

Title: Independence, choice and control Accompanying IA for the White Paper "Caring for our future: reforming care and support" IA No: 7062 Lead department or agency: Department of Health Other departments or agencies:	Impact Assessment (IA)
	Date: 03/07/2012 <hr/> Stage: Consultation <hr/> Source of intervention: Domestic <hr/> Type of measure: Primary legislation <hr/> Contact for enquiries: Caroline Allnutt, Department of Health
Summary: Intervention and Options	RPC Opinion: AMBER

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, Measure qualifies as
N/A	£0m	£0m	No NA

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

Care and support is too focused on intervention at the point of crisis, rather than helping individuals to maintain independence and prevent the onset of care needs. Rather than being shaped around the needs of individuals, services have developed on the basis of systems, structures and funding flows. There are still significant barriers preventing people from having choice and control over how their needs are met. In particular, access to high quality information and advice is variable in terms of quality and access across the country. The extent to which care and support is personalised and integrated with other public services has implications for quality of outcomes, user experience and efficient use of public resource.

What are the policy objectives and the intended effects?

To improve outcomes and experience of care and secure a more effective use of public and community resources. Specifically to improve the evidence base for preventative approaches; incentivise innovative approaches to investment in prevention; promote the welfare of older people through a wider range of housing options; enable all care users to have independence, choice and control and to achieve their desired outcomes; ensure that health, care and other public services work together to improve outcomes and experience; enable people to understand what support is available and how to access it; enable people to make informed choices and provide access to transparent information about available services.

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

As set out in the White Paper, take forward the following policy proposals: Improve the focus on prevention by accelerating the roll-out of assistive technology, developing an evidence base for investment in prevention and exploring new investment approaches; provide capital funding to support the specialised housing market; set out in legislation an entitlement to personal budgets for people eligible for care and support; develop direct payments for people in residential care; exempt earnings from residential financial assessment; ensure that outcome measures support integration; provide a national information and signposting service including a directory of services; introduce a statutory duty on local authorities to provide information and advice; improve local authorities' web-based information and advice services; make available additional provision of advice and support; make clearer the duty for local authorities to share information; and develop best practice models for support and representation services.

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

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

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

Signed by the responsible Minister:  Date: 3/7/12

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

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

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	50	61	559

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

The recurring costs are mainly the costs to local authorities of information, advice and support services and of disregarding earned income in the means test for residential care and capital costs over 5 years to Department of Health for specialised housing. The transitional costs comprise mainly costs to councils for proposals to promote greater personalisation and to DH for proposals to improve information and advice.

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

The direct costs are monetised. There will be opportunity costs where councils decide to re-prioritise their budgets to promote prevention measures and more integrated care. There may also be additional costs arising from increased demand for services as a result of improved information provision and some additional low costs as a result of the duty to share information with individuals, carers and their families. Those investing in social impact bonds will experience costs and benefits.

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	5	42

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

The benefits could not be monetised, with the exception of the cash gains to care users in care homes whose earned income will be disregarded in the means test (but part of these gains will be offset by costs to councils).

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

Non-monetised benefits relate mainly to welfare gains to users and carers from the proposals to promote a greater focus on prevention, integration, personalisation and improved information, advice and support services. Depending on the scheme, there may be potential for savings, especially in the long run, associated with integration.

Key assumptions/sensitivities/risks

Discount rate (%)

3.5

There is uncertainty about some of the costs, in particular the costs of advice and support services. There is limited evidence on the benefits of some of the proposals. Social impact bonds are dependent on external investment. The impact of the proposal on specialised housing will be examined in a further impact assessment.

BUSINESS ASSESSMENT (Option 1)

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

Summary of impact

1. This Impact Assessment provides analysis of the relative costs and benefits of proposals set out in the White Paper “Caring for our future: reforming care and support”. In particular it discusses the impact of proposals set out in Chapters 3, 4 and 7 of the White Paper relating to the following policy areas:
 - Prevention
 - Housing
 - Personalisation
 - Integration
 - Information and advice
2. This is a consultation stage Impact Assessment. Some of the proposals discussed below will need to be implemented through primary legislation. The Government has announced its intention to publish a draft Care and Support Bill for pre-legislative scrutiny, after which formal introduction to Parliament will follow as soon as possible. Regulatory proposals – by which we mean those that require new legislation – will therefore be subject to a further final stage Impact Assessment when the Care and Support Bill is formally introduced into Parliament.
3. For completeness, we want our stakeholders and Parliament to be clear on the potential costs and benefits for the totality of the White Paper proposals. Therefore, alongside the draft regulatory proposals, this Impact Assessment also sets out the potential costs and benefits of those measures set out in the White Paper that do not require new legislation to be implemented. For these non-legislative proposals, we have made clear where the Government plans to undertake further testing, development and engagement with the sector.
4. For the purposes of this Impact Assessment, we have assumed that proposals that require legislative enactment will be implemented from 2015/16, although this is subject to the passage of legislation through Parliament. Other proposals that do not require enactment through primary legislation may be implemented earlier. This is made clear in the detail below.
5. The proposals set out in the White Paper have been developed in light of the publication of two important reports that made recommendations on how to reform care and support. The Law Commission’s report on adult social care recommended bringing together all the different elements of social care law into a single, modern adult social care statute.¹ The Commission on Funding of Care and Support, chaired by Andrew Dilnot, made recommendations about how the cost of care should be shared between the individual and the state as a partnership, as well as other important recommendations for the reform of care and support.²
6. In September 2011, the Government launched *Caring for our future*, a period of focused engagement with people who use care and support, carers, local councils, care providers, and the voluntary sector. The aim of the engagement was to bring together the recommendations from the Law Commission and the Commission on Funding of Care and Support with the Government’s *Vision for Adult Social Care*, published November 2010, and to discuss priorities for reform with stakeholders.
7. This extensive engagement has informed development and appraisal of the proposals set out in the White Paper. Engagement took the form of meetings, conferences, workshops and correspondence. Events were led by members of the care and support community and involved the input of users, carers, local councils, care providers and the voluntary sector. In addition, the Department of Health has also used literature reviews and workshops held with academic experts to inform policy development. This process has enabled us to discuss the effectiveness of a range of policy options and associated costs and benefits.
8. These proposals do not involve any additional regulatory measures that impose costs on business or civil society. The changes to the law proposed in the White Paper relate to the responsibilities of local

¹ http://www.justice.gov.uk/lawcommission/docs/lc326_adult_social_care.pdf

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

authorities and other public sector partners for planning and commissioning of adult social care services and for meeting the needs of their local population.

9. The primary objective of the White Paper is to improve outcomes for individuals, enabling people to maintain independence, health and wellbeing. We believe that proposals aimed at enhancing diversity of service provision and improving user choice will also offer positive opportunities for independent and civil society organisations. As explained below, responding to the proposals set out in the White Paper may result in additional costs for providers of social care services but we anticipate that they will also open up business opportunities and that providers will choose to participate where they perceive that the benefits of doing so outweigh the costs. Ultimately, it will be for providers of social care to decide on a voluntary basis how they wish to respond.

10. Table 1 provides a summary of impact for each proposal discussed in more detail below:

Table 1: Summary of impact

Policy Theme	Proposal	Is legislation required?	Implementation date	Costs fall to	Benefits accrue to
Prevention	A: Support to roll-out of assistive technology through the <i>Three Million Lives</i> programme	No	n/a ¹	n/a ¹	n/a ¹
	B: A single social care evidence library providing evidence around social care preventative interventions	No	From April 2013	DH	Councils, care users and carers and citizens
	C: Develop in a number of trailblazer areas new ways of investing in preventative interventions in social care	No	From April 2013	DH, councils, social investors	Councils, care users and carers, citizens and social investors
	D: Statutory duty on local authorities to prevent or delay needs for care and support	Yes	2015/16	None	Care users, carers and citizens
Housing	E: Provide capital funding to support the specialised housing market for those with care and support needs	No	From April 2013	DH	Users of additional specialised housing
Personalisation	F: Set out in legislation an entitlement to personal budgets	Yes	2015/16	Councils	Care users/carers
	G: Develop and test the use of direct payments in residential care	No	2013	DH	Care users
	H: Exempt earned income from the residential care financial assessment	Amend existing regulations & guidance	April 2013	Councils	Care users
Integration	I: Build on the provisions of the Health and Social Care Act to set out further actions to support integrated care	No	Actions will be published in a report in autumn 2012	n/a ²	n/a ²
Information	J: New national care and support information portal including a directory of services	No	From April 2013	DH	Care users, carers, citizens and providers
	K: Statutory duty on local authorities to provide information and advice	Yes	2015/16	None	Care users, carers and citizens
	L: Improve local authorities' web-based information and advice services	No	From 2014/15	Councils	Care users, carers and citizens
	M: Additional provision of advice and support to help	No	From 2013/14	Councils	Care users, carers

	people arrange care and support				
	N: Make clearer the duty for local authorities to share information with individuals, carers and families	Yes	2015/16	Councils	Care users, carers
	O: Develop and disseminate best practice for support and representation services	No	2013/14 to 2014/15	DH	Care users, voluntary and private sector

¹ Implementation, costs and benefits are being considered in the DH "Three Million Lives" Programme

² Costs and benefits will depend on the actions presented in the report

11. Table 2 below sets out how we estimate costs and benefits will be profiled over a ten year appraisal period. Year 1 of implementation is assumed to be 2012/13.

12. The table shows the costs by organisation incurring expenditure. Where costs are incurred by providers, we expect that some of these costs will at some point be passed on to local authority commissioners and people funding their own care. Some of the costs shown in the table are opportunity costs rather than new cash costs.

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

Proposal	Agent	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total	Average annual
Prevention – Transition cost	DH	0.3	1.5	1.2	0.5	0.0	0.0	0.0	0.0	0.0	0.0	3.5	
Housing – Recurring cost	DH	0.0	40.0	40.0	40.0	40.0	40.0	0.0	0.0	0.0	0.0	200.0	
Information – Capital transition cost	DH	0.0	0.0	20.0	12.5	0.0	0.0	0.0	0.0	0.0	0.0	32.5	
Information – Transition cost	DH	0.3	0.7	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.3	
Information – Transition cost	LA	0.0	2.5	2.5	2.5	0.0	0.0	0.0	0.0	0.0	0.0	7.5	
Information – Recurring cost	LA	0.0	0.0	7.5	20.0	45.0	62.5	62.5	62.5	62.5	62.5	385.0	38.50
Personalisation – Transition cost	DH	0.23	0.9	0.9	0.68	0	0	0	0	0	0	2.7	
Personalisation – Transition cost	LA	2.75	0	0	0	0	0	0	0	0	0	2.75	
Personalisation – Recurring cost	LA	0.0	2.7	2.7	2.7	2.8	2.8	2.8	2.9	2.9	2.9	25.3	2.53
Personalisation – Recurring Savings	User	0.0	5.3	5.4	5.4	5.5	5.6	5.7	5.7	5.8	5.8	50.2	5.02
Total													
Transition cost	DH	0.8	3.1	22.5	13.7	0.0	0.0	0.0	0.0	0.0	0.0	40	
Transition cost	LA	2.8	2.5	2.5	2.5	0.0	0.0	0.0	0.0	0.0	0.0	10.3	
Recurring cost	LA	0.0	2.7	10.2	22.7	47.8	65.3	65.3	65.4	65.4	65.4	410	41
Recurring cost	DH	0.0	40.0	40.0	40.0	40.0	40.0	0.0	0.0	0.0	0.0	200	20
Total cost		3.5	48.3	75.2	78.9	87.8	105.3	65.3	65.4	65.4	65.4	661	
Cost (Discounted)		3.5	46.6	70.2	71.2	76.5	88.7	53.2	51.4	49.7	48.0	559	
Recurring savings	User	0.0	5.3	5.4	5.4	5.5	5.6	5.7	5.7	5.8	5.8	50	5
Savings (Discounted)	User	0.0	5.1	5.0	4.9	4.8	4.7	4.6	4.5	4.4	4.3	42	
Net Cost (NPV)												517	

* Not all benefits associated with these proposals are monetised; only direct cash savings are therefore included within this table.

Evidence Base (for summary sheets)

This section includes:

- I. Problem under consideration
- II. Rationale for intervention
- III. Policy objectives and proposals:
 - *Prevention*
 - *Housing*
 - *Personalisation*
 - *Integration*
 - *Information*
- IV. Impact of policy proposals
- V. Risks
- VI. Specific impact tests

I. PROBLEM UNDER CONSIDERATION

Overview

1. People should be supported to stay well and independent for as long as possible. When they do need care and support, they should be able to exercise choice and control over how that support is delivered, to meet their own individual needs and preferences. However, rather than being shaped around the needs of individuals, services have developed based on systems, structures and funding flows. There are still significant barriers preventing people from having choice and control over how they are supported to achieve their desired outcomes. This has affected the extent to which care and support is personalised and integrated with other public services, with consequential implications for quality of outcomes, user experience and efficient use of public resource.
2. The current care and support system is geared too much towards intervention at the point of crisis, rather than helping individuals to postpone or prevent onset of care needs and loss of independence. Many older adults currently live in accommodation that does not suit their care needs.
3. The quality and availability of information is a critical enabler for both consumers and commissioners to make choices and drive up quality.³ Better access to information can play an important role in enabling greater collaboration at local level. Together, increased access to quality information and joined up working across local public services can support better planning and prevention and enable more personalised approaches to care.

A greater focus is required on prevention and early intervention

4. As set out in the Government's *Vision for Adult Social Care*, a considerable proportion of care needs could be avoided, reduced or delayed as a result of earlier intervention.⁴ The *Vision* stated that prevention is best achieved through community action working alongside statutory services, and described local government's role as being a catalyst for social action. The *Vision* described carers as the first line of prevention and articulated the need to properly identify them and offer personalised support.⁵
5. During the *Caring for our future* engagement, we heard that the current system is geared too much towards intervention at the point of crisis rather than helping individuals to postpone or prevent the onset of illness or loss of independence. Assessment and eligibility systems focus on whether people are 'needy' enough to be in the system. A recent DH survey suggested that around 80% of local

³ This is discussed in more detail in the corresponding IA "Quality, care providers and the workforce".

⁴ Department of Health, *A Vision for Adult Social Care: Capable Communities and Active Citizens*, 2010.

⁵ Proposals to further support and improve outcomes for carers are discussed in more detail in the corresponding IA "Assessment, eligibility and portability for care users and carers".

authorities currently set their eligibility criteria threshold at substantial or critical levels of need, meaning that they do not make support available to people who are assessed as having moderate or low needs. Only 2% provide funding at "low" levels, indicating that investment is not focused on avoiding people's needs from getting worse. Support for people to plan for key transition points in their lives, navigate the system and build connections with others is patchy or inefficient.

