits of the policy will outweigh the costs.

# Annex A

Assumption	Risks/Limitations
<p>Progression of a case through the CJS (eg, proportion proceeded in the Magistrates v. Crown courts, proportion sentenced to immediate custody):</p> <ul style="list-style-type: none"> <li>We use data from section 44 of the 2005 Mental Capacity Act: Ill-treatment or neglect of a person lacking capacity by anyone responsible for that person's care to estimate proportions for the new offence.</li> <li>We assume that the proportion of offenders proceeded against for the proxy offence that get a custodial sentence will be the same for the new offence of <i>ill-treatment or wilful neglect</i>. We also assume that the proportions of people tried in the Magistrates and Crown Court will be the same as for proxy offence.</li> </ul> <p>Source: MoJ internal analysis, 2013.</p>	<ul style="list-style-type: none"> <li>There is a risk that more/fewer offenders may be tried in the magistrates' courts or the Crown Courts and that more/fewer offenders may be sentenced to custody.</li> <li>There is a risk that more/fewer defendants will be sentenced to immediate custody.</li> </ul>
<ul style="list-style-type: none"> <li>We assume that the Average Custodial Sentence Length (ACSL) given for the proxy offence will be the same for the new offence of <i>ill-treatment or wilful neglect</i>. Data from 2012 shows that the ACSL for the proxy offence was approximately 11.9 months.</li> </ul> <p>Source: MoJ internal analysis, 2013.</p>	<ul style="list-style-type: none"> <li>There is a risk that the ACSL given will be shorter/longer.</li> </ul>
<p>CPS costs:</p> <p>The estimated CPS costs consist of two broad categories, advocacy costs and Activity Based Costings (ABC). The primary purpose of the ABC model is resource distribution, and has several limitations (see risks). The range of costs reflects the different ABC and advocacy costs for guilty plea and effective trials, as well as the assumption that 22% of the cases would be prosecuted in the Magistrates' and 78% in the Crown Courts.</p> <p>Source: MoJ internal analysis, 2013.</p>	<ul style="list-style-type: none"> <li>The key limitation of the ABC model is that it is built purely on staff time and excludes accommodation and other ancillary costs (e.g. those associated with complex cases and witness care). It also relies on several assumptions. This could mean there is a risk that costs are underestimated. For further information about how CPS ABC costs are calculated please see the following CPS guidance (CPS, 2012): <a href="http://www.cps.gov.uk/publications/finance/abc_qui_de.pdf">http://www.cps.gov.uk/publications/finance/abc_qui_de.pdf</a>.</li> </ul>
<p>HMCTS costs:</p> <p>Magistrates Courts Costs</p> <p>To generate the costs by offence categories, HMCTS timings data for each offence group were applied to court costs per sitting day. Magistrate's court costs are £1,200 per sitting day in 2012/13 prices. A sitting day is assumed to be 5 hours. The HMCTS costs are based on average judicial and staff costs, found at HMCTS Annual Report and Accounts 2012-13. HMCTS timings data from the Activity based costing (ABC) model, the Timeliness Analysis Report (TAR) data set and the costing process.</p>	<p>Timings data for offence categories:</p> <ul style="list-style-type: none"> <li>The timings data are based on the time that a legal advisor is present in court. This is used as a proxy for court time. Please note that, there may be a difference in average hearing times as there is no timing available e.g. when a DJ(MC) sits.</li> <li>Timings do not take into account associated admin time related with having a case in court. This could mean that costings are an underestimate. There is some information is available on admin time, however we have excluded it for simplicity.</li> <li>The timings are collection of data from February 2009. Any difference in these timings could influence costings.</li> <li>The timings data also excludes any adjournments (although the HMCTS ABC model does include them), and is based on a case going through either one guilty plea trial (no trial) or one effective trial. However a combination of cracked, ineffective and effective trials could occur in the case route. As a result the costings could ultimately be underestimates.</li> <li>Guilty plea proportions at the Initial hearing from Q2 in 2012 are used, based on the Time Analysis Report. As these can fluctuate, any changes in these proportions could influence court calculations (effective trials take longer in court than no trials (trials where there was a guilty plea at the initial hearing).</li> </ul> <p>HMCTS average costs per sitting day:</p> <ul style="list-style-type: none"> <li>HMCTS court costs used may be an underestimate as they include only judicial and staff costs. Other key costs which inevitably impact on the cost of additional cases in the courts have not been considered; for example juror costs.</li> </ul>

