Final stage impact assessment

Title: Local authority and integrated care board (ICB) duties in relation to visiting and involvement in care decisions

Type of measure: Primary legislation

Stage: Final

Source of intervention: Domestic

Department or agency: Department of Health and Social Care (DHSC)

Other departments or agencies:

IA number: DHSCIA9730

RPC reference number: N/A

Contact for enquiries: healthlegislation@dhsc.gov.uk

Date: 28/08/2026

Summary: Intervention and Options

Cost of preferred (or more likely) option (base year = 2026/27)

Total net present social value (in £m): N/A

Business net present value (in £m): N/A

Net cost to business per year (in £m): N/A

What are the policy objectives of the action or intervention and the intended effects?

- To embed visiting as a core component of high-quality care, giving visiting rights more prominence across the system and reinforcing the importance of family, friends and carers as partners in care.
- To help ensure that visiting is considered in local authority and integrated care board (ICB) strategic planning and commissioning, and is recognised as a key element of person-centred, compassionate care.
- To improve consistency of visiting practice across health and social care settings, reducing variation and unnecessary restrictions.
- To support the health and wellbeing and care outcomes of people with care needs by facilitating regular contact, connection and visits from family, friends, and carers.

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

Option 1: Business as usual – leave Regulation 9A: visiting and accompanying in care homes, hospitals and hospices and existing guidance in place, alongside the implementation of commitments made following the Regulation 9A review to improve its effectiveness. These commitments include improvements to monitoring, data quality, awareness and complaints processes which are expected to drive improvement in practice. While these commitments are expected to support some improvement in visiting practice, there would remain no explicit system-level duties to promote visiting, inconsistent practice would likely persist, and cultural change would likely be slow.

Option 2: Introducing an individual visiting right – this approach would not deliver materially different practical outcomes or additional benefits to those already provided by Regulation 9A. While it would establish a standalone legal right to visitors in primary legislation, such a right would require a corresponding duty on providers to facilitate visiting, which already exists through Regulation 9A. There will always be circumstances where restrictions on visiting may be necessary, meaning any legal right would still need to be subject to exceptions in practice.

Creating a separate right in primary legislation would risk singling out visiting above other important aspects of care, such as safe care and treatment, and food and drink, which are covered by the Care Quality Commission's existing fundamental standards. This would also complicate enforcement, separating it from the Care Quality Commission's integrated assessment of care quality, and complicating regulatory interpretation, inspection, and enforcement, without adding significant benefit. In addition, a court-enforceable right is expected to be costly and time-consuming for individuals and providers, while creating additional pressures on the justice system.

Option 3: (Preferred) Place duties on health and care commissioners to promote visiting and the involvement of family, friends and carers in decisions about care – this is the preferred option as it will embed promotion of visiting at all levels of the system to strengthen visiting rights in practice, drive cultural and behavioural change, while preserving the coherence of the existing regulatory framework. It is proportionate to the scale of the issue and avoids significant additional burdens.

Will the policy be reviewed? It will not be reviewed. If applicable, set review date: N/A				
Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	**Micro** Yes	**Small** Yes	**Medium** Yes	**Large** Yes

What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)	**Traded:** N/A	**Non-traded:** 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: G Morton Date: 8-9-26

Summary: Analysis & Evidence — Policy Option 1 (BAU)

Description: (Business as usual) Retain existing Regulation 9A and guidance in place.

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
2027 to 2028	2026 to 2027	10-year appraisal period	**Low:** £0	**High:** £0	**Best Estimate:** £0

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£0	-	£0	£0
High	£0		£0	£0
Best Estimate	£0		£0	£0

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

N/A – No monetised costs for option 1 as this is the business as usual scenario and represents the baseline against which other options are assessed.

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

While some improvements are expected through the wider implementation of commitments arising from the Regulation 9A review, gaps in system-level duties to promote visiting will likely remain. Without further intervention, inconsistent practice would likely be unchanged, and cultural change across the system is likely to be slower.

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

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

N/A – No monetised benefits for option 1 as this is the business as usual scenario and represents the baseline against which other options are assessed.

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

The benefit of the business as usual is that no additional familiarisation, implementation or administrative costs would be incurred by health and care commissioners or providers.

Distributional impacts

N/A

Key assumptions/sensitivities/risks	Discount rate	N/A
There is a policy assumption that, while implementation of commitments arising from the Regulation 9A review may lead to some improvements in visiting practice, the existing system alone is unlikely to drive consistent change across the sector. This would leave gaps in system-level duties to promote visiting unaddressed, with variation in practice likely to persist and cultural change expected to be slower than under further intervention.		

Business assessment (Option 1)

Direct impact on business (Equivalent Annual) £m:		
Costs: N/A	Benefits: N/A	Net: N/A

Summary: Analysis & Evidence — Policy Option 2

Description: Legislation for an individual right to visits / a 'care supporter' with duties on providers to facilitate visiting and accompanying.

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
N/A	N/A	N/A	**Low:** N/A	**High:** N/A	**Best Estimate:** N/A

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	N/A	-	N/A	N/A
High	N/A		N/A	N/A
Best Estimate	N/A		N/A	N/A

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

N/A – No costs have been monetised for option 2

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

Most providers should already be complying with the existing duties under Regulation 9A. Therefore, introducing a standalone right in primary legislation would not be expected to result in material additional compliance costs for providers as the underlying behaviours and duties required in practice would remain largely unchanged. Providers that are currently not complying with Regulation 9A may still incur costs associated with coming into compliance, but these are costs they would already face under the existing regulatory framework and therefore are not additional costs attributable to Option 2.