6. A health and social care system that intervenes at crisis points rather than in a preventative manner is likely to deliver poorer outcomes. For example, too many older people are admitted to hospital as emergencies that could be avoided if the right community services were in place.⁶ It should be noted that there is a scarcity of evidence on the cost-effectiveness of prevention. The evidence that exists suggests that it is cost neutral at best rather than cost saving.
 7. Current barriers to an improved focus on prevention include:
 - Risk aversion – local authorities see it as risky to spend on lower need rather than higher need;
 - Pressure on resources – immediate needs are prioritised over longer term prevention;
 - Barriers in shifting expenditure upstream, and concerns that prevention requires new investment leading to double running rather than divestment to a strategic prevention shift;
 - Difficulties in identifying and targeting who can best benefit from prevention;
 - Difficulties in measuring success.
 8. There are a number of reasons why the system does not focus sufficiently on prevention and early intervention. The following factors are discussed in more detail below:
 - a. Lack of joined up thinking and coordinated response across local systems;
 - b. Lack of effective information for commissioners;
 - c. Individuals are not supported and enabled to contribute.
- A. Lack of joined up thinking and coordinated response across local systems
9. Reducing demand for high cost, long-term interventions requires co-ordinated responses across health, care and other services, such as housing and leisure. However, investment in prevention in one sector can lead to savings in another and those savings are often not shared. For example, performance of managers may not be measured using benefits realised in a different sector.
 10. Allen and Glasby draw on Audit Commission work to suggest that prevention is not prioritised because of a "vicious circle" where pressures on acute hospitals lead to sooner discharges, insufficient rehabilitation and less money for prevention, more use of expensive residential care and increased acute admissions.⁷ Responses to the *Caring for our future* engagement suggested that payment mechanisms do not incentivise preventative approaches across the whole system. For example, investment in social care prevention, designed to reduce emergency admissions to NHS acute hospitals, may not directly benefit social care commissioners.
 11. There was also a strong view emerging from the *Caring for our future* engagement that prevention should extend beyond health and social care into other public services such as housing, employment, leisure and transport. Local authorities have an essential role through commissioning and provision of universal services to deliver a preventative approach.⁸ However, at present localities generally do not consider the holistic overall needs of an individual and how resources across the whole system can be used to promote better outcomes and efficiency.
 12. We know, for example, that while there are pockets of good practice, integrated approaches to prevention and early intervention across health, social care, public health and wider local government services that support health and wellbeing are not mainstream. There is a need to incentivise the different parts of the system to work together in a much more integrated way. Key

⁶ Department of Health, *Shaping the future NHS: long term planning for hospitals and related services consultation document on the findings of the national beds inquiry*, 2000.

⁷ Allen, K., and Glasby, J., "*The (Multi-) Billion Dollar question: Embedding Prevention and Rehabilitation in English Health and Social Care*", *Journal of Integrated Care*, 2010.

⁸ Further discussion of proposals to support commissioning capability can be found in the corresponding Impact Assessment "Quality, care providers and the workforce".

levers will be health and wellbeing boards, the new responsibilities of local authorities for public health, effective use of re-ablement monies including joint commissioning of services and NICE standards to drive up quality in key areas such as falls in care settings, incontinence and dementia.

13. These levers can support greater risk and reward sharing, innovation and the potential for different forms of investment across localities such as Social Impact Bonds (SIBs). SIBs encourage risk and reward sharing with investors from the private sector and could be used to finance preventative solutions. It will also be important to create the right conditions to stimulate joint approaches – for example better collection and dissemination of the evidence base and more effective outcome measures.

B. Lack of effective information for commissioners

14. The *Caring for our future* engagement suggested that there is little shared understanding of prevention and early intervention between planners, commissioners, service delivery and users and that there is no single, trusted authority to articulate what works. It is difficult to measure the impact of early interventions and this can inhibit investment across health and social care.
15. Responses to the engagement suggested there should be a strategic national knowledge programme, to help show which interventions work best at which trigger and transition points, such as diagnosis, a fall, bereavement, or becoming a carer.

C. Individuals are not supported and enabled to contribute

16. By nature, preventative approaches require collaboration with the individual, who may feel that there is “nothing wrong with them” and therefore they do not cooperate, waiting for a crisis point. Alternatively, they may not be prepared to pay for interventions that are not funded by their local authority. The *Caring for our future* engagement suggested a deficit in information and navigation support for individuals, particularly people funding their own care, which could lead to private individuals not investing in preventative measures.
17. The engagement also highlighted a shared view that the system should support and enable a new relationship between the state, individuals, families and communities to enable people to live well and independently, using all individuals’ and communities’ skills and assets.
18. As an increasing proportion of social care funding is made available through personal budgets, individuals should be encouraged through information and support to consider the possible preventative benefits of their choices. Evidence from the IBSEN evaluation of the personal budgets pilots suggested that 15% of people spent some money from their personal budget on equipment, aids and adaptations, and 37% on leisure and exercise activities.⁹ This suggests some desire on the part of individuals to spend on preventative interventions, which should be facilitated further.

Access to appropriate housing solutions to help meet or prevent onset of need

19. During the *Caring for our future* engagement, we heard that housing should be at the heart of any reform of the care and support system if we are to transform its focus from crisis to prevention and wellbeing. This echoes what was said in the reports of both the Law Commission and the Commission on Funding of Care and Support. The English House Condition Survey (2007) estimates that approximately 35% of vulnerable¹⁰ owner-occupiers and more than 50% of vulnerable adults who rent privately live in a property that is non- decent.¹¹

⁹ Glendenning, C. et al, *Evaluation of the Individual Budgets Pilot Programme Final Report*, IBSEN 2008.

¹⁰ ‘Vulnerable’ is defined in terms of benefit receipt. A household is classified as vulnerable if in receipt of “income support, housing benefit, attendance allowance, disability living allowance, industrial injuries disablement benefit, war disablement pension, pension credit, child tax credit and working tax credit”. Care and Repair England (2006) suggest that this definition may in fact lead to an optimistic view for older people, due to relatively low uptake of benefits for this group.
<http://www.careandrepair-england.org.uk/handyperson/pdf/handypersonreport.pdf>

¹¹ Department for Communities and Local Government, *English House Condition Survey*, 2007.

20. Many people with a care need value the independence associated with remaining in their own home. However, unsuitable housing represents a risk to an individual's health and in turn to the cost of providing health and care. Demographic pressures mean that more people will face such circumstances in coming years. In addition to adapting existing housing, enabling people to take early decisions about where they live could prevent or delay health and care needs, or better equip people to maintain independence once they develop care needs.

Types of Housing

21. Generally, to date, forms of housing for older and disabled people have fallen into the categories of sheltered accommodation, or residential care. Traditionally, sheltered accommodation is a form of grouped housing (most often flats), with a warden on site if residents are in need of assistance. Residents live in their own home, and can receive domiciliary care in the same way as other homeowners. Traditional sheltered accommodation is usually rented and tends to be run by registered social landlords. It is therefore unlikely to offer a viable option for the majority of people approaching older age who are homeowners looking to downsize.
22. Residential care involves a number of people living together, with communal facilities, supported by care staff who are available around the clock. Residents will have sufficient care needs for them to be unable to live unsupported. Care homes are mostly provided via a private market and are usually rented. There are cultural issues associated with residential care and it is widely seen as an undesirable choice to move into an 'old people's home'.
23. Specialised housing is a broad term for types of housing for older or disabled people that falls between these terms. (It encompasses forms of housing known as Extra-Care, Sheltered Plus and other names.) Basic principles underpinning much of specialised housing (notably Extra-Care) are that individuals have their own front door, with some provision of communal facilities (such as a common room and canteen), and that they receive care depending on their level of need in their own home as if they were receiving domiciliary care. The level of warden-support varies across different schemes.
24. Models of specialised housing vary greatly. Schemes are run either by private companies or by housing associations. Some schemes are predominantly owner-occupied and appeal directly to homeowners seeking to downsize from a family home, who may or may not have a care need (but expect to develop one). These are sometimes referred to as 'retirement villages'. In some schemes, most residents rent (often with state assistance) and have high care needs. Since clients live in their own flat and care plans are focussed around the individual, these are classified differently from residential homes.
25. The plethora of choices offered by different specialised housing models means that it is difficult to generalise. Furthermore, this lack of definition can lead to confusion and mis-selling. However, the flexibility of care provision allowed by most schemes, as well as the independence offered by continuing to have one's own front door, suggest that appropriately sold targeted specialised housing is more likely to appeal to people who are planning more effectively for the future. In addition, the option of continuing to own your own home is likely to appeal to the vast majority of people aged over 60, who are currently mainly homeowners.

Barriers to access to appropriate housing solutions

26. We should assume that more older and disabled people would move into more appropriate accommodation if a greater number of people perceived the discounted future benefits to be greater than discounted future costs (including opportunity costs). We suggest that there are various market failures that prevent these groups from accurately valuing the costs and benefits associated with their housing options. The following factors are discussed in more detail below:
- a. Informational imperfections;
 - b. Transaction costs;
 - c. Supply shortages.

A. Informational imperfections

27. Many older and disabled people are not aware of the full range of housing options available to them. For example, a DH survey regarding Extra-Care Housing (ECH) found that:

*“Providers from all three sectors, public, private and not for profit, indicated that not only was the concept [of ECH] entirely unfamiliar to many older people and their families, but where it was known the proliferation of different descriptions and models of ‘housing with care’ was a source of confusion.”*¹²

28. If people are not aware of the benefits associated with specialised housing, they are not likely to value it to the extent that a fully informed individual would. In turn, poorly informed individuals are less likely to choose specialised housing. Ultimately, this represents inefficiency for society, which would be better off if each individual selected the housing solutions that most closely match their underlying preferences and their care needs.
29. Moving house may have significant monetary, time and psychological and physical wellbeing costs for individuals. Such costs represent a disincentive to moving into more appropriate accommodation. Magnusson Turner notes that “elderly, well-established households are less inclined to move”.¹³ Similarly, case study analysis found that intensive support for older people moving into purpose built accommodation could minimise the stress associated with relocation.¹⁴
30. Transaction costs are particularly important as they are incurred before any benefits of the new accommodation can be enjoyed. If individuals value their present state more highly than future states, the front-loaded nature of transaction costs means that they are more heavily weighted when the individual is making housing decisions. Therefore, reducing transaction costs could encourage older and disabled people to move into accommodation that reflects their preferences and care needs.

B. Supply Shortages

31. Housing options for older or disabled people are often limited and unevenly distributed across England. For many people who develop care needs, the only clear options are sheltered accommodation or residential care, or staying in unsuitable private housing. Many choose to stay in their home until they reach a crisis point and are forced into more traditional sheltered housing or residential care settings. Glendinning et al note that “older people often approach services at a time of crisis when they feel vulnerable or unwell and find decision making difficult.”¹⁵
32. New forms of specialised housing, such as those designed in line with the principles of the Housing our Ageing Population Panel for Innovation¹⁶, are seen as a particularly appropriate way to supplement people’s choices, as they can allow continued home ownership, have generally positive health outcomes and are usually more cost effective than residential care.^{17 18}
33. Access to capital remains an issue in the public and non-profit sector, which typically relies on subsidies for expansion (such as the Department of Health’s Extra-Care Housing Fund, which was discontinued in 2010). A lack of capital may also become an important constraint on private developers in the future. Private specialised housing developments such as Extra-Care are less attractive to private equity than ordinary housing, due to definitional problems, business models that do not provide ongoing returns and lengthy lead times.¹⁹ The latter may be particularly important given the current macroeconomic uncertainty.

¹² DH Care Networks, Housing LIN Report “Marketing Extra Care Housing”

http://www.housinglin.org.uk/library/Resources/Housing/Support_materials/Reports/Report_18_.pdf

¹³ Magnusson Turner, L., “Who Gets What and Why? Vacancy Chains in Stockholm’s Housing Market”, *International Journal of Housing Policy* Volume 8, Issue 1, 2008.

¹⁴ O’Shea, N., for EAC’s FirstStop Advice, “Helping older people choose the right home for them”, 2012.

¹⁵ Glendinning, C et al, *Evaluation of the Individual Budgets Pilot programme*, IBSSEN, 2008.

¹⁶ <http://www.homesandcommunities.co.uk/housing-ageing-population-panel-innovation>

¹⁷ Baumker, T., Netten, A., and Darton, R., *Costs and outcomes of an extra-care housing scheme in Bradford*, 2008.

¹⁸ Darton, R. et al, *Evaluation of the Extra Care Housing Initiative*, PSSRU, 2011.

¹⁹ Laing and Buisson, *Extra Care Housing UK Market Report*, 2011/12.

Personalised care and support

34. People should be supported to remain well and independent for as long as possible and to achieve their desired outcomes. Where people do require additional support, as set out in the 2011 *Open Public Services* White Paper, individuals and carers should have choice and control over the services they use.²⁰
35. Direct payments – cash payments in lieu of services - have been available since 1997 and were extended to older people in 2001 and people who lack capacity in 2009. Personal budgets (a notional budget for care) were introduced from April 2008 and local authorities received £520 million in grant over 3 years (2008-11) to transform their systems and to deliver budgets at an individual level. A personal budget can be taken by an individual as a direct (cash) payment; as an account held and managed by the local authority in line with the individual's wishes; as an account placed with a third party; or as a mixture of these approaches.
36. There is evidence that people can achieve a better quality of life if they are in control of their funding through a personal budget. The evaluation of the individual budget pilots (undertaken between 2005 and 2007) showed that almost half of those with an individual budget reported changes in their view of what they could achieve.²¹ Personal budgets can also offer better value for money, according to evidence from the Audit Commission.²²
37. The *Vision for Adult Social Care* set out the Government's aim that everyone who is eligible for a personal budget should have access to one, preferably as a direct payment, by April 2013.²³ However, feedback from the *Caring for our future* engagement suggests that the pace of delivering this goal has been uneven across the country. Data for 2010/11 shows that 28.9% of users nationally received self-directed support.²⁴ However, at an individual local authority level, this varied from 4% of users to 98.5% of users. People using care and support say that it is very difficult to get a personal budget in some places and there are still too many barriers, including how information and advice is provided.
38. The National Personal Budgets Survey²⁵ suggested that user experience of the process varied widely, but many reported difficulties. The main difficulties cited were around accessing information and advice, having one's needs assessed, understanding what a personal budget could be spent on, being in control of what the budget was spent on, and planning and managing one's care and support. Less than half of the personal budget holders surveyed felt that the council had made it easy or very easy for people to change their care, choose the best option from a range of services, or voice their opinions or complain.
39. There is some evidence that particular groups of people find it difficult to access a personal budget. A recent report from the Alzheimer's Society found that 63% of people with dementia had not been offered a personal budget, despite the control that it can bring to people accessing services and those who care for them.²⁶ Homeless people and those with drug or alcohol addictions are also underrepresented. There was also evidence from the *Caring for our future* engagement that local authorities are not making as much use as they might of the regulations enabling a suitable person to manage direct payments on behalf of users who lack capacity and are restricting this only to people appointed by the Court of Protection.
40. There are several reasons why progress in enabling people to have choice and control and to achieve their desired outcomes has not occurred faster or more consistently. These barriers are discussed in more detail below and include:
 - a. A legislative framework that does not support the consistent use of personal budgets and expectations of a personalised services across all local authorities.