Assumption	Risks/Limitations
<p>HMCTS costs:</p> <p>Crown Courts Costs</p> <p>Timings data for types of case (eg, indictable only, triable either way) were applied to Crown court costs per sitting day. This was added to the cost of the initial hearing in the Magistrates, as all criminal cases start in the Magistrates courts. Crown Court cost is £1,600 per sitting day in 2012/13 prices, assuming a sitting day is 5 hours. The HMCTS costs are based on average judicial and staff costs, found at HMCTS Annual Report and Accounts 2012-13.</p>	<p>Timings data for types of cases:</p> <ul style="list-style-type: none"> <li>The average time figures which provide the information for the timings do not include any down time. This would lead to an underestimate in the court costing.</li> <li>Timings do not take into account associated admin time related with listing a case for court hearings. This could mean that costings are an underestimate.</li> <li>The data which informed the timings data excludes cases where a bench warrant was issued, no plea recorded, indictment to lie on file, found unfit to plead, and other results.</li> <li>Committals for sentence exclude committals after breach, 'bring backs' and deferred sentences.</li> </ul> <p>HMCTS average costs per sitting day:</p> <ul style="list-style-type: none"> <li>HMCTS court costs used may be an underestimate as they include only judicial and staff costs. Other key costs which inevitably impact on the cost of additional cases in the courts have not been considered; for example juror costs.</li> </ul>
<p>Legal Aid costs:</p> <p>We assume an eligibility rate of 50% for cases in the magistrates' courts and 100% in the Crown Court.</p> <p>The average legal aid cost in the Magistrates assumed was around £400, and £5,300 in the Crown Court (based on Crime Lower Report and Crime Higher Report, Legal Aid Agency).</p> <p>We use an average cost including all offence types from the dataset that includes both standard and non-standard fees to estimate the cost to the Legal Aid Agency.</p>	<ul style="list-style-type: none"> <li>There is a risk that variance in the Legal Aid eligibility rate assumed for cases in the magistrates' courts would impact the costings.</li> <li>Assuming 100% eligibility for Legal Aid in the Crown court carries several risks. Firstly, an individual may refuse legal aid. Secondly, an individual may contribute to legal aid costs. Lastly, the size of this contribution can vary. This could mean that the costings provided are a slight overestimate.</li> <li>There is a risk that the cost could be higher for specific new offences where Legal Aid is paid under the more expensive non standard fee scheme.</li> </ul>
<p>Prison costs:</p> <p>We assume that 50% of a prison sentence over 12 months is served on probation and that there is no element of licence for a sentence under 12 months. The proportions of offenders who are sentenced to probation are determined by the proportion of those who receive an over 12 month sentence. We assume that half the given ACSL is served. The cost per prison place is £28,000 in 2012/13 prices (NOMS management accounts addendum (2011)).</p>	<ul style="list-style-type: none"> <li>The cost of additional prison places is also dependent on the existing prison population, as if there is spare capacity in terms of prison places then the marginal cost of accommodating more offenders will be low due to existing large fixed costs and low variable costs. Conversely, if the current prison population is running at or over capacity then marginal costs may be significantly higher as contingency measures will have to be found.</li> </ul>
<p>Probation costs:</p> <p>Costs for probation and community sentences are £2,600 per year in 2012/13 prices.</p> <p>The probation costs are based on national costs for community order/ suspended sentence order, found at NOMS, Probation Trust Unit Costs, Financial Year 2012-13.</p> <p>Source: MoJ internal analysis, 2013.</p>	<ul style="list-style-type: none"> <li>Costs represent the national average fully apportioned cost based on delivery by 35 Probation Trusts in 2012/13.</li> <li>Unit costs are calculated from the total fully apportioned cost of relevant services divided by starts in that year and do not consider which elements of cost are fixed and which will vary based on service volumes. Major changes to the volume, length or content of community sentences or the characteristics of the offender population could affect the unit cost.</li> <li>The costs consist of costs for both (a) managing the sentence and (b) delivering court-ordered requirements. Excludes centrally managed contract costs for Electronic Monitoring and Sentence Order Attendance Centres.</li> </ul>