However, creating a separate right in primary legislation could introduce additional complexity to the existing enforcement system. Depending on the final design of the legislation and the route through which the right would be enforced, there may be additional costs to providers, regulators and public bodies associated with interpreting, administering and enforcing the new right alongside the existing Regulation 9A framework. A court-enforceable right could also result in additional legal and litigation costs for individuals, providers and the wider justice system. These potential legal and enforcement costs have not been monetised, as the scale of such costs would depend on the final legislative design, the extent to which legal remedies were used in practice, and behavioural responses by individuals and providers, all of which are highly uncertain. There is not sufficient evidence on likely volumes of legal cases or associated costs to produce a robust monetised estimate.

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A	-	N/A	N/A
High	N/A		N/A	N/A
Best Estimate	N/A		N/A	N/A

Description and scale of key monetised benefits by 'main affected groups' N/A – No benefits have been monetised for option 2	
Other key non-monetised benefits by 'main affected groups' The benefits of Option 2 would likely be similar to those under Option 1 (Business as usual). As Regulation 9A already effectively affords a right, the benefits of Option 2 are unlikely to be significantly more than at present as the same issues may persist resulting in a similar level of compliance.	
Distributional impacts N/A	
Key assumptions/sensitivities/risks Discount rate	N/A
Having reviewed the current framework and compared it with what primary legislation could deliver a standalone right (Option 2) is not considered to deliver materially different practical outcomes or additional benefits to those already provided by Regulation 9A. Instead, it could risk disrupting the wider regulatory framework under the Care Quality Commission fundamental standards, complicating enforcement, and increasing burdens on providers and regulators.	

Business assessment (Option 2)

Direct impact on business (Equivalent Annual) £m:		
Costs: N/A	Benefits: N/A	Net: N/A

Summary: Analysis & Evidence — Policy Option 3 (Preferred)

Description: Place duties on health and care commissioners to promote visiting and the involvement of family, friends and carers in decisions about care.

Full economic assessment

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
2027 to 2028	2026 to 2027	10-year appraisal period	**Low:** N/A	**High:** N/A	**Best Estimate:** N/A

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	£784k	1	£65k	£1.44million
High	£784k		£181k	£2.62million
Best Estimate	**£784k**		**£111k**	**£1.91million**

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

All costs below are in real present value terms:

- Local authorities and ICBs: Upfront direct familiarisation and implementation costs of updating websites or guidance (transition costs) – the present value is estimated at £658k in total for local authorities (or £4.3k per local authority) and £126k in total for ICBs (or £3.5k per ICB), in the first year of the appraisal period only.
- Local authorities and ICBs: Ongoing annual direct administrative costs associated with continued engagement with providers and promotion of visiting or carer involvement – the present value over the 10-year appraisal period is estimated at £950k in total for local authorities (£107k total or around £0.7k per local authority in Y1, declining each year thereafter in real present value terms) and £179k for ICBs (£20.1k total or around £0.6k per ICB in Y1, declining each year thereafter in real present value terms).
- Relative to the scale of overall commissioning activity, the total estimated costs to local authorities and ICBs are minimal. Local authorities' total net services expenditure was £134.2billion in 2024 to 2025, of which £25.3billion was spent on adult social care, and ICBs are expected to commission £179billion of services in 2027 to 2028.

More detail on how these costs were monetised can be found in the 'Monetised and non-monetised costs and benefits of each option' section below.

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

- Care homes: The majority of care homes are complying with Regulation 9A, however, there may be some indirect administrative costs for the non-compliant ones from coming into compliance (like costs of arranging visits, escorting visitors, infection control). These have been illustratively quantified only to show the potential scale of these costs (but this is likely to be a high estimate, see 'Monetised and non-monetised costs and benefits of each option' section).
- Hospitals and hospices: The increased focus on the issue of visiting by ICBs may result in non-compliant hospital or hospice providers taking action to come into compliance, which may result in some additional indirect administrative costs to these providers. However, it is not expected that there will be significant additional costs to hospitals or hospices, and these have not been quantified. For more detail on why, see the '*Indirect administrative costs to*

hospitals and hospices' subsection of the 'Monetised and non-monetised costs and benefits of each option' section in this IA.

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A	-	N/A	N/A
High	N/A		N/A	N/A
Best Estimate	N/A		N/A	N/A

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

No benefits have been monetised. For more detail on why, see the 'Monetised and non-monetised costs and benefits of each option' section below.

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

Examples of benefits not monetised include the increase in wellbeing for care home residents and patients in hospital or hospice settings, the increase in wellbeing for visitors (carers, family members, friends) from being able to visit their relatives or friends and have more involvement in their care, and potential cases where staff time is freed up if visitors carry out some care responsibilities, allowing staff to focus on other tasks.

Distributional impacts

The evidence indicates that the policy will have a primarily positive overall impact, with some differential benefits reflecting existing patterns of service use. Groups more likely to use health and social care services (including disabled people, older adults, and pregnant women and new mothers) are expected to experience disproportionately positive impacts through improved social connectedness, support, and involvement in care decisions. No adverse differential impacts have been identified.