²⁰ Cabinet Office, *Open Public Services*, 2011.

²¹ Glendinning, C et al, *Evaluation of the Individual Budgets Pilot programme*, IBSSEN, 2008.

²² Audit Commission, *Improving value for money in adult social care*, 2011.

²³ Department of Health, *A Vision for Adult Social Care: Capable Communities and Active Citizens*, 2010.

²⁴ Provisional figures published by the Health & Social Care Information Centre, in December 2011.

²⁵ Think Local Act Personal, *The National Personal Budgets Survey*, 2011.

²⁶ Alzheimer's Society, *Getting personal? Making personal budgets work for people with dementia*, 2011.

b. Lack of information and advice provided to people using care and support to enable them to make choices.

41. The current system of financial assessment also creates potential barriers to people in residential care taking up employment. This is discussed in Section C below.

A. The legislative framework does not support cultural and systemic change

42. There are a number of cultural and organisational barriers to progress in local authorities making a universal offer of self-directed support to people using care and support. Reasons might include: perceived higher costs; low priority given to this principle by councils; inertia; vested interest; or the perception by individuals that a higher workload is required by a more responsive and flexible service.²⁷

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

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

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

46. Not all groups of users are able to access personal budgets and direct payments. Current regulations do not allow those in long-term residential care to access to direct payments. This disparity in access to personalised support was highlighted during the *Caring for our future* engagement and chimes with the Law Commission's view that choice and control should not be limited only to people in community settings. Some local authorities have begun to introduce Individual Service Funds (ISFs) as a personal budget option for people in residential settings (mainly adults of working age with complex packages) who have some (limited) control over the delivery of their care and support, but progress has been slow.

B. Lack of information and advice to facilitate choice

47. Access to quality information and advice is crucial to support people to make informed choices both before and once they need care and support (this is explored in more detail below). This applies to both those receiving care and support from their local council and those funding their own care. However, evidence suggests that there is inadequate provision of information to both state-funded care users and in particular to people funding their own care.²⁸ Many self-funders do not access local authority information or take up assessments as they receive no support due to their financial position.

48. Evidence from the *Caring for our future* engagement, supported by research from the Personal Outcomes Evaluation Tool, showed that people were much more likely to take control of their care and support funding through a direct payment if they had received support with making choices about the care they wanted, and with articulating how that care should help them achieve their

²⁷ Audit Commission reports, *Improving Value For Money in Adult Social Care*, June 2011 and its earlier report *Financial Management of personal budgets* which said that whilst personal budgets were unlikely to produce significant cash savings, satisfaction and outcomes were improved. Overall 'personal budgets offered improved outcomes for a similar or slightly reduced spend'.

²⁸ National Audit Office, *Oversight of User Choice and Provider Competition in Care Markets*, September 2011 - "...69 per cent of those funding their own care do not feel sufficiently informed about the financial implications of long-term care." and "Users report very different levels of support across local authorities, and best practice in implementing personal budgets is not as widely shared as it needs to be."

goals.²⁹ Such help might take the form of 'brokerage' or 'advocacy'. However, the coverage of this type of support is variable across the country – and very often people who are funding their own care and support will not have access to it.

C. Barriers to employment created by the current structure of financial assessment

49. Being in residential care does not preclude an ability or desire to work. However, the current charging regulations remove the monetary incentive to take up employment, thus preventing individuals from achieving their desired outcomes.
50. In residential care, individuals are assessed to identify how much they contribute to their care from earned income, some benefits and other eligible assets such as savings. There is no discretion allowed within paragraphs 10 and 13 of the Assessment of Resources Regulations, which state that local authorities should include any earned income in their financial assessment.
51. Most individuals in residential care will have limited assets to pay for care, and therefore will have to pay out of earned income, if they have any. If they do not have earned income they still receive care, since the local authority provides a safety net. Individuals in local authority supported residential care are therefore financially no better off from working and the charging rules act as a disincentive to work. This is further explained in Annex A below.
52. There have been calls from stakeholder groups such as Disability Rights UK to consider changing the treatment of earned income. While there are also non-monetary incentives for people to take up employment, a survey by Disability Rights UK found that just over 1% of people in residential care are currently working. The Joint Committee on Human Rights (JCHR) stated in their recent report that:
- “There appears to be an anomaly in the charging policy for residential care which creates a significant work disincentive, thus impeding access to independent living. The Government also appear not to recognise the extent to which people living in residential care are able to engage in paid work. We urge the Government to take action to remove this disincentive as soon as possible.”*³⁰
53. The recommendation from the JCHR was based on evidence provided by local authority supported residents who stated they have had offers of employment, but they lack the incentive to take them up due to the treatment of earned income.
54. Increasing incentives for employment is consistent with other areas of Government policy, which look to help disabled adults achieve their desired outcomes, including employment.

Integration

55. An effective focus on prevention and personalised support requires a joined up, integrated approach across public services. The right systems, structures, skills and behaviours need to be in place to incentivise all these services to join up around the people that use them, and respond to their needs effectively.
56. The *Caring for our future* engagement undertaken jointly with the NHS Future Forum on integrated care found that, whilst the quality of health and care is generally of a high standard, there are often significant gaps and overlaps between services.³¹ This can result in multiple assessments, delays and mixed messages. Despite islands of good practice, there are many barriers to improved integration which remain, resulting in very patchy progress overall.³² As well as barriers to better integrated health, adult social care and housing services, we also heard during the engagement that the transition between children's and adult social care was often a source of worry for young people, their families and carers.

²⁹ In Control, *Personal Outcomes Evaluation Tool*, 2011.

³⁰ Human Rights Joint Committee 23rd report, February 2012 - <http://www.publications.parliament.uk/pa/jt201012/jtselect/jtrights/257/25702.htm>

³¹ NHS Future Forum, *Integration: a report from the NHS Future Forum*, 2012.

³² Audit Commission, *Joining up health and social care*, 2011.

57. Lack of effective integration can lead to the following problems:

Poor experience – health and care users can sometimes find the system fragmented, confusing and frustrating. They often have to apply or explain their needs to multiple people or organisations. National Voices suggest that patients and service-users “are tired of organisational barriers and boundaries that delay or prevent [their] access to care.”³³

Poor health and social care outcomes – poor communication and fragmented services can lead to care packages that do not reflect care needs. A CQC report found that “the level of integration between organisations had a significant impact on whether people using the services and their carers could get the right help at the right time”.³⁴ In turn, individuals and their families do not always receive the most appropriate support to help them stay well and independent for as long as possible. For example, preventable hospital admissions, unnecessarily long stays in acute health settings and avoidable admissions to residential care may result from a lack of integration between health and social care services.³⁵ Similarly, the Audit Commission suggests that emergency admissions in health care are a high-level indicator of the efficacy of the health and social care interface.³⁶

Inefficiencies between systems – uncoordinated visits by professionals or the need to have multiple health and social care interactions can lead to a delay in provision, unnecessary bureaucracy and wasted resources. As discussed above in relation to prevention, commissioners currently have little incentive to look across the whole health and social care economy when taking decisions.

58. Integrated working across health and social care could offer potential both for efficiency savings and improving outcomes for people. Many councils see partnership working as an important way of achieving efficiencies.³⁷ The Audit Commission estimated that primary care trusts (PCTs) could save about £132 million a year if all the areas with high emergency admissions, after taking account of their population's characteristics, reduced activity to match the current national average.³⁸ A potential way of achieving this level of savings is through better integration of health and social care services.

59. A lack of integration between health and social care services impacts on a number of groups:

- Older people – integration is particularly important for older people due to “their high use of services straddling the care and cure boundaries, and the risk that fragmented care will deliver poor outcomes”. According to research carried out by Nuffield Trust nearly 10% of people over the age of 75 receive both health and social care services.³⁹
- People with long-term conditions – Beland et al assert that because their needs straddle organisational barriers, integration could improve outcomes for this group.⁴⁰
- Carers – Alaszewski, Billings and Coxon suggest that integration “both epitomizes best practice and correlates well with the expressed preferences of *both* users and carers” [original emphasis].⁴¹ Kodner’s analysis of the PRISMA intervention in Canada also finds that integrated services can reduce the burden on carers.⁴²

³³ National Voices, *Principles for integrated care*, 2011.

³⁴ Care Quality Commission, *The state of health care and adult social care in England*, 2009.

³⁵ Huws, D. et al, *Impact of case management by advanced practice nurses in primary care on unplanned hospital admissions: a controlled intervention study*, 2008.

³⁶ Audit Commission, *Joining up health and social care*, 2011.

³⁷ Audit Commission, *Improving Value for Money in Adult Social Care*, 2011.

³⁸ Audit Commission, *Joining up health and social care*, 2011.

³⁹ Curry, N. and Ham, C., *Clinical and service integration: the route to improved outcomes*, 2010.

⁴⁰ Beland, F. et al, *A system of integrated care for older persons with disabilities in Canada: results from a randomized control trial*, 2006.

⁴¹ Alaszewski, A., Billings, J. and Coxon, K., *Integrated health and social care for older persons: Theoretical and conceptual issues*, 2003.

⁴² Kodner, D., *All Together Now: A Conceptual Exploration of Integrated Care*, 2009.

The underlying causes of the problem

60. Attempts to improve the integration of health and social care are not new but there is still significant variation in the extent to which health and social care services are joined up across England.
61. Many of the barriers to integration are longstanding and are rooted in the separate structures and cultures of health and social care. The NHS is tax-funded and free at the point of delivery, while social care is means tested and can include contributions from users or be entirely self-funded.
62. Furthermore, evidence has shown that whenever organisations are faced with financial difficulties, there is a tendency to make decisions that damage joint working relationships. Integrated services can lead to efficiencies, for example, through changing structures and removing duplication, but evidence indicates that integration costs before it pays due to the need for upfront investment.⁴³
63. There is a broad consensus in the literature that such barriers are compounded by:
- a. The lack of conceptual clarity surrounding the term.
 - b. The lack of clarity of evidence - there is conflicting evidence on whether integration delivers better value for money. For example, although Northern Ireland is considered an example of integration, there is no clear evidence of actual benefits.⁴⁴
 - c. The complexity of policy and organisational contexts at central and local levels of governance - meaning that there is no single best way to secure improvements in integration.
64. Integration should not be regarded as an end in itself but a means to an end.⁴⁵ Many previous approaches to integrated working have tended to focus on organisational and process arrangements; however, there is evidence to suggest that organisational integration is neither necessary nor sufficient to ensure improved outcomes.⁴⁶ Evaluations and academic analysis has also tended to focus on processes rather than outcomes for service users and effectiveness.⁴⁷
65. This is particularly problematic given that new models of integrated care often require significant investment and time before the benefits are felt by health and care users. Indeed, many of the studies that concluded that integrated care was not cost effective were conducted over short time periods, whilst many of the benefits will accrue as individuals remain independent well into the future.⁴⁸ For example, those integrated services that have a focus on early intervention are designed to prevent needs escalating and therefore, their real benefits will be realised over time.

Information, advice and support

66. Information is a critical enabler for joined up working, effective prevention and personalisation of support. People should be able to understand how care and support works before they develop a care need and to plan early for the support that they and their families might need later in life. Once they need care, everyone should know where to go to access care and support, how to get help to choose care and what standard and quality of care to expect. This will drive up quality and improve outcomes.
67. Any interventions on information, advice and support will only be of value (or otherwise will be limited in value) if there is a range of good quality services available to those that need them. Conversely, people need to know what services are available in order to make the best use of improvements in

⁴³ Leutz, W.N., *Five laws for integrating medical and social services: lessons from the United States and the United Kingdom*, 1999.

⁴⁴ Heenan, D. and Birrell, D., *Organizational Integration in Health and Social Care: Some reflections on the Northern Ireland Experience*, 2009.

⁴⁵ Glasby, J., Health Services Management Centre (HSMC), *The case for social care reform – the wider economic and social benefits*, February 2010.

⁴⁶ Curry, N. and Ham, C., *Clinical and service integration: the route to improved outcomes*, 2010.

⁴⁷ Dowling, B., *Conceptualising successful partnerships*, 2004.

⁴⁸ Windle K. et al, *National Evaluation of Partnerships for Older People Projects*, 2010.

quality.⁴⁹ The availability of high quality information and advice needs to take account of the needs of carers as well as people using care and support.⁵⁰

68. Evidence from recent consultations suggests that information is not routinely being provided in the most effective manner; either to help people take steps to prevent or delay the onset of social care needs or to help those users and carers who do have needs to identify and access appropriate support.
69. Firstly, people do not anticipate needing care and do not understand how the care and support system works. Ipsos MORI research in 2010 found that 54% of the public think that, should they need to use services in the future, they will be free at the point of use.⁵¹
70. This lack of understanding about how care and support works means that very few people plan ahead for their care needs. This can also mean a lack of financial preparation: an ICM poll on behalf of Counsel and Care, Carers UK and Help the Aged found that 87% of people had not made any plans to pay for personal care in older age, while just 5% of people had plans in place already.⁵² It can also mean that people are unaware of the potential benefits of putting in place preventative support, such as aids, adaptations and assistive technology, before they become needed.
71. Secondly, once people do develop a care need, there is a lack of information on available support. When people do need support, they often do not know what local authorities are required to offer. A survey from 2010 suggested that 42% of people did not know that local authorities offered a free assessment of a person's needs.⁵³ People struggle to access and navigate the system, often finding it difficult to distinguish between health, housing and care services.
72. There is a shortage of high quality, reliable information about organisations and individuals offering care, the quality of that care, and the experience of others using those services. This means that people find it difficult to make effective choices about their care, undermining their independence and potentially putting their human rights at risk.
73. In summary, the *Caring for our future* engagement led to the following conclusions about problems with the provision of information and advice:
 - People do not know or have a clear idea of what social care is, how it is organised, funded, assessed and how it relates to other services. The public profile and therefore understanding of social care issues is low, with the result that people are less likely to take steps to plan for their potential care needs.
 - People do not know how or where to access the information that would help them plan and prepare at key points in their lives, or support them to make appropriate choices if they are in receipt of care or expect to need care in the near future.
 - Individuals, including self-funders, and carers need access to a comprehensive range of help to navigate the care system and support them to get the right 'personalised' care.
74. Similar issues have identified in research evidence:^{54 55 56}
 - There is a need for better signposting, in particular information about where and how to *start* to find out about social care – there is a lot of information but accessing it can be difficult.
 - Information needs to be made easily available at times in people's lives when support is needed – especially at a point of crisis.

49 This is explored in the corresponding Impact Assessment "Quality, care providers and the workforce", as is the importance of information for local authority commissioners.

⁵⁰ Issues relating to carers' assessments and eligibility for services are discussed separately in the corresponding Impact Assessment "Assessment, eligibility and portability for care users and carers".

⁵¹ Department of Health/Ipsos MORI, *Public attitudes towards care and support*, 2010.

⁵² Counsel and Care, Carers UK and Help the Aged, *Scary, depressing and confusing: Voter's view of Social Care revealed*, 2008.

⁵³ Counsel and Care, *Exclusive Research Reveals Widespread Confusion over Care for Older People*, 2010.

⁵⁴ Picker Institute Europe, *Assessing information about health and social care services*, 2007.

⁵⁵ Hudson, B. and Henwood, M., *People who fund their own care and support*, commissioned by SCIE, ADASS, Joseph Rowntree Foundation, 2009.

⁵⁶ ADASS, LGA, IDeA, *Transforming adult social care: access to information, advice and advocacy*, 2010.

- Information and advice needs to be tailored to individuals' needs.
 - The quality of information provision could be improved, for example the presentation of information on websites or in leaflets or the knowledge of helpline staff.
 - All the same issues apply to self-funders but in addition, some local authority services may too quickly dismiss this group without giving them proper support.
 - In a survey of care users, 26% said they found information and advice very or fairly difficult to find. Crucially, those that found information and advice difficult to find were generally less satisfied with the care services that they received.⁵⁷
 - In a survey of carers who are in touch with social services, 26% said they found information and advice very or fairly difficult to find.⁵⁸
75. Furthermore, the quality of information services may be variable across the country. Based on research undertaken by CQC, Easterbrook found significant geographical variation, with authorities that were least effective in providing information and advice more likely to be in urban areas.⁵⁹
76. A survey of Adult Social Services Directors in 2009 suggested that respondents were on the whole “working towards better information, advice and advocacy services and a more strategic approach” but few were there yet.⁶⁰ Most Directors responding did not have documented strategies in place and did not believe that current information services were being strategically commissioned.
77. There are a number of reasons underpinning the lack of transparent information and advice. These are in described in more detail below. In summary the problem stems from:
- a. Inability of individuals and families to demand good information;
 - b. Lack of incentives on the supply side; and
 - c. Lack of clarity in the legal framework regarding information provision.
- A. Inability of individuals and families to demand good information
78. There are currently high costs associated with collecting information about prices, quality and availability in social care markets.⁶¹ There are more than 62,400 employers in the sector, an average of over 400 per local authority, many of which are small and medium sized firms.⁶² For an individual to look at sufficient numbers of these firms to enable useful comparison would require significant time investment. Time is often at a premium for those going through transitions and people may therefore use media reporting, informal advice and habit as the bases for their decisions.⁶³
79. People in lower socio-economic groups may have less skills and resources to seek information. This is also the group that is more likely to require social care services.⁶⁴
80. Evidence suggests that people are not aware of the information that is available.⁶⁵ They do not always perceive it to be of value or that they could be better off if they sought information to evaluate care options.⁶⁶ If individuals are not aware of all of the goods and services in the marketplace, they are highly unlikely to purchase the combination that most closely matches their preferences.

⁵⁷ Information Centre, *Adult Social Care Survey 2010-11*, 2011.

⁵⁸ Information Centre, *Personal Social Services Survey of Carers in England 2009-10*, 2010.

⁵⁹ Easterbrook, L., *Getting over the threshold for advice: issues arising from the Care Quality Commission's unpublished review of English social services' response to people's 'first contact' for information, advice, help or support*, 2011.

⁶⁰ ADASS, LGA, IDeA, *Transforming adult social care: access to information, advice and advocacy*, 2010.

⁶¹ Lent, A. and Arend, N., *Making choice: how can choice improve local public services*, 2004.

⁶² http://www.skillsforcareanddevelopment.org.uk/Researchanddevelopment/understanding_the_sfcandd_sector.aspx

⁶³ Ipsos MORI, *Public opinion research on social care funding: A literature review on behalf of the Commission on the Funding of Care and Support*, 2011.

⁶⁴ Baxter, K., et al, “Making informed choices in social care: the importance of accessible information”, *Health and Social Care in the Community*, 16 (2), 2008.

⁶⁵ ADASS, LGA, IDeA, *Transforming adult social care: access to information, advice and advocacy*, 2010.

⁶⁶ Sykes, W., Hedges, A., Groom., C. and Coleman, N., *Opportunity Age Information Indicators Feasibility Study*, DWP Working Paper No. 47, 2008.

B. Lack of incentives on the supply side

81. Poorly performing firms have a disincentive to provide accurate information about their services⁶⁷, and others use highly complex contracts that cannot be clearly interpreted⁶⁸. Moreover, information around quality can be subjective and may require labour-intensive collection. Investing in this research may be particularly unattractive if, as set out above, the demand for information and advice is limited.
82. Because (potential) care recipients are not aware of all of the options available to them, this affords social care providers a degree of market power. Salop and Stiglitz show that providers could increase their prices above the level that would have prevailed if information were freely available.⁶⁹ OFT find that limited price transparency and complex contracts give care home providers “scope to introduce arbitrary fee increases”.⁷⁰

C. Lack of clarity in the legal framework regarding information provision

83. Local authorities are responsible for providing information, advice and support services in their local area. Section 1(2) of the Chronically Sick and Disabled Persons Act 1970 (c.44) as amended by Section 9 of the Disabled Persons (Services, Consultation and Representation) Act 1986, currently imposes a duty on local authorities to provide information on welfare services available in the authority’s area. This provision is limited in scope to non-residential services provided under section 29 of the National Assistance Act 1948.
84. The current view is that in practice this does not equate to a coherent duty to provide a broader information offer on care and support. The Law Commission’s report from May 2011 discussed this in detail and made a specific recommendation that any new statute should place a duty on local authorities to provide information and advice services in their area. This was further supported by the report of the Commission on Funding of Care and Support.

II. RATIONALE FOR INTERVENTION

85. Government intervention is required to provide better incentives for partnership working and provision of high quality information with the aim of encouraging a cultural shift towards an integrated, preventative and personalised approach. Greater legal clarity is required on the provision of information and advice and on personal budgets, as recommended by the Law Commission and the Commission on Funding of Care and Support and endorsed during *Caring for our future* engagement discussions. Greater legal clarity can only be effected through the introduction of primary legislation.

A stronger focus on prevention and joined up services

86. Government intervention is required to remove organisational barriers to greater prevention and integration and improving incentives for commissioners, including through the collection and dissemination of evidence on what works across health, public health and social care. This should facilitate increased joint commissioning across health, social care and public health and allow for the implementation of services that use the “whole person” approach. Incentives for individuals to take preventative steps should also be improved – for example by encouraging take-up of new technology based solutions.
87. It is likely to be more efficient for Government to disseminate best practice on integration and prevention than local areas on their own, to identify which models of integration work better.

⁶⁷ Salop, S. and Stiglitz J., 'The theory of sales: a simple model of equilibrium price dispersion with identical agents', American Economic Review, December 1982.

⁶⁸ Office of Fair Trading, *Care homes for older people in the UK: A market study*, 2005.

⁶⁹ Salop, S. and Stiglitz J., 'The theory of sales: a simple model of equilibrium price dispersion with identical agents', American Economic Review, December 1982.

⁷⁰ Office of Fair Trading, *Care homes for older people in the UK: A market study*, 2005.

Access to specialised housing

88. In many areas of the country, there is currently a shortage of supply in specialised housing. Poor access to capital remains a major constraint on providers. We expect private developers to find capital more difficult to raise in the future whilst public and not-for-profit providers are being held back by the absence of major subsidies. Only Government is able to intervene to provide the injection of capital required to overcome current limitations of access.

An improved offer of information

89. Government intervention is also required to provide a range of information for users, carers, commissioners and providers to overcome current informational failures and help all parties to make more informed decisions. Government needs to provide coordination and direction to ensure more consistent, comprehensive and joined-up access to information to help inform people about the benefits of support and advice, and reduce the costs of searching for information, which is often required at short notice.

90. As recommended by the Law Commission, primary legislation is required to provide a firm basis for a more consistent offer of information and advice, with local authorities being able to exercise flexibility in how they meet their duties in this respect. Legislation is also required to ensure that everyone is able to request the assistance of their local authority in the arrangements for meeting their eligible needs for care and support, regardless of their finances. In turn, this will support people to make more effective choices.

Personalisation, independence and control

91. Government needs to intervene to ensure that all local authorities offer personal budgets, thereby giving all users and carers equal access to the potential benefits of personalisation. Currently not all local authorities are acting to make the availability of personal budgets to all a reality, despite the clear policy direction set out in the Government's *Vision for Adult Social Care*. The need for Government intervention to drive forward progress has been recognised by both the National Audit Office⁷¹ and the Public Accounts Committee⁷², as well as the *Caring for our future* engagement. Primary legislation is therefore necessary to ensure that everyone eligible for care and support is able to access a personal budget.

92. In order to undertake development and testing of how personalisation can be extended for people in residential care, Government intervention is also required to amend current regulations regarding access to residential care.

93. People in employment who are supported by local authorities in residential care currently have all of their earned income charged to pay for care. This creates a disincentive for individuals to take up employment since the individual is financially no better off working than not working. Government intervention is required to remove the current legislative barriers to people in residential care taking up employment. This would support more disabled people to take up employment and pursue their desired goals.

III. POLICY OBJECTIVES AND PROPOSALS

94. The overarching policy objective is to secure better outcomes, improved experience of care for users and carers and a more effective use of resources across public services and communities. In support of this objective, the Government has set out several proposals in the White Paper *Caring for our*

⁷¹ National Audit Office, *Oversight of User Choice and Provider Competition in Care Markets*,

2011 - "Users report very different levels of support across local authorities, and best practice in implementing personal budgets is not as widely shared as it needs to be."

⁷² Public Accounts Committee, *Oversight of User Choice and Provider Competition in Care Markets*, 57th Report, 2011 - "The Department has no power to compel local authorities to implement personal budgets... These failures undermine the Department's ability to deliver its policy objective, yet the Department has no power to intervene to ensure the target for all eligible users to have personal budgets by April 2013 is achieved."

future to bring about a greater focus on prevention and personalisation of support, underpinned by increased availability of quality information, support and advice and facilitation of integrated approaches to care.

95. Experts within and outside the Department of Health were consulted as part of the development of White Paper policy measures discussed in these Impact Assessments. Consultation took the form of one to one meetings, group discussions and workshops. Experts included care users, commissioners, providers and academics. In these discussions, the merits of the policy proposals were discussed in terms of effectiveness and associated costs and benefits. Alternative options were also discussed.

96. As is made clear in detailed discussion below, some of these proposals will be taken forward in primary legislation through provisions in the draft Care and Support Bill, while some require amendments to existing secondary legislation. Others can be taken forward in collaboration with the care sector without the need for new or revised legislation. Although these proposals have been listed under relevant objectives, the overall package of proposals should be seen as interdependent and mutually reinforcing.

Description of policy objectives and proposals set out in the White Paper

Policy theme	Objectives	Policy proposals
Prevention	<ul style="list-style-type: none"> • Improve the evidence base regarding the cost-effectiveness of preventative interventions to support local commissioning decisions so that more people are supported to live independently for longer in their own homes, delaying or preventing the need for more costly, crisis based interventions; • Incentivise innovative approaches to investment in prevention. 	<p>A. Accelerate the roll-out of assistive technology and other evidence based interventions across health and social care;</p> <p>B. Work with a range of expert bodies to ensure there is a single social care evidence library providing evidence around social care preventative interventions;</p> <p>C. Develop in a number of trailblazer areas new ways of investing in preventative interventions in social care;</p> <p>D. Introduce a statutory duty on local authorities to prevent or delay needs for care and support.</p>
Housing	<ul style="list-style-type: none"> • Promote the welfare of disabled and older people by offering a wider range of effective care with housing options that promote their independence and wellbeing. 	<p>E. Provide capital funding to support the specialised housing market for those with care and support needs.</p>
Personalisation	<ul style="list-style-type: none"> • Support care users and carers to maintain independence and increase choice and control over their care and support; • Ensure that all individuals receiving care and support are able to realise these benefits; • Create greater incentives for employment for disabled adults in residential care. 	<p>F. Set out in legislation an entitlement to personal budgets for all those eligible for care and support;</p> <p>G. Develop and test direct payments for people in residential care settings;</p> <p>H. Exempt earned income from the financial assessment in residential care.</p>
Integration	<ul style="list-style-type: none"> • Ensure that health, care and other public services work together to improve outcomes and experience, reflecting the needs and preferences of individuals. 	<p>I. Build on the provisions of the Health and Social Care Act 2012 to set out further actions to support integrated care.</p>

Information, advice and support	<ul style="list-style-type: none"> • Enable people to understand what is available and to make informed choices supported by a comprehensive framework for information and advice connecting between national and local level; • Enable care users and carers to find their way more easily through the care and support system and related public services and in so doing assume greater control over their lives; • Increase transparency of information regarding the quality of care and support to enable people to make informed choices and deliver greater incentives to drive up quality of care. 	<ul style="list-style-type: none"> J. Introduce a new national care and support information portal including a directory of services; K. Introduce a statutory duty on local authorities to provide information and advice; L. Improve local authorities' web-based information and advice services; M. Provide additional provision of advice and support to help people arrange care and support; N. Make clearer the duty for local authorities to share information with individuals, carers and families; O. Develop and disseminate best practice models for support and representation services.
--	--	---

IV. IMPACT OF POLICY PROPOSALS

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

Prevention proposals

Objectives:

- Improve the evidence base regarding the cost-effectiveness of preventative interventions to support local commissioning decisions so that more people are supported to live independently for longer in their own homes, delaying or preventing the need for more costly, crisis based interventions;
- Incentivise innovative approaches to investment in prevention.

Option 1: Do nothing

98. ONS population projections suggest that the number of people aged 85 and over will rise from 1.3m in 2008 to 3.3m in 2033. A recent DH survey suggested that around 80% of local authorities currently set their eligibility criteria threshold at substantial or critical levels of need.⁷³ Only 2% provide funding at “low” levels, suggesting that investment in some local authorities is not focused on avoiding people’s low-level needs from getting worse. There are some examples of good practice where local authorities are investing in prevention and early intervention, despite setting eligibility criteria at critical or substantial. However, feedback from the *Caring for our future* engagement suggests this is not widespread. A lack of investment in prevention could contribute to ultimately poorer health and wellbeing outcomes for individuals at higher unit costs.

99. As discussed above, without intervention, current barriers to an improved focus on prevention will remain in many areas. Lack of evidence about effective commissioning for prevention and difficulties in measuring success prevent a coordinated focus across local systems on shifting the emphasis to early action and more effective use of available resources.

Option 2: Implement the following proposals:

- A. Accelerate the roll-out of assistive technology and other evidence based interventions across health and social care;

⁷³ Analysis of White Paper proposals to improve equity of access to assessment and eligibility for care and support is provided in the corresponding Impact Assessment “Assessment, eligibility and portability for care users and carers”.