Key assumptions/sensitivities/risks Discount rate 3.5%

Assumptions:

- To monetise direct additional administrative costs to local authorities and ICBs, in the central case it is assumed that the policy will result in 24 additional hours of admin time per year (2 hours per month) for each of the 153 local authorities and 36 ICBs, reflecting that work associated with meeting this duty is expected to largely be integrated into their existing processes.
- To monetise the total direct upfront familiarisation and implementation costs to local authorities and ICBs, it is assumed that this will take 1 full-time equivalent 4 weeks of time per local authority and per ICB in the first year of the appraisal period only (2027 to 2028).
- 1 full-time equivalent works 37 hours in local authorities and 37.5 hours in ICBs, so this is 148 hours (37x4) of staff time per local authority and 150 hours (37.5x4) of staff time per ICB (this may be split between multiple teams or people as different service lines will be involved in meeting the duty, like commissioning and policy).

Sensitivities:

- The upfront familiarisation or implementation cost to local authorities and ICBs is heavily sensitive to the hours assumed above (1 full-time equivalent for 4 weeks). This assumption will be tested with sector partners through a new burdens assessment process which will be completed before the duty comes into force.
- The Adult social care provider statistics, England: quarterly update shows that in the week ending 14 May 2026, 99.3% of care homes in England were able to accommodate residents receiving visitors. This figure has been stable since September

2022. However, the data on care homes not facilitating visiting (used to illustrate the potential scale of costs to care homes) is subject to response rates and data issues, with the questions being open to interpretation and data being self-reported by each care home location. There can also be legitimate reasons that homes may temporarily restrict visiting.

  - Some homes that had recorded being unable to facilitate visiting have since stated (via a follow-up survey as part of the Regulation 9A review) that they selected the incorrect option and that no restrictions were actually in place. The data is not intended to monitor provider location compliance with Regulation 9A, but it is the best data available on care homes not currently facilitating visitors.
  - The reasons for any reported care home visiting restrictions are unknown, and it is possible some restrictions will be justified and will not be affected by this measure.

- It is assumed that the care homes that reported not allowing visiting are representative in terms of their number of residents, and that there is less variation in the size of homes or locations than in the size of providers.

There is no formal, systematic mechanism for collecting data on visiting restrictions in hospitals or hospices because it is difficult to get an accurate picture of visiting practices in these settings, therefore, costs have not been quantified for these settings (for more information see below).

For more detail on how costs were quantified and the parameters used to do so, see the 'Monetised and non-monetised costs and benefits of each option' section below. For information on risks and assumptions see the 'Risks and assumptions' section below.

Business assessment (Option 3, Preferred)

Direct impact on business (Equivalent Annual) £m:		
Costs: *No direct costs to businesses*	Benefits: *No direct benefits to businesses*	Net: N/A

Evidence Base

Problem under consideration and rationale for intervention

Maintaining meaningful contact with family, friends and carers is essential for the health and wellbeing of people in health and care settings.[1] The National Institute for Health and Care Excellence (NICE) guidelines about shared decision making note that shared decision-making is critical to ensuring people are genuine partners in decisions about their care and support. Family, friends and carers often play an essential role in providing assistance, support and advocacy for those accessing care.

The COVID-19 pandemic brought into sharp focus the profound impact that restrictions on visiting can have on individuals. While these measures were necessary to protect the most vulnerable, evidence shows that visiting restrictions were associated with increased loneliness, depression and behavioural deterioration among people receiving care, [2] [3] as well as having a significant impact on their families, friends and carers.

More broadly, the absence of family, friends and carers can negatively affect clinical outcomes and quality of care. For example, family presence has been linked to reduced incidence of delirium and lower use of sedative medication, while absence of visitors is associated with increased confusion, sleep disturbance and poorer pain management.[4]

Family, friend and carer involvement also supports effective communication and shared decision-making, with restrictions on visiting shown to delay critical decisions, including at end-of-life.[4] This is particularly important for people with cognitive impairments, a learning disability or communication needs, who may rely on others to support decision-making and day-to-day care. Evidence indicates that increased family involvement in care homes is associated with improved quality of life and reduced behavioural symptoms for people living with dementia.[5]

In addition, family, friends and carers can contribute to care delivery, provide reassurance and emotional support, and support coordination of care, which may improve patient experience and reduce pressure on staff.[4]

In response to the challenges and lessons learned during the COVID-19 pandemic, DHSC introduced Regulation 9A, a Care Quality Commission fundamental standard on visiting and accompanying in care homes, hospitals and hospices, via the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The regulation places duties on health and care providers to facilitate visiting and accompanying as standard unless there are exceptional circumstances in which the visit would pose a significant risk to health, safety or wellbeing which cannot be mitigated.

In April 2025, DHSC, in partnership with NHS England and the Care Quality Commission, launched a post-implementation review of Regulation 9A, to consider whether it has been effective in meeting its objectives. The review considered the experiences of those receiving care, their families and representatives, providers, and health experts, as well as information from the Care Quality Commission, the Local Government and Social Care Ombudsman, the Parliamentary and Health Service Ombudsman, and other UK nations.

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[1] Health Research Authority (2019). Effective family involvement to improve patient wellbeing and safety. Research summary (viewed July 2026)
[2] Hugelius K and others (2021). Consequences of visiting restrictions during the COVID-19 pandemic: An integrative review. International Journal of Nursing Studies 2021: volume 121, page 104000. (viewed July 2026)
[3] Mulla RT and others (2025). Consequences of loneliness/isolation and visitation restrictions on the mood of long-term care residents without severe dementia pre-COVID-19 and during COVID-19: a scoping review. BMJ open (2025): volume 15(3), page e090522. (viewed July 2026)
[4] Morgan JD and others (2023). An integrated review: connecting Covid-era hospital visiting policies to family engagement. Frontiers in Public Health (2023): volume 11, page 1249013. (viewed July 2026)
[5] Kasugai S and others (2025). Family visits among nursing home residents during the COVID-19 pandemic: a cross-sectional study. BMC geriatrics (2025): volume 25(1), page 517 (viewed July 2026)

DHSC published the outcome of the review of CQC Regulation 9A in March 2026. It found Regulation 9A has reinforced the principle that visiting is integral to care, by clarifying expectations and giving families, friends and carers greater confidence to challenge restrictions; however, consultation responses and focus groups have identified that it has not delivered consistent change across the system. Awareness and understanding remain variable, and there are gaps in data, monitoring and escalation. Without government intervention, visiting policies are assumed to remain inconsistent and the full potential of the benefits is unlikely to be realised.

Description of options considered

Option 1: Business as usual

Leave Regulation 9A and existing guidance in place. This would leave a duty on providers to facilitate visiting and accompanying with no accompanying duty on commissioners to promote visiting. There are also commitments following the review of Regulation 9A which should help to improve monitoring, data quality, awareness and complaints processes. However, while these commitments are expected to support some improvement in visiting practice, there would remain no explicit system-level duties to promote visiting, inconsistent practice would likely remain unchanged, and cultural change would be slow.

Option 2: Introducing an individual visiting right

Legislation for an individual right to visits or a ‘care supporter’ with duties on providers to facilitate visiting and accompanying. This option was carefully considered alongside stakeholder views, however DHSC considers that Regulation 9A currently provides that legal right. Having reviewed the current framework and compared it with what primary legislation could deliver, a standalone right is not considered to deliver materially different practical outcomes or additional benefits to those already provided by Regulation 9A.

Any legal right would still need to be subject to exceptions where restrictions are necessary to protect health, safety or wellbeing. Introducing a new right in primary legislation would require corresponding duties and qualifications, which are already set out in Regulation 9A. Also, it would risk singling out visiting above other important aspects of care, such as safe care and treatment, and food and drink, which are covered by the Care Quality Commission’s existing fundamental standards. This would also complicate enforcement, separating it from the Care Quality Commission’s integrated assessment of care quality, and complicating regulatory interpretation, inspection, and enforcement, without adding significant benefit. In addition, a court-enforceable right could be costly and time-consuming for individuals and providers, while creating additional pressures on the justice system.

Option 3: (Preferred) Place duties on ICBs and local authorities

This bill proposes to place duties on health and care commissioners to promote visiting and the involvement of family, friends and carers in decisions about care is the preferred option. This is because the duties will strengthen compliance with the existing visiting right through commissioning and wider local engagement and complaints procedures. It places a clear expectation on commissioners of health and care services to help ensure that providers they commission properly uphold individuals’ legal rights under Regulation 9A. It should drive cultural and behavioural change across the system and help embed the importance of protecting visiting rights at all levels. This option preserves the existing regulatory framework, with enforcement of Regulation 9A remaining with the Care Quality Commission. Local authorities and ICBs would continue to be accountable to the Care Quality Commission and the Secretary of State for Health and Social Care (Secretary of State), respectively. It is proportionate to the issue and avoids placing additional burdens on the system.

Policy objective

The policy objective is to strengthen visiting rights and recognise the role of families, friends or carers so that people receiving care can maintain meaningful contact and have those close to them involved in decisions about their care. This is essential for the health and wellbeing of people in health and care settings. It is a fundamental component of high-quality, person-centred, compassionate care, supporting people to have genuine choice and control and, for many, is critical to dignity, wellbeing and recovery.

By placing duties on commissioners to complement those on providers under Regulation 9A, visiting should be embedded as a system-level priority in strategic planning and commissioning. This will help to ensure that visiting is consistently considered by local authorities and ICBs and prioritised at every level of the health and care system. In doing so, it will give visiting greater visibility and status as a core component of high-quality, personalised care, reinforce the role of families, friends and carers as essential partners in care, and improve consistency of visiting practice across health and social care settings by reducing variation and unjustified restrictions.

This approach will support a shift in culture, mitigate the risk of inappropriate restrictions arising, and limit the need for reactive enforcement. By facilitating regular contact with family, friends and carers, it will also improve the wellbeing and care outcomes of people with care needs and help ensure that their rights are upheld in practice.

This primary legislative change will be supported by statutory guidance to ICBs and local authorities, setting out expectations for how they should promote the importance of visiting and contact with family, friends, carers and representatives through their existing functions. The legislation alone would be unlikely to achieve the intended cultural and behavioural change across the system. As the legislation is intended to operate alongside this guidance, the equality impacts presented in this assessment are indicative of the combined effect of the legislative change and the implementation of the accompanying guidance.

These new duties are intended to complement the provider duties under Regulation 9A. However, this impact assessment, and the corresponding equalities impact assessment aim to consider the impact of the commissioner duties set out in this policy alone.

For ease of reference, this assessment may at times use the term "visiting" as a collective description of the activities supported by the proposed duties. Unless otherwise stated, this includes opportunities to receive visitors, to be accompanied when attending hospitals and hospices where appropriate and, for care home residents, to take trips outside the care home. References to visiting should also be read alongside the separate duty relating to the involvement of family, friends and carers in decisions about care, where relevant. This terminology is not intended to alter the distinct legal effect of each duty.

Summary and preferred option with description of implementation plan

Although Regulation 9A established visiting as a fundamental standard, implementation is inconsistent, with gaps in awareness, monitoring, and escalation. There is currently no explicit legal duty on commissioners (ICBs and local authorities) to promote visiting or support its delivery locally.