- B. Work with a range of expert bodies to ensure there is a single social care evidence library providing evidence around social care preventative interventions;
 - C. Develop in a number of trailblazer areas new ways of investing in preventative interventions in social care;
 - D. Introduce a statutory duty on local authorities to prevent or delay needs for care and support.
100. In addition to these proposals, other proposals set out in the White Paper *Caring for our future* and analysed in more detail below will also improve incentives for both commissioners and individuals to invest in prevention. Particularly relevant in this regard are proposals for accessible, high quality information, advice and navigation and proposals to incentivise investment in housing based solutions to enable people to remain independent in their own homes. More joined up approaches at local level and personalised approaches to care will also support a focus on early, tailored interventions to avoid escalation of need to the point of crisis.

Proposal A: Accelerate the roll-out of assistive technology and other evidence based interventions across health and social care

101. The *Three Million Lives* campaign launched by the Department of Health in December 2011, aims to accelerate the roll-out of telehealth and telecare in the NHS and social care during a five year programme to develop the market. The Department's Concordat with the telecare industry sets out an ambition to improve the lives of millions of service users and carers through telecare services.
102. Building on this campaign, and using the findings on cost effectiveness and quality of life gains from the Whole System Demonstrator sites⁷⁴, DH will work with industry through the *Three Million Lives* campaign to achieve the following:
- Incentivise new types of technology-based assistive provision for people using care and support such as rent or maintenance models that local authorities could manage with industry;
 - Create a more diverse retail market so that individuals are more aware of telecare and able to purchase equipment directly, either by their own means or through their personal budget.
103. Assistive technology will also be considered in the integration framework to be co-produced with partners across the new health and care system and published later this year (as described in more detail under Proposal I below).

Costs

104. The investment cost and benefit model proposed for telehealth is being developed and covered in detail as part of the *Three Million Lives* campaign.⁷⁵
105. Further information on the cost effectiveness of telecare is awaited from the Whole Systems Demonstrator pilots. Based on the results of this, decisions will be made in the *Three Million Lives* campaign on the extent to which DH will support the roll-out of telecare.

Benefits

106. During the *Caring for our future* engagement, we heard that telecare has the potential to enhance the care and support system by enabling a personalised, low cost and high quality preventative service to be accessed in the home. This can improve outcomes for people, their families and carers.
107. Some early evidence suggests that it is possible for telehealth and telecare to be cost effective. However, by far the most reliable evidence on telecare will be from the Whole System demonstrator sites evaluation, and these will be used as the basis for any costings in the *Three Million Lives* campaign.

⁷⁴ The Whole System Demonstrator (WSD) programme is a two year research project funded by the Department of Health to find out how technology can help people manage their own health while maintaining their independence. The WSD programme is believed to be the largest randomised control trial of telecare and telehealth in the world to date.

⁷⁵ Department of Health, *Whole System Demonstrator Programme: Headline Findings*, December 2011.

Proposal B: Work with a range of expert bodies to ensure there is a single social care evidence library providing evidence around social care preventative interventions

108. The Government will establish a new national social care evidence library, to improve how evidence can be accessed and used by commissioners and other stakeholders. Making use of existing evidence and available information about preventative interventions, the Government will work with a range of expert bodies to ensure there is a single, central repository for evidence from April 2013. The evidence base would be made available across local services including local authorities, the NHS and other providers. We will also focus on options for identifying and addressing significant gaps in the evidence base where new research may be needed.
109. We would expect the evidence library to include evidence around the cost effectiveness of particular interventions, how actions in one part of the care and support system may generate savings in another, and tools for quantifying the benefits of particular services for people's quality of life. It should also include evidence around support for people with caring responsibilities, to promote their wellbeing.
110. The work could encompass, for example:
- Outcome measuring tools built to national standards;
 - Tools for cost-benefit evaluations of preventative interventions;
 - Gathering evidence on the effect of actions across health and care;
 - Tools for quantifying and monetising quality of life benefits;
 - Championing long-term prevention research.

Costs

111. This proposal would involve the following:
- Conducting an evidence review on the effectiveness and cost effectiveness of preventative interventions in social care;
 - Analysing the results and organising the results into a format suitable for placing into an online portal;
 - Designing and building an online portal.
112. Evidence from similar sized evidence reviews sponsored by DH (for example for the Social Care Outcomes Framework) suggests that an evidence review and analysis could involve a one-off cost to DH of around £200,000. Experience from a similar evidence portal for the Public Health Outcomes Framework suggests that the organisation of this evidence, together with the development and population of an online portal could involve a one-off cost to DH of around £300,000. It is possible that all this work could be commissioned from a partner organisation.

Benefits

113. User experience is likely to be improved through investment in preventative interventions, although it is unclear to what extent. An online portal would give commissioners the opportunity to review available information on preventative interventions and best practice within adult social care. There is already a wide range of evidence in systematic review papers that preventative interventions can deliver improvements in health and care outcomes.^{76 77 78} By making this information available in one place, decisions can be made as to which services and interventions deliver the best results, which are the most cost effective in the long term, and what are the research gaps that need to be filled.

⁷⁶ Gillespie, L., Robertson, M., Gillespie, W., Lamb, S., Gates, S., Cumming, R. and Rowe, B., *Interventions for preventing falls in older people living in the community*, Cochrane Review, 2010.

⁷⁷ Turner, S., Arthur, G., Lyons, R., Weightman, A., Mann, M., Jones, S., John, A. and Lannon, S., *Modification of the home environment for the reduction of injuries*, Cochrane Review, 2011.

⁷⁸ McClure, R., Turner, C., Peel, N., Spinks, A., Eakin, E. and Hughes, K., *Population-based interventions for the prevention of fall related injuries in older people*, Cochrane Review, 2008.

Proposal C: Develop in a number of trailblazer areas new ways of investing in preventative interventions in social care.

114. This proposal aims to encourage more innovative uses of resources in order to stimulate greater investment in preventative services.
115. The *Caring for our future* engagement highlighted Social Impact Bonds (SIBs) as a way of attracting new investment to provide upfront funding for prevention and early intervention, and enabling commissioners to be confident that payment will be based on results. Effectively SIBs are a form of payment by results contract, where interventions to improve social outcomes such as reduced hospital admissions are financed by private investors. Investors are then repaid on the investment, according to the degree to which the outcomes improve through the intervention.
116. However, while SIBs are being taken forward in some parts of the country – for example in Leeds on non-elective hospital admissions - they are not used widely across health and care. We propose to develop the use of SIBs from 2013 in a number of trailblazer projects, focusing on interventions that help people to remain at home or reduce admissions to hospital. Projects will be undertaken in partnership with key local stakeholders such as clinical commissioning groups, the NHS Commissioning Board and local authorities. We will investigate research approaches to assessing the challenges involved in setting up and running such projects.
117. Projects could draw from existing evidence about effective preventative interventions – for example from the Partnerships for Older People Projects (POPPs)⁷⁹, or the prevention of medication errors in care homes. A business case will be required for each SIB to establish whether it is likely to be effective. Further details about the trailblazer projects will be published in autumn 2012.

Costs

118. There are likely to be costs associated with running SIB pilots. Experience with the SIB at HMP Peterborough for example suggested that the “transactional” legal and measurement aspects of setting up pilots were significant – possibly around 10% of the size of external investment.⁸⁰
119. The HMP Peterborough example had an external investment of £5 million. If we assume that five similar interventions could be established in social care with similar levels of external investment, this would be a £25 million external investment, which could generate a £2.5 million one-off transactional cost to the Department of Health and its partners (for example participating local authorities).
120. It is unclear exactly how much research expenditure would be required to support this proposal, as the exact details of a review have not yet been planned, but will build on other evidence reviews by external academics and other similar social finance vehicles. We assume for indicative purposes that research costs are likely to be in the range of £250,000 to £750,000 from the DH funded Policy Research Programme. This should not be taken as a commitment but as a broad indication only.

Benefits

121. As discussed above for Proposal B, an assessment of the available evidence suggests that prevention interventions are cost neutral at best. Therefore, it is unclear whether this intervention would generate overall savings in more intensive “downstream” social care or health interventions, or better overall health or social care outcomes. Examining the financial return to investors from the trailblazer projects will provide some additional information on this issue.
122. Under the SIB model, a significant proportion of the monetised benefits would be claimed by the SIB investors, although the exact terms would be decided with each bond.

⁷⁹ Department of Health, *National Evaluation of Partnerships for Older People Projects: final report*, January 2010.

⁸⁰ For more information on the HMP Peterborough example, see Ministry of Justice, *Lessons learned from the planning and implementation of the Social Impact Bond at HMP Peterborough*, May 2011.

123. If increased funding was delivered through the addition of new funding through SIBs, then it is reasonable to assume that both health and care outcomes and experience would be improved through the provision of new services.

Proposal D: Introduce a statutory duty on local authorities to prevent or delay needs for care and support

124. The Law Commission recommended that reform of the social care legislation should better reflect the balance of the local authority's modern role towards the whole local community, and universal services provided on this basis. As part of this recommendation, the Commission proposed that local authorities should have new general duties to provide or arrange services that are aimed at the prevention of needs for care and support.

125. The Government therefore proposes as part of its modernisation of the law to introduce a new duty on local authorities to provide or arrange such services or facilities to prevent or delay the onset of needs for care and support, or to reduce the escalation of such needs. The duty would require local authorities to take such steps as it considers necessary to contribute towards these aims. It would not specify the precise measures to be pursued or services to be provided, since these are matters for local discretion and will be agreed with other partners. However, the general duty would require the local authority to consider the extent to which it can make use of existing local assets (services, facilities or other resources) in performing this function, in addition to having regard to its responsibility to undertake a joint strategic needs assessment.

126. This duty would allow local authorities freedom to make their own arrangements, supported by statutory guidance. It has been designed on the basis of the required position in existing statutory guidance (see Prioritising Need, paragraphs 33-40), to codify best practice, rather than create a new function or burden.

Costs

127. We do not expect this duty to give rise to any new costs on local authorities. The duty reflects established practice and existing statutory guidance, and codifies such practice in primary legislation, as opposed to extending the scope of local authority responsibilities.

Summary of costs and benefits of Option 2

Table 3

Proposal	Agent	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
A. Supporting roll-out of <i>Three Million Lives</i> telecare and telehealth												
Transition Cost	DH	0	0	0	0	0	0	0	0	0	0	0
B. Social care evidence library for social care preventative interventions												
Transition Cost	DH	0.2	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5
C. Develop new ways of investing in preventative interventions in social care.*												
Transition Cost	DH	0.1	1.2	1.2	0.5	0.0	0.0	0.0	0.0	0.0	0.0	3.0
Total												
Capital Transition Cost	DH	0	0	0	0	0	0	0	0	0	0	0.0
Transition Cost Total	DH	0.3	1.5	1.2	0.5	0.0	0.0	0.0	0.0	0.0	0.0	3.5
Recurrent Cost Total	LA	0	0	0	0	0	0	0	0	0	0	0.0
Recurrent Cost Total	DH	0	0	0	0	0	0	0	0	0	0	0.0
Costs Grand Total		0.3	1.5	1.2	0.5	0	0	0	0	0	0	3.5

* Additional assumed opportunity costs to social investors of c. £25m not included here

Housing proposals

Objective:

Promote the welfare of disabled and older people through offering a wider range of effective care with housing options that promote their independence and wellbeing.

Option 1: Do nothing

128. Despite some growth over the last decade, the Extra-Care Housing (ECH) market in England remains relatively small. In 2009, the Elderly Accommodation Council estimated that some 43,000 public or privately provided ECH units exist in England.⁸¹ Laing and Buisson estimate that tighter definitions of ECH may reduce this figure to between 25,000 and 30,000, of which a minority is privately funded.⁸² This is roughly 5 -10% of the registered care home market or just 1% of the UK population aged over 75. In contrast, 15% of Americans aged 75 or over live in comparable 'assisted living' units.
129. In spite of recent land-price volatility, private provision of ECH is expected to grow with a "substantial pipeline of developments" underway.⁸³ Moreover, awareness of ECH providers, which is currently poor and cited as a barrier to demand, could well be expected to improve as a result of proposals regarding provision information and advice, discussed in more detail below. Finally, we expect the National Planning Policy Framework, published in March 2012 by the Department for Communities and Local Government, to reduce the burden of current planning procedures on ECH providers. Therefore, we expect some growth in the ECH market over coming years.
130. However, poor access to capital remains a major constraint on providers. We expect private developers to find capital more difficult to raise in the future, whilst public and not-for-profit providers are being held back by the absence of major subsidies.⁸⁴
131. If more appropriate housing solutions are not available at prices that people are willing to pay, demographic pressures will lead to more vulnerable adults living in housing that is insufficiently equipped to meet their needs, which may lead to them needing to access care at a time of crisis.

Option 2: Implement Proposal E to provide £200m of capital funding to support the specialised housing market for those with care and support needs

132. As part of the Government's focus on stimulating infrastructure development, we will set up a new capital fund worth £200m over five years to encourage providers to develop new accommodation options for older people and younger disabled adults. This is in line with announcements in the Government's recently published Housing Strategy to improve the supply of housing options, including for older and disabled people.⁸⁵
133. We expect all types of developers to work in partnership with local commissioners to make applications to the fund. The form that this fund will take has not yet been finalised, so at this point it is difficult to estimate how many units of housing it will lever. However, as an example, the DH Extra-Care Housing Grant that ran from 2004 to 2010 is estimated to have contributed to the building of a total of approximately 6000 units, from a £227m capital investment.⁸⁶ This previous fund covered an average of 55% of the funding for each development. Under the new fund, we will expect a larger percentage of the funding to come from private investment.⁸⁷

⁸¹ Elderly Accommodation Council, cited in Laing & Buisson, Extra Care Housing UK Market Report 2011/12.

⁸² Laing & Buisson, Extra Care Housing UK Market Report 2011/12.

⁸³ *Ibid.*

⁸⁴ *Ibid.*

⁸⁵ HM Government, *Laying the Foundations: A Housing Strategy for England*, November 2011.

⁸⁶ <http://www.housinglin.org.uk/AboutHousingLIN/DHExtraCareHousingFund/>

http://www.housinglin.org.uk/library/Resources/Housing/DH_funded_ECH_schemes_to_date.pdf

⁸⁷ Netten A., Darton R., Baumker T. and Callaghan L., *Improving housing with care choices for older people: an evaluation of extra care housing*, 2011 - <http://www.pssru.ac.uk/archive/pdf/dp2774.pdf>

134. More details about the fund will be published by October 2012. We therefore include an estimated unit cost of Extra-Care Housing (a prominent form of specialised housing), which will be incurred if the market for this form of housing expands, and a summary of the benefits. The Department will publish a separate Impact Assessment when the precise use of the funding is agreed.