This policy seeks to complement Regulation 9A by placing duties in primary legislation on commissioners (ICBs and local authorities) to promote visiting and the involvement of family, friends and carers in decisions about care. It does this by:

- introducing a new duty on ICBs to promote appropriate opportunities for people to receive visitors and, where appropriate, to have someone accompany them when attending hospitals and hospices; and
- amending the Care Act wellbeing principle to require local authorities to have regard to the importance of involving other people in decisions, receiving visitors and, for care home residents, having appropriate opportunities to take trips outside the care home.

These duties are intended to support greater consistency in how visiting, accompanying and involvement in care decisions are considered locally.

Statutory guidance will be developed for ICBs and local authorities to support them to deliver these duties. That guidance will set out expectations, aligned to existing ICB and local authority functions, covering the following activities:

- **supporting providers** – disseminating information and guidance to share best practice, identify issues and take steps to address them;
- **information and advice** – ensuring people and their carers have access to information they need to understand and support their care needs, including what they can expect from providers and how to make a complaint;
- **continuous improvement** – using existing and future intelligence to identify patterns and take appropriate action where issues arise; and
- **commissioning** – considering information gathered on compliance with visiting regulations when exercising commissioning duties.

The policy and guidance are expected to come into force in April 2027, and together aim to support a shift in culture, moving towards a default position that recognises the importance of contact with the family, friends and carers of residents and patients in delivering safe, effective, and compassionate care. This primary legislation is the first, but necessary, step to enable this change.

Theory of change

The theory of change for this proposal is set out below:

- **Inputs**: primary legislation creates duties on local authorities and ICBs, as well as statutory guidance to support them to deliver these duties.
- **Outputs**: Local authority and ICB activities to: (i) promote visiting and contact with family, friends and carers as integral to care; (ii) improve information and guidance to care recipients, their relatives, friends and carers, and providers; and (iii) ensure that commissioning considers providers' visiting practice.
- **Outcomes**: improved provider adherence with visiting regulations meaning fewer restrictions and better communication when restrictions are necessary; and greater awareness of visiting rights and responsibilities among care recipients, their relatives, friends and carers, and providers.
- **Impacts**: increased wellbeing and quality of life for care recipients, their relatives, friends and carers.

Monetised and non-monetised costs and benefits of each option (including administrative burden)

This IA provides a proportionate assessment of costs and benefits based on the best available evidence and in line with HMT Green Book guidance.

Option 3: (Preferred) Place duties on ICBs and local authorities

This primary legislative change will be supported by statutory guidance to ICBs and local authorities, setting out expectations for how they should promote the importance of visiting and contact with family, friends and carers through their existing functions. The legislation alone would be unlikely to achieve the intended cultural and behavioural change across the system. As the legislation is intended to operate alongside this guidance, the estimated costs, benefits, and impacts presented in this assessment are indicative of the combined effect of the legislative change and the implementation of the accompanying guidance.

Costs

Direct familiarisation and implementation costs to local authorities and ICBs

The main cost to local authorities and ICBs will be the upfront time commitment required for them to familiarise themselves with the new legislation and how this applies to them, as well as costs associated with updating websites and guidance and so on. Assuming it takes a full-time employee 4 weeks in each of the 153 upper tier local authorities and 36 ICBs in England to do this, including oncosts of 22%, this upfront cost has been estimated at £658k in total for local authorities (or £4.3k per local authority) and £126k in total for ICBs (or £3.5k per ICB) in the first year of the appraisal period only.

Following this initial upfront time commitment, over time delivery of the duty should become more of a maintenance activity, requiring less dedicated time. This is captured in the ongoing administrative costs below.

Direct administrative costs to local authorities and ICBs

There are likely to be some small ongoing administrative costs to local authorities and ICBs throughout the appraisal period, associated with continued engagement and promotion of visiting and family, friend and carer involvement in decisions with service providers. These are small costs as this work is expected to become part of existing processes. Assuming each of the 153 upper tier local authorities in England spend 24 hours per year (2 hours per month) to do this, the ongoing cost to local authorities has been estimated to have a real present value of £107k in the first year of the appraisal period (or £698 per local authority), declining each year thereafter in real present value terms (total real present value of £950k over the 10-year appraisal period).

Assuming each of the 36 ICBs in England also spend 24 hours per year (2 hours per month) to do this, the ongoing cost to ICBs has been estimated to have a real present value of £20.1k in the first year of the appraisal period (or £559 per ICB), declining each year thereafter in real present value terms (total real present value of £179k over the 10-year appraisal period).

The additional burden on local authorities and ICBs is expected to be low and administrative, estimated at around 2 hours per month per organisation. This reflects that the proposed duties do not create new delivery functions but instead clarify and reinforce expectations within existing statutory responsibilities.

The proposed duties are closely aligned to existing legal functions placed on local authorities and ICBs, including:

- promoting wellbeing, quality, and diversity of services;
- providing information and advice;
- improving quality and outcomes; and
- commissioning and market oversight.

In practice, this means that most required activity is already undertaken as part of routine business (such as provider engagement, quality monitoring, commissioning decisions, and responding to intelligence). The policy primarily requires organisations to explicitly consider visiting and carer involvement within those existing processes, rather than introducing new processes or systems.

Additional work is expected to be within existing processes, rather than standalone workstreams, and is expected to be absorbed within business-as-usual activity, with only limited additional coordination and documentation required. For example:

- incorporating visiting and family, friend and carer involvement into routine provider discussions and forums;
- signposting and sharing existing guidance (like Regulation 9A, contract conditions and public-facing materials); and

- reflecting relevant intelligence (like complaints, Care Quality Commission findings) when carrying out existing oversight and commissioning functions.