Costs

135. Once completed, ECH developments will require a number of inputs to maintain their service. Baumker and Netten estimate the following cost components, summarised by a weekly unit cost of £416 (a range of £174 - £1,241).⁸⁸

Table 4 – ECH Unit Cost

Cost component	Mean (£)
Capital, including land	106
Housing management	53
Support costs	10
Activities cost	3
Social care	102
Health care	65
Living expenses	80
Unit Cost	416

136. ECH compares favourably with conventional residential care, which costs between £520 and £980 per client per week.⁸⁹

Benefits

137. Improving access to ECH widens the range of care options available to older and disabled people. This benefits a number of groups in society:

- (a) People with care needs: Evaluative reports have shown that ECH is more effective than residential and nursing care with regards to both costs and outcomes.⁹⁰ Therefore, those moving into ECH with an ongoing care need will benefit from improved wellbeing, whilst the individual, the state and so the taxpayer may benefit from lower costs of providing care.
- (b) People without care needs: This group will benefit from more suitable housing and improved social opportunities. Baumker et al's survey of ECH residents found that housing and social reasons were cited as 'very important' by up to 35% of respondents.⁹¹ Laing and Buisson also suggest that this group will benefit from greater certainty about their future, as their new home may be suitable for a wide range of future care needs.⁹²

138. There are also other benefits to be gained from the decision by individuals to move into ECH:

- (c) Movement into ECH increases the supply of ordinary housing on local property markets. In turn, this will have a positive impact on others in the area who are able to move into accommodation that more closely matches their preferences.

⁸⁸ Baumker, T. and Netten, A., *The Cost of Extra Care Housing*, PSSRU, 2001.

⁸⁹ Darton, R. et al, *Evaluation of the Extra Care Housing Initiative*, Personal Social Services Research Unit, 2011.

⁹⁰ Netten, A., Darton, R., Baumker, T. and Callaghan, L., *Improving Housing with Care Choices for Older People: An Evaluation of Extra Care Housing*, PSSRU, 2011.

⁹¹ Baumker, T. and Netten, A., *The Cost of Extra Care Housing*, PSSRU, 2001.

⁹² Laing & Buisson, *Extra Care Housing UK Market Report 2011/12*.

- (d) Families of those moving into ECH benefit from improved peace of mind. Laing and Buisson note that “the big attraction to family members...is the reassurance that...there is 24-hour on site emergency cover”.⁹³

Personalisation proposals

Objectives:

- Support care users and carers to maintain independence and increase choice and control over their care and support;
- Ensure that all individuals receiving care and support are able to realise these benefits;
- Create greater incentives for employment for disabled adults in residential care.

Option 1: do nothing

139. Local government received a total of £520 million in grant funding over the period 2008 -11 to transform the way in which they delivered care and support, as set out in the cross-Government and cross-sector Concordat *Putting People First*. In particular this set out that:
- By April 2010, everyone presenting for adult social care for the first time should be offered a personal budget;
 - By April 2011, 30% of people receiving community-based services should receive a personal budget.
140. While 447,000 of 1.53 million care users and carers – 29.2% - were in receipt of a direct payment or a personal budget at March 2011⁹⁴, these figures mask significant variations across the country and variable access for different types of care user.
141. There is likely to be some increased access to personalised care in the absence of any further intervention. However, the barriers to providing access to personalised care identified above suggest that this improvement would be variable across the country. Therefore the benefits of personalisation are either unlikely to be universally realised or maximised without a legal framework that underpins the new approach.
142. By maintaining current financial assessment rules, care home residents will continue to face a disincentive to work. This will continue to impede their access to employment as part of independent living.

Option 2: Implement the following policy proposals:

- F. Set out in legislation an entitlement to personal budgets for all those eligible for care and support;
- G. Develop and test direct payments for people in residential care settings;
- H. Exempt earned income from the residential care financial assessment.

143. In addition, Proposals J to O to improve access to information and advice are intended to encourage and support people to realise the full potential of personal budgets to improve outcomes and experience of care and support. These proposals are discussed in detail below.

Proposal F: Set out in legislation an entitlement to personal budgets for all those eligible for care and support

144. Under this proposal, legislation would set out that everyone eligible for care and support⁹⁵ would be provided with a personal budget, giving them a clear allocation of resources so that they can control as much of their care and support as they wish. This would mean that local authorities would no longer have a choice about whether or not to offer a personal budget.

⁹³ *Ibid.*

⁹⁴ Figures published by the Information Centre in March 2012.

⁹⁵ With the exception of emergency and end of life care, advice and one-off pieces of equipment, etc.

145. Supported by the White Paper proposals on information and advice discussed below, these changes in the law, including provision of a statutory basis for care planning and the content of care and support plans, will help to deliver the vital step change required and reduce the scope for variation. A re-designed statute will ensure personalisation is one of the defining features of the care and support system, rather than something that is done in spite of the system - which is what is happening in many places currently.
146. The draft Care and Support Bill will also set out a duty on local authorities to inform people about which of their needs could be met through a direct payment, and an individual's right to request a direct payment to meet some or all of their needs.

Costs

147. Local authorities are already moving towards a more personalised system in line with the *Vision for Adult Social Care*, which set out an ambition for providing everyone eligible with a personal budget by April 2013. If this aim is achieved, there will be no additional costs. Councils that have fully embraced personalisation do not cite increased costs.⁹⁶ However, as set out above, the provision of personal budgets varies widely, both geographically and by user group. This is exacerbated by personal budgets having no legal basis.
148. Perceptions of increased costs can be a barrier to local authorities making progress with personalisation. The IBSEN evaluation found the costs and complexities of implementing individual budgets (where a number of budget streams were brought together from across local and central Government) alongside traditional resource allocation systems and service provision were major challenges.⁹⁷ However, it is important to bear in mind not only that these were the experiences of the pilot sites who may have faced difficulties in terms of being early implementers, but also, that the individual budget pilots were dealing with six separate funding streams. Personal budgets involve only one funding stream for adult social care and are therefore much simpler to administer.
149. As personal budgets have been in existence since 2008, there is now a wealth of best practice guidance and information sharing on personal budgets for local authorities to access on the *Think Local, Act Personal* website that should negate these 'early implementer' costs.
150. At the margins, there are likely to be some additional costs to local authorities for the increased roll-out of personal budgets, where systems are not yet fully in place for personal budgets. The costs set out below represent a maximum cost estimate of this proposal as we assume that the only driver for increased roll-out of personal budgets is the introduction of legislation – in reality, this is not likely to be the case.
151. In a survey conducted in 2008 by LGA and ADASS, it was shown that 19 local authorities (13%) already had systems in place for all user groups to receive personal budgets and that 51 (34%) had a system in place only for some people.⁹⁸ It could therefore be assumed that 81 local authorities will experience full set-up costs if all care users are to access personal budgets, and 51 local authorities are likely to experience some cost in developing their systems for all user groups.
152. Since the survey was conducted in 2008, there has been wider roll-out of personal budgets. Table 5 below compares the extent to which local authorities have rolled out personal budgets in 2010/11 compared to 2008-09 using National Indicator NI130 – the proportion of community based users receiving self-directed support.

⁹⁶ Audit Commission, *Improving Value For Money in Adult Social Care*, 2011. Thirty-six per cent of councils cited personalisation as a driver of better value for money in 2009/10. This rises to 45 per cent for 2010/11. Better value came mostly from improved outcomes, not savings.

⁹⁷ Glendinning, C. et al, *Evaluation of the Individual Budgets Pilot programme*, IBSEN, York, 2008.

⁹⁸ LGA, ADASS, *Putting people first: measuring progress*, 2009.

Table 5:

Proportion of community based users receiving self directed support	Number of local authorities providing self-directed support to this proportion	
	2008/09	2010/11
5% or less	55	1
10% or less	125	3
20% or less	149	32
30% or less	150	68
40% or less	150	130

Source: Information Centre – National Indicator Set publication

153. This suggests that by 2010/11, the start-up costs of personal budgets have been borne by most local authorities. In estimating additional costs, we make the following assumptions based on the table above:
- As an upper limit: full set-up costs still need to be borne by local authorities where less than 10% of users receive personal budgets (3 local authorities) plus some set-up costs (50%) for the rest of local authorities where less than 20% of users receive personal budgets (29 local authorities).
 - As a lower limit: full set-up costs still need to be borne by local authorities where less than 5% of users receive personal budgets (1 local authority) plus some set up costs (50%) for the rest of local authorities where less than 10% of users receive personal budgets (2 local authorities).
 - Set-up costs for individual budgets are estimated to cost £300,000 per local authority in 2012/13 prices.⁹⁹
154. This gives set-up costs in the range of £0.5 million to £5 million for 2012/13. These figures are based on roll-out as at 2010/11 - since there is likely to be more progress between 2010/11 and 2011/12, these are likely to be overestimates of the residual set-up costs.
155. The IBSEN evaluation suggested that there are also likely to be additional support costs for assessment, planning and support (brokerage or advocacy). We have assumed these additional costs are covered by additional funding for advice and support services under Proposal M discussed below.
156. The IBSEN research found that those receiving individual budgets incurred higher health care costs than the control group but did not explore the reasons for these higher costs. This may have been due to uncertainties IBSEN found in how these costs arose. One possibility is that the offer of an individual budget in the pilots may have prompted recipients to become more aware of possible unmet health needs. Any such effect seems less likely outside the context of a pilot study. Since there is no clear intuitive reason why personal budgets for social care should generate higher health care costs, we assume that they will not normally do so.

Benefits

157. Where as a direct impact of the proposals someone receives a personal budget who would have not done otherwise, the evidence base suggests they will accrue benefits. Results from a six-month follow-up undertaken by IBSEN with those offered individual budgets showed that 47% of people who had accepted the individual budget reported that their view of what could be achieved in their lives had changed a lot and 19% reported that it had changed a little. A third of this group reported that their view had not changed at all. Older people were significantly less likely than other user groups to report that the process had changed their view on what could be achieved.¹⁰⁰
158. Using the social care outcome measure “ASCOT”¹⁰¹, IBSEN found that people in the individual budget group were significantly more likely to report that they felt in control of their daily lives (48%, $p < 0.05$) compared with those in the comparison group (41%).

⁹⁹ Glendinning, C. et al, *Evaluation of the Individual Budgets Pilot programme*, IBSEN, York, 2008.

¹⁰⁰ Please note that proxy interviews were used in 24% of the total cases as some respondents were unable to communicate.

¹⁰¹ ASCOT (Adult Social Care Outcomes Toolkit) <http://www.pssru.ac.uk/ascot/>

Ascot is a measure developed in partnership by PSSRU which can be used to measure an individual’s social care related quality of life (SCRQOL) and identify outcomes. A range of instruments and data entry tools are provided which measure

159. When looking at each user group individually, IBSEN found that although there were some differences between the individual budget and comparison groups for younger physically disabled people, none of them reached statistical significance.
160. The results suggest that people with learning disabilities in the individual budget group were more likely than those in the comparison group to feel they had control over their daily lives (p=0.054).
161. The Audit Commission has also recognised the wider benefits of personal budgets that are not confined to care and support outcomes (for example economic growth, increasing employment opportunities).¹⁰²
162. In Control published the National Personal Budget Survey (also known as the Personal Outcomes Evaluation Tool (POET)) in June 2011.¹⁰³ This suggests that personal budgets are likely to have generally positive impacts on the lives of all groups of personal budget holders and the people who care for them. The likelihood of people experiencing a positive impact from a personal budget is maximised by a support process that keeps people fully informed, puts people in control of the personal budget and how it is spent, supports people without undue constraint and bureaucracy, and fully involves carers (see Proposal M below). Under these conditions, personal budgets can and do work well.
163. As with the findings from POET, the NAO commissioned Ipsos Mori to conduct consumer research, published alongside its report on Care Markets.¹⁰⁴ The evidence from this research supports the Government's policy to encourage more people to take their personal budget as a direct payment as this leads to greater choice and control for users as well as greater creativity.
164. The main headlines from the report were that:
- direct payments offered the most flexibility and control for people;
 - personal budgets traded a little of this off for less responsibility and complexity;
 - effective support planning helped people make the best use of their budget; and
 - in terms of switching providers, direct payments appeared to offer a genuine choice to budget holders, but people needed help to make the switch.

Proposal G: Develop and implement in a small number of areas the use of direct payments for people who have chosen to live in residential care

165. People in residential care should have as much control of their care and support as people living in the community. The Law Commission made a specific recommendation about extending the option of direct payments to people moving into residential accommodation. Currently, regulations restrict this to no more than four weeks in any 12 month period, mainly for respite care. The Government agrees with the Law Commission that it is time to reconsider this. However, because the impacts are likely to be complex and variable, it wishes to test this in a number of locations first. We will shortly invite expressions of interest from interested local authorities to participate in a project that will begin in 2013. Further research and review is needed to quantify benefits. The exact details of the research and review have not yet been planned, but will build on other evidence reviews by external academics examining aspects of personalisation. Government will use evidence gathered as a basis to inform how best to proceed.
166. Views gathered as part of the *Caring for our future* engagement have been largely positive about this and the majority of people have welcomed it, as long as the impacts are properly evaluated and assessed. During the engagement, some small providers of physical disability and learning disability services were particularly keen to break down the care and hotel costs to improve care services. Some larger providers of care homes, mainly for older people, wanted to examine how disaggregating care and accommodation costs would affect the different fees paid for by local

SCRQOL and outcomes across 8 key domains (accommodation cleanliness and comfort; control over daily life; dignity; food and nutrition; occupation; personal cleanliness and comfort; safety; and social participation and involvement).

¹⁰² Audit Commission, *Financial Management of Personal Budgets*, 2010.

¹⁰³ <http://www.in-control.org.uk/media/92851/national%20personal%20budget%20survey%20report.pdf>

¹⁰⁴ Ipsos Mori, *Users of Social Care Budgets*, July 2011.

authority and self-funded care home residents. Commissioners were also keen to better understand the distribution of cost within a package of residential care.

167. Introducing more flexibility around this would also give providers an opportunity to innovate and move away from the current model of care, enabling them to move into areas such as stroke rehabilitation. There would be less of a cliff-edge between short and long-term care. For NHS and local authority commissioners, there could be some continuity and efficiencies, particularly around people who need NHS Continuing Healthcare by improving joint commissioning arrangements. Personal budgets and personal health budgets need to be brought together, particularly once personal health budgets for people receiving NHS Continuing Healthcare, many of whom will be in a residential or nursing care setting, are offered from 2014.

Costs

168. The costs of developing and implementing this approach across a range of localities, groups (older people, learning disability, physical disability, mental health) and settings (residential and nursing care homes, NHS Continuing Healthcare) are estimated to be £0.9 million per annum.

169. This is likely to be in the range of between six and eight sites with a project manager, costing £55,000 per annum including provider information. Assuming one to two FTE posts are required to work on this project over the period, we estimate that there will be in-house project management and support costs of £100,000 per annum over the period of the project. All these costs will fall to DH. We assume for indicative purposes that research costs are likely to be about £650,000 from the DH funded Policy Research Programme. This should not be taken as a commitment but as a broad indication only.

Benefits

170. The primary aim of the project is to assess the core policy of providing direct payments for residential care. However, over the longer term and with a wider roll-out, there may be opportunities for savings across health and care through improved joint commissioning. The project should provide an evidence base for this. We would also wish to explore through the project how people going into residential care who do not choose to have a direct payment can have more personalised care.¹⁰⁵ Again, the project should be able to ascertain the extent of these potential benefits across the health and social care system as a whole.