Many local authorities and ICBs already engage providers on quality issues, including visiting practices where relevant, support implementation of guidance through local networks, and consider patient and carer feedback in service oversight and commissioning. The policy therefore provides greater national consistency and clarity of expectation, rather than introducing fundamentally new responsibilities.

Indirect administrative costs to care home providers

This policy does not directly impose costs on businesses under the preferred Option 3, as the duty falls on ICBs and local authorities, and relevant businesses should already be complying with the existing Regulation 9A and will be engaging with local authorities where appropriate. However, the increased focus on the issue of visiting and carer involvement in decisions by local authorities may result in non-compliant care home providers taking action to come into compliance and improve visiting access, which may result in some additional indirect administrative costs to these providers. The following analysis seeks to illustrate the potential scale of these indirect costs to care home providers, however these are not included in summary tables or total costs of the policy and are purely illustrative scenarios.

Data self-reported through Capacity Tracker indicates that an average of 87 care homes per month were not permitting residents to receive visitors in the 12 months to May 2026 (out of an average of almost 14,500 Care Quality Commission registered care homes over the same period).

Illustrative costs

If all 87 of these care homes came into compliance and facilitated visits and all their residents (calculated at 25 residents on average per care home) now received an assumed 2 visitors per week on average (assumption based on responses to the 2023 consultation), it is estimated that total indirect administrative costs to care homes could be as high as £907k in the first year of the appraisal period (or £10.4k per care home), declining in real present value terms each year thereafter (total real present value of £8.1million over the 10-year appraisal period). This assumes that each additional visitor requires 15 minutes of care worker admin time to arrange or facilitate the visit.

However, these costs are likely to be a high estimate as some of the care homes may have justifications for their responses (like data entry errors in responding to Capacity Tracker, temporary refurbishments, justified restrictions), and therefore the reported restrictions were potentially temporary meaning there would be no additional cost as there would be no change in behaviour as a result of the measure. Some of these homes may have decided to resume visiting in future regardless of the policy, with the number of homes self-reporting that they do not facilitate visiting tending to fluctuate from month-to-month (this was as low as 15 homes in May 2024, for example), hence the use of a 12-month average to quantify costs.

Note that the data on care homes not facilitating visiting is also subject to response rates and data issues, with the questions being open to interpretation and data being self-reported by each care home location. For instance, some care homes that had recorded being unable to facilitate visiting have since stated (via a follow-up survey as part of the Regulation 9A review) that they selected the incorrect option and that no visiting restrictions were actually in place – the data is not intended to monitor provider location compliance with Regulation 9A but is still the best data available on care homes not facilitating visitors.

If approximately half the number of care homes (44 homes) additionally facilitated visiting following the introduction of the policy, for example, using the same assumptions outlined

above, total estimated indirect administrative costs to care homes would fall to £459k in the first year of the appraisal period (remaining at £10.4k per care home), declining in real present value terms each year thereafter (total real present value of £4.10million over the 10-year appraisal period).

Indirect administrative costs to hospitals and hospices

ICBs will be required to promote visiting and the involvement of family, friends and carers in decisions about care in hospital and hospice settings. However, the policy reinforces and strengthens existing practice, with visiting and family, friend and carer involvement already widely permitted in both NHS and independent hospitals and hospices. The increased focus on the issue of visiting and carer involvement by ICBs may result in non-compliant hospital or hospice providers taking action to come into compliance, which may result in some additional indirect administrative costs to these providers. A certain amount of flexibility is, however, assumed to have been built into their usual operations as this is already a requirement under Regulation 9A.

There is currently no formal, systematic mechanism for collecting data on visiting restrictions in hospitals and hospices because it is difficult to meaningfully measure visiting in those settings as there can be variation in practice between or within providers, wards and departments which would likely not be reflective of the overarching picture. Palliative care and end-of-life care services are broad, holistic services provided by a range of professionals and providers, generalist and specialist, across the NHS, social care, and voluntary sector organisations such as hospices. Additionally, most hospices are independent, charitable organisations which makes it difficult to collect data from these settings.

Therefore, it is not anticipated that there will be any significant additional costs to these settings, and these have not been able to be quantified.

Cost table

Cost description	**Direct or indirect?**	**Monetised or non-monetised?**	**Central cost estimate (real present values, 10-year total)**
Ongoing administrative costs to local authorities	Direct	Monetised	£950k
Ongoing administrative costs to ICBs	Direct	Monetised	£179k
Upfront costs to local authorities	Direct	Monetised	£658k
Upfront costs to ICBs	Direct	Monetised	£126k
Costs to care home providers	Indirect	Non-monetised	N/A
Costs to hospitals and hospices	Indirect	Non-monetised	N/A
Total real present value of monetised costs			£1.91million

Benefits

This policy is expected to have a positive impact on wellbeing for patients and residents across both adult social care and health settings by strengthening expectations around visiting and involvement in care. Placing clearer duties on commissioners to promote visiting and the involvement of family, friends and carers in decisions about care may drive more consistent practice across the system. Commissioners are well positioned to set expectations through

contracts, oversight, and assurance, which in turn may reduce variation between providers and limit overly restrictive approaches.

For individuals receiving care, more consistent access to family, friends and carers may deliver a range of benefits. Evidence from the Regulation 9A review indicates that regular contact with loved ones can:

- support emotional wellbeing and reduce loneliness and distress;
- help maintain relationships, identity, and sense of dignity;
- improve overall experience of care and quality of life; and
- provide reassurance and advocacy, particularly for people who may struggle to communicate their needs.

Regulation 9A already establishes that visiting should be facilitated as a normal part of care. The proposed commissioner duties are intended to support more consistent implementation of those existing requirements by embedding promotion of visiting and family, friend and carer involvement within local oversight, commissioning and improvement activity.

In settings where people continue to report barriers to visiting, increased attention from commissioners should lead to more consistent facilitation of visiting and carer involvement in decisions, improving emotional support, social connection and quality of life. By promoting a culture of open visiting, the duties should help ensure that restrictions are only introduced where proportionate and justified, and that they are clearly communicated and kept under review. This may give patients and residents greater confidence that their rights will be respected.

This may also improve the way care is planned and delivered. Supporting the involvement of carers and people important to residents and patients in decision-making may:

- enable better sharing of information about a person’s preferences, history, and needs (in line with the person’s wishes about what information they want shared);
- support more personalised and responsive care;
- strengthen shared decision-making, particularly during periods of illness, recovery, or end-of-life care; and
- improve continuity between formal care and support provided by families.

In many hospices and parts of the health system, visiting is already flexible and aligned with these principles, with restrictions typically limited to exceptional circumstances. In these settings, the policy is expected to reinforce good practice and provide clearer national expectations, rather than requiring significant change. This may help sustain existing approaches and ensure they are consistently applied.

The scale of these benefits will be proportionate to the number of additional people facilitated to receive visitors, which is dependent on the number of care homes, hospitals and hospices that additionally facilitate visiting and family, friend and carer involvement as a result of the policy. The total scale of the benefit is likely to be small, given the small number of care homes that do not currently allow visiting and could change their behaviour as a result. However, these benefits have not been monetised as this is dependent on the discretionary decisions of providers, and the current data available on provider locations restricting visits does not provide sufficient information to predict which locations would be able and choose to lift restrictions following the introduction of the policy.

Other non-monetised benefits

Potential benefits resulting from the policy that have not been monetised include potential increases in wellbeing to residents, patients and carers from carers being able to have greater involvement in care decisions, as well as increases in wellbeing for visitors from being able to visit their loved ones and have more involvement in their care.

Greater involvement of family, friends and carers may also help to free up some staff time where visitors are able to support aspects of care or provide informal assistance, reducing pressure on staff and allowing them to focus on other tasks. This may contribute to improved relationships between residents, families, and staff, supporting a more collaborative, person-centred approach to care. This would result in benefits to providers that have not been quantified.

Longer-term, this policy should help to improve the quality of local provision and lead to better outcomes for local people. Increased focus on the promotion of visiting and carer involvement could potentially lead to administrative savings for providers and local authorities if compliance with Regulation 9A improves and the number of complaints about restrictions decreases as a result.

Option 2: Introducing an individual visiting right

Costs

Option 2 (introducing an individual right to visits or a ‘care supporter’ in primary legislation) would not be expected to deliver materially different practical outcomes to the existing Regulation 9A framework. Any legal right would require corresponding duties on providers to facilitate visiting and accompaniment, which are already established through Regulation 9A. As a result, the underlying expectations and behaviours required of providers would remain largely unchanged.

Most providers should already be complying with Regulation 9A and therefore would not be expected to incur material additional compliance costs as a result of this option. However, creating a separate right in primary legislation could introduce additional complexity to the existing regulatory and enforcement framework. Depending on the final legislative design and route of enforcement, there may be additional costs to providers, regulators and public bodies associated with interpreting, administering and enforcing the new right alongside the existing Regulation 9A framework. A court-enforceable right could also result in additional legal and litigation costs for individuals, providers and the wider justice system. These potential costs have not been monetised due to significant uncertainty around the final legislative design.

Benefits

The benefits of Option 2 are expected to be similar to those under Option 1 (Business as usual). Regulation 9A already establishes a legal framework requiring providers to facilitate visiting and accompaniment. Evidence from the review suggests that current challenges relate primarily to the consistency of implementation, awareness, monitoring and oversight rather than the absence of a legal right. As a result, introducing a standalone right in primary legislation is not expected to deliver significantly greater benefits or materially improve compliance compared with the existing framework.

Option 1: Business as usual

No costs or benefits have been quantified for Option 1, as this is the business as usual scenario and represents the baseline against which other options are assessed.

Direct costs and benefits to business calculations and impact on small and micro businesses

Relevant businesses should already be compliant with Regulation 9A. This policy imposes new duties on local authorities and ICBs, so there is no direct cost to business as a result of this measure. However, the increased focus on the issue by local authorities and ICBs may result in non-compliant providers taking action to come into compliance, and therefore, limited additional indirect administrative costs for those providers.

These duties could deliver indirect benefits to business, but as the application of the duty will vary by ICB and local authority, and there is uncertainty around compliance with Regulation 9A, these are uncertain and therefore unquantified. These commissioner duties to promote visiting and the involvement of family, friends and carers in decisions about care may mean that providers have better access to clear, up-to-date information on visiting, and therefore this may reduce time spent sourcing guidance. It may also strengthen relationships between providers and local authorities and ICBs, and reduce administrative burden where people better understand their visiting rights and the reasons for decisions.