Proposal H: Exempt earned income from the residential care financial assessment

171. By removing earned income from the financial assessment for residential care, individuals will be able to realise monetary gains from working. This should act as an incentive for disabled people to take up employment where possible.

172. Individuals in residential care affected by this policy fall into two categories: those who are currently working and those who will take up employment as a result of the change. The effect of the policy on these two groups determines its costs and benefits.

Costs

173. There will be additional costs to local authorities where they no longer take into account the earned income of those individuals currently working in charging for residential care costs.

174. A survey carried out by Disability Rights UK estimated that 1% of working age adults in residential care currently work. Since there are around 54,000 people aged 18-64 in residential care, this corresponds to around 500 individuals currently working. We have assumed they work 20 hours a week, at a median wage of £11 per hour, again based on discussions with Disability Rights UK. Individuals are allowed to keep £22.60 per week out of their earned income as their Personal

¹⁰⁵ This could link well with the proposal for a Provider Quality Profile, discussed in the corresponding Impact Assessment “Quality, care providers and the workforce”.

Expenses Allowance (PEA).¹⁰⁶ Therefore, the financial loss to the local authority as a result of this policy change is the individual's wage minus PEA (£22.60 per week). Taking into account demographic pressures, this gives an upper estimate of an additional cost of £5.35 million per year to local authorities.

175. However, conversations with local authorities suggest the amount of charges received from earned income is currently limited. Few individuals earn more than £22.60, so there is no significant income from earnings for local authorities. Therefore, the lower range of the estimate is nil.
176. Our range of cost estimates is therefore from nil to £5.35 million, giving us a central estimate of £2.67 million costs in the first year of implementation, 2013/14. Costs will rise over the years due to demographic pressures.
177. As this is a transfer of resources from local authorities to working residential care recipients, the costs to local authorities correspond exactly to the benefits that would be realised by those currently working in residential care.
178. We believe there will be some small administration costs to local authorities as a result of financial assessors changing protocol and updating charging arrangements for those currently earning. Individuals already have their care package and financial situation reviewed on a regular basis. The application of the change to charging rules can be applied at no additional cost to the local authority during these reviews. There may be some small fixed cost to local authorities to learn and understand the new rule and how to apply it.
179. There is a complex interaction between individuals taking up employment, local authority charges and the benefit liability of Department for Work and Pensions. Individuals who choose to take up employment may see their benefits decrease as a result, although this should be limited through the introduction of Universal Credit. When earned income is exempt, local authorities will still take account of income from benefits. If this decreases as a result of taking up employment, the local authority receives less income but DWP saves the same amount in less benefit payments. The total amount of this transfer between DWP and councils cannot be estimated reliably since it will depend on individual circumstances.

Benefits

180. The main monetised benefit is to those taking up employment as a result of the legislative barrier being removed. This may be those currently working increasing their level of employment, or those not working taking up a job.
181. The monetary benefit gained from increased employment is uncertain. There is little information on the numbers who currently do not work but would do so if earnings were ignored in the charging system for residential care. We have assumed that some 400 to 500 care home residents will take up employment if earnings are disregarded and that they would work on average 20 hours per week at a wage of £11 per hour. This is highly tentative and illustrative only. The estimated monetary benefit to these residents is up to £5 million per annum.
182. An additional benefit accrues to individuals who are currently working in residential care and contribute their earnings towards their care. The cost to the local authorities estimated above would be the exact benefit to those currently working in residential care. Therefore, it is a transfer from local authorities to working residential care recipients.
183. Monetised costs and benefits per year are outlined below, based on upper estimates calculated and excluding the transfer between local authorities and DWP. Because we envisage individuals taking up employment as a result of the proposal, there will always be a positive net benefit. This net benefit comprises the earnings from work that would not be realised without the exemption of earnings from the means test for residential care. This is on the assumption that the additional work is a slight increase in productive output in the economy.

¹⁰⁶ PEA increased to £23.50 from April 2012. This Impact Assessment uses 2010/11 as the price base year.

Table 6: Monetised costs and benefits per year

	Current Earnings		New Earnings
	Loss to the local authority	Gain to the individual	Gain to the individual
Exempt all earnings	£2.67m	£2.67m	£2.67m

184. The assumptions underlying these costs are to illustrate the maximum loss and gain. Despite these assumptions, the resulting costs identify the small scale and distribution of impacts. For simplicity, we have used a central estimate of costs and benefits in summary analysis.

Non-monetised impacts

185. Individuals who are currently prevented from taking up employment will realise the non-monetary benefits of employment. These are currently realised by those who currently choose to take up employment, but do not see any cash benefit. These are varied, including social interaction, purpose and mental agility. They can be summarised through measuring social wellbeing, which finds that employed individuals have on average higher social wellbeing than the unemployed.^{107 108}

186. Costs over ten years use the same assumptions and are presented below in table 7, which shows the effect of demographics, reflecting that we expect there to be more individuals in residential care in the future who could work or will be working.

Table 7: Costs and benefits of Proposal H, with net impacts for exempting earned income

	2013/ 14	2014/ 15	2015/ 16	2016/ 17	2017/ 18	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/ 23
Cost to local authorities	-£2.7m	-£2.7m	-£2.7m	-£2.8m	-£2.8m	-£2.8m	-£2.9m	-£2.9m	-£2.9m	-£2.9m
Benefit to individuals currently working in residential care	£2.7m	£2.7m	£2.7m	£2.8m	£2.8m	£2.8m	£2.9m	£2.9m	£2.9m	£2.9m
Benefit to individuals who choose to take up employment	£2.7m	£2.7m	£2.7m	£2.8m	£2.8m	£2.8m	£2.9m	£2.9m	£2.9m	£2.9m

¹⁰⁷ Dolan, P. et al, “Do we really know what makes us happy? A review of the economic literature on the factors associated with subjective well-being”, Journal of Economic Psychology, 2008.

¹⁰⁸ Office for National Statistics, *Measuring Subjective Wellbeing in the UK, Analysis of experimental subjective well-being data from the Annual Population Survey, April - September 2011*.

Summary of costs and benefits of Proposals F, G and H

Table 8

Proposal	Agent	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total	Average annual
F. Legislation to entitlement to a personal budget													
Transition Cost	LA	2.75	0	0	0	0	0	0	0	0	0	2.75	
G. Develop and test direct payments in residential care													
Transition Cost	DH	0.23	0.9	0.9	0.68	0	0	0	0	0	0	2.7	
H. Exempt earned income from residential care financial assessment													
Recurrent Costs	LA		2.7	2.7	2.7	2.8	2.8	2.8	2.9	2.9	2.9	25.3	2.53
Recurrent Savings	User		5.3	5.4	5.4	5.5	5.6	5.7	5.7	5.8	5.8	50.2	5.02
Total													
Transition Cost	DH	0.23	0.9	0.9	0.68	0	0	0	0	0	0	2.7	
Transition Cost	LA	2.75	0	0	0	0	0	0	0	0	0	2.75	
Recurrent Costs	LA	0.0	2.7	2.7	2.7	2.8	2.8	2.8	2.9	2.9	2.9	25.3	2.53
Costs Grand Total		2.98	3.57	3.60	3.41	2.77	2.81	2.84	2.88	2.91	2.94	30.7	
Recurrent Savings	User		5.3	5.4	5.4	5.5	5.6	5.7	5.7	5.8	5.8	50.2	5.02
Savings Grand Total		0.0	5.3	5.4	5.4	5.5	5.6	5.7	5.7	5.8	5.8	50.2	
Net Savings (NPV)												18.9	

Integration proposals

Objective:

Ensure that health, care and other public services work together to improve outcomes and experience, reflecting the needs and preferences of individuals.

187. The Government believes that it is up to local areas to identify the best way of integrating services rather than prescribing a specific model of integration. Government's role is therefore to ensure that the barriers to integration are removed to facilitate this coordination at local level.

188. We analyse the impacts of our options on two levels. First, we analyse the change in incentives towards integration of health and care. Second, where proposals incentivise integration, we discuss the likely impact of more integrated models on health outcomes and cost-effectiveness of health and care (Annex B). It should be emphasised that we are not proposing to mandate any of the interventions in Annex B, they are included only as illustrative demonstrations of impact.

Option 1: Do nothing

189. Demographic pressures will exacerbate the current problems created by silo working. Without a more coordinated and coherent framework for integration, current shortcomings will be magnified as more people come into contact with a wide range of health and care services. This implies that without change, more care users will experience problems navigating a complex system, more people will have unnecessarily poor health and social care outcomes, and the wider population will suffer from inefficiency in the use of public funds.

Option 2: Implement Proposal 1 to build on the provisions of the Health and Social Care Act to set out further actions to support integrated care

190. We expect a number of existing initiatives, as well as the provisions set out in the recent Health and Social Care Act 2012 to help erode organisational, cultural and financial barriers to integrated care. These are set out in more detail in the White Paper.

191. The draft Care and Support Bill will also set out a duty on the local authority to promote integration of services, along similar lines to the duty on the local NHS already enacted by the 2012 Act. In addition, the draft Bill will provide for further duties of cooperation which encourage local partners to work together to improve the wellbeing of local people.
192. As a next step, the Government will publish later this year a framework to support improvements in integrated care and remove barriers that prevent integrated approaches becoming the norm. This will be co-produced with partners including the NHS Commissioning Board, Monitor, local government, people who use health and care services and carers. Some of the areas the work will consider are:
- a. Measuring people's experience of integrated care
 - b. Sharing the tools and innovations that promote integrated care
 - c. Aligning incentives
 - d. Developing models of co-ordinated care for older people
- a. Measuring people's experience of integrated care**
193. Differences between performance indicators have been identified as a key barrier to integration of health and social care services.¹⁰⁹ Wistow argues that "an appropriate mix of accountabilities...is critical to improve care outcomes and to the design of a framework for the effective governance of integration".¹¹⁰
194. As set out by the NHS Future Forum, "You can only improve what you measure". The Department proposes to pursue the Future Forum's recommendation to develop '*a new generation of patient reported experience measures that evaluate patients' experiences across whole journeys of care, and within and between services*'. The Forum also recommended that "*The Department of Health should seek to achieve greater alignment and coherence between the national outcomes frameworks for the NHS, public health and adult social care.*'
195. We will explore better ways to measure and understand people's experience and views of integrated care so that this information can be used to drive further improvements. The Department is investigating the best way to use the information collected across the health and care outcome frameworks to support integration. For example, the current patient experience indicators within Domain 4 of the NHS outcomes framework – '*Ensuring that people have a positive experience of care*' – only focus on experience within services rather than across whole care journeys.
- b. Sharing the tools and innovations that promote integrated care**
196. There are a number of existing models of integrated care that can serve as exemplars to others. We will work with national partners to share best practice in a simple and accessible way, including practical tools that can be tailored for local use, such as model contracts and support for leadership development.
- c. Aligning incentives**
197. The NHS Future Forum advised that '*Much of the difficulty in re - structuring models of care for patients is that the funding mechanisms currently disincentivise integration. We heard that it is particularly important that there are payment mechanisms that support new integrated pathways, so that the money can follow the patient to the best type and setting of care.*'
198. We will explore how new payment systems can be further developed to support integrated care. For example, as highlighted by the Future Forum, 'Year of Care' tariffs give patients and people who use services greater flexibility about how they manage long-term conditions, such as cystic fibrosis, a mental health condition or complex, multiple conditions.

¹⁰⁹ See for example, Ham, C., Smith, J., *Removing the policy barriers to integrated care in England*, The Nuffield Trust, 2010.

¹¹⁰ Wistow G., *Integration this time? Liberating the NHS and the role of the local government*, Local Government Association, 2011.

d. Developing models of co-ordinated care for older people

199. The NHS Future Forum identified particular groups who would particularly benefit from integrated approaches to commissioning and delivering services. We will pursue the development and piloting of contracts covering all health and social care needs for older people, including preventative services to identify and manage the needs of those living with ill health and at high risk of hospital admission.

Costs

200. At this stage, it is not possible to estimate the costs of the actions associated with improving integrated care, as we will need more details of what these actions entail. We will further assess the impact of these actions when we publish the integration framework later this year.

Benefits

201. We expect that a coherent narrative for integration will signal to providers, commissioners and the public that integration will be fundamental to the future of care. Moreover, we expect that taking action in the above-mentioned areas will encourage integration at a number of levels. First, it will encourage commissioners to source models of care that take their patients through a seamless journey. In turn, this will encourage health and care providers to cooperate across traditional organisational boundaries to offer integrated products. Finally, the integrated experience indicator will encourage patients to reflect on their care journey as a whole, rather than the health and care journeys separately, and so hold commissioners to account for the entirety of their care journey.

202. The Department of Health is not mandating a particular model of integration, so benefits are not easy to estimate at individual level. Annex B contains illustrative impacts of two models of integrated care to give an indication of the likely impacts on individuals.

203. Evidence from the Integrated Care Pilots (ICPs) evaluation report found no overall significant changes in the costs of secondary care utilisation. However, for case management sites, there was a net reduction in combined inpatient and outpatient costs (reduced costs for elective admissions and outpatient attendance exceeding increased costs for emergency admissions). The evidence from ICPs shows that integrated care can lead to improved quality of life if well led, well managed and tailored to local circumstances and patient needs.¹¹¹

204. However, improvements are not likely to be evident in the short-term. Evidence from the ICPs supports conclusions made by Ovretveit that savings are not likely in the short-term and certainly not inevitable.¹¹² However, case management approaches used in the pilots could lead to an overall reduction in secondary care costs. The ICPs findings also support the findings of Powell Davies and colleagues, in that the most likely improvements following integrated care activities are in healthcare processes.¹¹³ Improvements are less likely to be apparent in patient experience or in reduced costs. Annex B contains illustrative impacts of two models of integrated care to give an indication of the likely impacts on individuals.

Costs and benefits at care user level

205. It is not possible to identify the specific impact of these proposals on integration, as the proposed account will set the details of action. Moreover, the Government is clear that integration is not an end in itself and for this reason is not mandating any particular model.

¹¹¹ Department of Health, *National evaluation of the DH integrated care pilots*, 2012.

¹¹² Ovretveit, J., *Does clinical coordination improve quality and save money?*, Health Foundation, 2011.

¹¹³ Powell Davies, G., Harris, M., Perkins, D., Roland, M., Williams, A., Larsen, K., et al. *Coordination of care within primary health care and with other sectors: a systematic review*, Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine, 2006.

206. However, the provisions of the Health and Social Care Act 2012 and the proposals set out in the White Paper aim to reduce the costs associated with implementing models of integrated care, and to make commissioners and local organisations aware of the benefits of these models. Therefore, we reasonably assume that these proposals will lead to closer working between services (although we are not able to say how close or in what form).

207. As health and care services work closer together, we believe that there will be higher take-up of integrated cost-effective services (again, we are not able to estimate what this take up will be). In Annex B, we use case study analysis and a review of the relevant literature to estimate the impacts of a number of models of micro-level integration. We also aggregate impacts to the national level for *illustrative purposes only*. We note that different localities will be working from different baselines and so impacts may be very different to the cases studied.