Risks and assumptions

Risk of duty not delivering intended benefits

- High-level duties may not drive meaningful change in practice especially if commissioners interpret the duty variably or take minimal action to demonstrate compliance. Commissioners may lack capacity to intervene and may prioritise other pressures (like capacity or finances) which means system-wide change may be uneven, and there may be resistance to change if not adequately supported or incentivised.
- **Mitigations**: The proposed changes work within the existing framework used by local authorities and ICBs so that visiting is embedded into safeguarding, commissioning, wellbeing, and prevention, rather than creating a separate framework. This should help ensure consistency across local authorities and ICBs and mean there is little to no additional burden.

Accountability risks

- Reliance on commissioner accountability in a pressured system may limit impact and this indirect enforcement (where the provider does not resolve the issue directly when the issue arises) may not provide clear or timely redress. Individuals experiencing restrictions may still feel they lack a clear and immediate route to timely resolution.
- **Mitigations:** Separate work to improve awareness of complaints routes for visiting restrictions aims to resolve issues at the most appropriate level. These new duties for local authorities and ICBs mean that alongside existing complaints processes and escalation routes for visiting restrictions under Regulation 9A (provider complaints processes with escalation to the local authority or ICB and ombudsmen, and with the Care Quality Commission as the regulator of Regulation 9A), people will be able to use local authority or ICB complaints processes if they feel local authorities or ICBs are not meeting these new duties.

Assumptions

- For care homes, Capacity Tracker (platform used to collect data from providers) data shows that in the week ending 14 May 2026, 99.3% of care homes in England were able to accommodate residents receiving visitors. This figure has been stable since

September 2022, though some of those reporting that they do not facilitate visiting will have made data entry errors, or will have temporary and legitimate reasons not to facilitate visiting. There is not comparative data for hospitals and hospices available, however, from the Regulation 9A review, DHSC understands that visiting practices remain inconsistent and that a cultural change is required.

- The modelling assumptions below are estimates and where possible based on the best available evidence, however there is uncertainty around how the duty will be implemented until the detailed guidance is developed.
- To monetise direct additional administrative costs to local authorities and ICBs, in the central case it is assumed that the policy will result in 24 additional hours (range 14 to 39 hours) of admin time per year (2 hours per month in the central case) for each of the 153 local authorities and 36 ICBs.
- To monetise the total direct upfront familiarisation costs and costs of updating websites or guidance to local authorities and ICBs, it is assumed that this will take 1 full-time equivalent 4 weeks of time per local authority and per ICB in the first year of the appraisal period only (2027 to 2028).
- 1 full-time equivalent works 37 hours in local authorities and 37.5 hours in ICBs, so this is 148 hours (37 hours over 4 weeks) of staff time per local authority and 150 hours (37.5 hours over 4 weeks) of staff time per ICB.
- Local authority social worker wages were £22.36 per hour in 2024 to 2025, and the ICB NHS worker wage selected was £17.91 per hour in 2024 to 2025 – these are then projected into future years using a weighted average of National Living Wage projections and Office for Budget Responsibility earnings forecasts, with the weights determined based on historic wage growth for those job roles between 2018 to 2019 and 2024 to 2025. Additional oncosts of 22% are then added to these wage values to calculate the cost per hour.
- To illustratively quantify indirect costs to care homes it is assumed that all 87 care homes (on average per month in the 12 months to May 2026) reporting they did not facilitate visiting will now facilitate visiting, and that 25 (on average) residents in each of these homes will now receive 2 (range 1 to 3) visitors per week on average. Each of these visits will require 15 minutes (range 10 to 20 minutes) of additional staff time to facilitate.
- Care worker wages and oncosts are calculated using the same approach as local authority or ICB workers above. The base independent sector care worker wage was £12.16 per hour in 2024 to 2025, and senior care workers were paid £12.91 per hour.

Monitoring and Evaluation

Implementation of the policy will be monitored as part of the Department's wider visiting policy programme, monitoring local authority and ICB activity, and how effectively this strengthens the visiting rights introduced through Regulation 9A.

Monitoring will draw on a range of existing intelligence sources, including Capacity Tracker data and intelligence from the Care Quality Commission, the ombudsmen, stakeholder engagement, and correspondence.

Monitoring will also be used to inform proportionate evaluation of whether the policy is achieving its intended effects in practice. This will include considering:

- whether local authorities and ICBs are embedding visiting and family, friend and carer involvement within relevant commissioning, oversight and improvement activity;
- whether people receiving care and those important to them experience clearer information, more consistent practice, and improved routes for raising concerns; and

- whether there is evidence of unintended consequences, continued non-compliance, or uncertainty about roles and responsibilities between providers, commissioners and regulators.

In response to findings from the Regulation 9A review that highlighted limitations in existing monitoring arrangements, DHSC aims to improve the quality of available data. This will include reviewing and refining Capacity Tracker visiting questions and associated completion instructions, improving consistency of interpretation, and ensuring providers have a clearer understanding of what constitutes a visiting restriction. This is expected to improve the reliability and usefulness of data collected from care home providers to support with better identification of emerging trends and potential compliance issues.

DHSC is also working closely with the Care Quality Commission to ensure visiting duties are embedded within relevant elements of its ongoing reform and improvement programme. This includes consideration of visiting and access to friends and family within the new assessment framework, inspector training and internal guidance, and future data and intelligence developments to consider how feedback in relation to visiting can be captured and used to inform monitoring and support regulatory oversight and policy evaluation.

Additionally, assurance will be provided by the Care Quality Commission and the Department. The Care Quality Commission assesses local authority duties under Part 1 of the Care Act 2014 and will therefore play a role in assessing how well local authorities discharge these new duties. As part of wider Health Bill proposals, performance assessment of ICBs will transfer from NHS England to the Secretary of State who must assess each ICB against how it has discharged its functions, including this new duty.