Summary

208. We believe that existing initiatives and measures set out in the Health and Social Care Act 2012 will go some way to eroding the barriers to integration outlined in the literature. Our aim is for action in the above-mentioned areas to lead to more use of integrated services. In turn, this could improve health outcomes, the quality of care and cost-effectiveness for care users and the wider population.

Information, advice and support proposals

Objectives:

- Enable people to understand what is available and to make informed choices supported by a comprehensive framework for information and advice connecting between national and local level;
- Enable care users and carers to find their way more easily through the care and support system and related public services and in so doing assume greater control over their lives;
- Increase transparency of information regarding the quality of care and support to enable people to make informed choices and deliver greater incentives to drive up quality of care.

Option 1: Do nothing

209. There may be small incremental changes in the provision of information, advice and support in the absence of any further intervention. However substantially there would be no change in the experience of people trying to access information, advice and support services and any improvement would be variable across the country. Where this has a detrimental impact on personalisation and the quality of life and outcomes for users (including self-funders) and their carers, this would also remain unchanged.

Option 2: Implement the following policy proposals:

Information, advice and navigation

- J. A new national care and support information portal including a directory of services;
- K. Statutory duty on local authorities to provide information and advice;
- L. Improve local authorities' web-based information and advice services;
- M. Additional provision of advice and support to help people arrange care and support.

Support and representation (advocacy)

- N. Make clearer the duty for local authorities to share information with individuals, carers and families;
- O. Develop and disseminate best practice models for support and representation services.

Information, advice and navigation

Proposal J: A new national care and support information portal including a directory of services

210. There is still little public understanding of what care and support means, its interconnection with health and other services (such as housing), how to make appropriate choices and what services are

available. There is currently no national explanation provided apart from for carers (Carers Direct), which will shortly be mainstreamed within wider Department of Health structures.

211. The Department is therefore proposing to fill this gap through the wider approach set out in its Information Strategy.¹¹⁴ From April 2013, the Government will provide a clear, universal and authoritative source of national information about the health, care and support system. There will be a new single portal for health and care which will consolidate the best of existing national online services such as NHS Choices - including Carers Direct - and NHS Direct. As part of this national information offer, the NHS 111 telephone service will help signpost callers that may also have social care needs to local social services and we will explore with current 111 providers future developments that support further integration as NHS 111 is fully rolled-out across England in 2013.
212. We propose that the portal would provide a national information and signposting service from which a person could navigate to the information, advice and support they might individually need at key points in their lives. A key aspect of this would be an explanation of care and support and its fit with public services.
213. This could include straightforward advice on:
- what an individual, family or carer should consider when purchasing and organising their own care arrangements;
 - what help and support is available including signposting to each local authority;
 - financial advice, housing and enhanced information on care providers.¹¹⁵
214. The text and content in this site could be shared (syndicated) with local authorities, voluntary sector and provider organisations, as could their own content with the national portal. Information could be updated automatically – increasing consistency and reducing the overall burden of maintaining content (prepare it once, then use it many times).
215. There remain a number of options for how such a national approach could connect to useful information on care providers – traditionally given through online service directories. Experience with Carers Direct is that national service directories can be costly and onerous to keep up-to-date, and they often lack detail at local level. We would therefore look for external providers to undertake this work with the potential for it to be delivered through a self-supporting model, perhaps with nominal charges to local authorities and providers.
216. A number of voluntary and not-for-profit organisations are looking to develop comprehensive service directories using self-financing models that all include user feedback on providers. Further work will be needed to explore the robustness of self-financing delivery models with stakeholders and the current private and independent sector organisations currently working in this field.

Costs

217. There will be a cost to Department of Health central programmes for the national information portal as part of the recently published Information Strategy.
218. The estimated costs of developing a service directory range from nil to £500,000 for developmental support. The scale of costs is based on informal discussions with potential providers.

Proposal K: Statutory duty on local authorities to provide information and advice

219. The Law Commission, supported by the Commission on Funding of Care and Support, recommended that legislation should include a duty on local authorities to provide information and advice services within their area to replace that contained in the Chronically Sick and Disabled Person Act 1970.

¹¹⁴ Department of Health, *The power of information: putting all of us in control of the health and care information we need*, May 2012.

¹¹⁵ Information on care providers will be available through the proposal for a Provider Quality Profile discussed in the corresponding Impact Assessment “Quality, care providers and the workforce”.

220. The Government therefore proposes to introduce a modernised duty on local authorities to provide information and advice services within their area so that people can get information on how the care and support system works locally and how they can access care and support, regardless of who pays for their care.
221. The duty would cover information on:
- the care and support system, including relevant individual rights and entitlements;
 - care and support available in the local area to meet different care needs;
 - how to access care and support, including assistance available to help individuals plan their care, and their rights to an assessment by the local authority.
222. This would allow local authorities freedom to make their own arrangements to ensure that they were meeting this duty, and provides the potential for guidance on best practice to be developed with the care and support sector. For example, it might be expected to cover web-based information (with links to a national information portal) and advice, as well as individual access to proportionate, one-to-one care navigation through independent 'brokerage' and 'advocacy'.

Costs

223. We do not expect the modernising of the terminology of the current duty in itself to give rise to any significant costs. We do know that information and advice currently provided is of variable quality and inconsistent across local authorities. Proposals L and M look to provide the base for increased quality and consistency above current provision.

Proposal L: Improve local authorities' web-based information and advice services

224. The sharing (syndication) of general content between any national information service and local authorities would support improved signposting and the consistency of information. However, local authorities have a greater need to use their IT systems to support personalisation and choice and the needs of self-funders. The Department of Health will therefore work with the sector to encourage these approaches to be adopted across England.
225. New and developing IT software is becoming available through a range of suppliers that provide an improved and connected approach to information to support personalisation. These facilitate and draw together information around prevention, re-ablement, care needs, and local provider information. They provide a wider coverage that enables online self-assessment and navigation to prevention as well as to relevant care options. They also have a focus on earlier intervention to support self-funders. Amongst other benefits, they look to provide better customer experience, reduce the call on more expensive phone and face-to-face advice and can provide volume data reports (not personal information) for planning and market analysis. Their development would be significantly enhanced by links to a comprehensive national service directory.
226. Working with demonstrator sites in the Common Assessment Framework (CAF) for Adults, most social care suppliers are developing 'citizen portals' that provide a person with access to their care records and will also enable a variety of interactions, such as self-assessment questionnaires, making an enquiry, obtaining information and advice and locating local services. These will become more widely available over the next year or two for local authorities to procure as part of their social care IT contracting. In the medium to longer-term, this will support an individual's access to their own health and care records, the facility for them to share this access with carers and family and greater operational integration of health and care.
227. Encouraging these approaches would allow for a more consistent approach to information and would significantly help people to obtain the advice they need to make appropriate, cost-effective decisions on their care. To reduce the burden of preparing content, authorities would be able to take content directly from the national site and have it updated automatically.

Costs

228. Costs given are for additional costs, over and above what authorities may spend currently on their website and are based on the current costs of an authority purchasing a new approach. Information and discussion with one local authority currently putting a web-based system in place suggests that the cost of purchasing the appropriate software and hardware is around £75,000 to £120,000 per authority. In addition to this, there will be costs of developing and improving the local content for the web-based system. Based on discussions with a couple of councils currently procuring systems on what this would entail, we have estimated this to be one FTE in total, costing around £50,000. We know that a few councils already have these systems in place - we have estimated this to be around 10%, based on our discussions with councils and knowledge of the sector. Therefore, in total we assume the transition costs of this proposal to be between £17 million and £23 million.
229. While all local authorities currently provide some website information services, very few have web-based systems of the sort being proposed – including space for care user ‘transactions’. We have therefore assumed that all local authorities would require funds to implement this development. In addition, there will be ongoing costs for the development of content for the system and response to issues raised. As referenced earlier, based on discussions with a couple of councils, if we assume 1.5 to 2.0 FTEs are required per year per authority (around £75,000 per authority), we estimate the total national cost per year to be between £10 million and £15 million. In the second year, costs of continued development will fall as capital.

Costs of increased demand effects of Proposals I, J and K

230. There is evidence to suggest that improved information can result in increased demand for care services. However, we do not have any evidence to suggest the scale of this increased demand. We have assumed that the reduction in unmet need is likely to be modest, especially for those who are eligible for local authority funded care. This is because the reason why most of these people are not accessing care is due to their lack of willingness to pay user charges. The improved information would need to result in individuals changing their minds on their willingness to pay these charges. This is different to increasing demand by just making people aware of the benefits of a service.
231. Therefore, if for example improved information resulted in a 5% reduction in unmet need, we estimate that this would result in increased spend of around £65 million of which not more than £10 million would be met by local authorities, with the rest met by individuals. These costs rise to £300 million in total of which not more than £65 million would be to local authorities, if we assume unmet need is reduced by 25% (see paragraph 233 below for details).
232. If there is increased demand on local authorities, spending will need to be reprioritised to meet this demand. There will be opportunity costs of the resulting foregone services. These have not been quantified. There is also the possibility that improved information could increase awareness of and have a consequential effect on the number of people applying for disability benefits. However, since far fewer people receive state-funded care and support than receive disability benefits, we therefore assume that proposals to improve information and advice are unlikely to result in a significant increase. These proposals, alongside proposals relating to assessment and support for carers, could also have an effect on demand for Carer’s Allowance and any passported benefits. The size of this impact will depend upon the characteristics of the people who claim – for example, an individual’s age, whether they are in paid employment and the extent of their caring role, will all affect whether they are eligible to receive Carer’s Allowance.
233. Further details and evidence to support this is set out below:
- **The availability of information affects the demand for services;** Protiere et al’s study, based on a French sample, found that willingness to pay for three health treatments increased significantly when participants were provided with more positive information about one of the treatments.¹¹⁶ This implies that improved information can increase demand for services.

¹¹⁶ Protiere, C., Donaldson, C., Luchini, S., Moatti, J. P. and Shackley, P., ‘The impact of information on non-health attributes on willingness to pay for multiple health care programmes’, *Social Science and Medicine*, 58, 2004.

- **Lack of information is often cited as a barrier to accessing care for different groups;** for example, Banks et al find that a lack of information is one of the major barriers to accessing services for older people.¹¹⁷ The same holds for younger people; Sloper et al show that information “is a crucial part of an effective transition service”, and that information provision is an area in need of further development.¹¹⁸
- **If improved information reduces barriers to service provision, it can reduce unmet need;** We do not have good information on the level of unmet need. However using survey data and modelling, Forder estimates that 300,000 older people with low intensity care needs do not receive formal or informal services. This equates to 1.2 million hours of unmet care need each year. Forder also estimates that 50,000 of those people with high intensity need forego 200,000 hours of care per week.¹¹⁹ PSSRU estimate that one hour of home care costs £18 to provide (including on-costs).¹²⁰

234. We do not have any evidence on the potential or likely scale of increased demand so we have modelled two scenarios, one that assumes unmet need is reduced by 5% and the other that it is reduced by 25%. We have assumed that the reduction in unmet need is likely to be modest because increased demand for local authority services would be as a result of individuals who had chosen not to take up the offer of services, primarily due to having to meet user charges, changing their minds.

- Using the estimates above, if improved information reduced unmet need by 5% for example, one could expect an increased spend on care of around £65 million per year (£55 million per year for low intensity and around £10 million for high intensity care). The research also suggests that about 20% of this unmet need is for people who are eligible for council support but face some user charges. This implies that of the increased spend, local authorities would meet approximately £10 million with the rest met by individuals. This assumes that those that would have to pay for or contribute to the costs of their own care would be willing to do so. If improved information reduced unmet need by 25% the increased costs in total would be around £300 million and those to local authorities would not be more than approximately £65 million.
- **There is some limited evidence that more information can change the composition of demand from care, towards more preventative services.** Research commissioned by Age Concern - “Bridging the Gaps”- investigated the outcomes of the Age Concern information and advice services. This identified that older people can gain financially through new and backdated benefit claims (a total of £7.29 million in new benefits and grants). Information can also lead to improved housing, access to transport and care and support. The consequential gains for individuals included: improved physical and mental health, greater confidence and increased social contact and involvement in the community. Finally, the research suggested that by facilitating access to mobility and safety equipment and adaptations¹²¹ and helping people navigate through the system, information services had a preventative effect by reducing demand on services, particularly health and care.¹²²

Benefits of Proposals J, K and L

235. It has not been possible to quantify all of the marginal benefits of improved information, as most are intangible. We have estimated the timesavings associated with simpler access to information. A discussion of the benefits associated with improved information can also be found in the Impact Assessment accompanying the Department of Health’s recently published Information Strategy.¹²³

¹¹⁷ Banks, J. et al, *Retirement, health and relationships of the older population in England*, Institute for Fiscal Studies, 2006.

¹¹⁸ Sloper, P., Beecham, J., Clarke, S., Franklin, A., Moran, N. and Cusworth, L., *Models of Multi-agency services for transition to adult services for disabled young people and those with complex health needs: impacts and cost*, 2010.

¹¹⁹ Forder, J., *Self-funded social care for older people: an analysis of eligibility, variations and future projections*, 2007.

¹²⁰ PSSRU, *Unit Costs of Health and Social Care*, 2011.

¹²¹ Citizens Advice, *Serious benefits, the success of CAB benefit take-up campaigns*, 2003.

¹²² It is important to note that the research used a combination of survey and case study methods and there was no control group.

¹²³ Department of Health, Impact Assessment of “The power of information: Putting all of us in control of the health and care information we need”, 2012.

236. A review of the literature suggests the following intangible benefits:
- Improving access to information can reduce anxiety.¹²⁴
 - Information is a precondition for choice.¹²⁵ Windle et al find that only 10% of respondents wanted someone to make decisions for them, whilst more than 50% wanted information and advice. This is particularly important for those that do not interact with their local authority, and may forego care altogether.
 - The *Caring for our future* engagement found that providing information would empower care users and carers as consumers. Facilitating choice also allows people to hold providers to account. Informed consumers have the potential to stimulate innovation, drive up quality and force down prices to competitive levels. Propper et al suggest that poor information limited the effectiveness of competition in healthcare markets in the UK.¹²⁶ Gaynor et al agree that improving information should increase the elasticity of demand for healthcare; that is, it should mean that providers have less price-setting power.¹²⁷
 - Improving information in a way that is accessible for all has the potential to reduce health inequalities. Dixon and Le Grand find that those from higher socio-economic groups are more likely to be able to access health-related information when required, and to understand this information. In turn, this implies they are better equipped to make health-related choices¹²⁸. Baxter et al suggest that
 - Providing information that is accessible to all can disproportionately improve choice for those in lower socio-economic groups.¹²⁹
237. Improving accessibility to information in a targeted manner should reduce the amount of time that care users and carers spend on decision-making. The value of an individual's time is difficult to quantify. Time saved is likely to be during a stressful period, in which each hour may be valued more highly than usual.
238. As an illustrative example, for carers we can assume that any time saved is invested in the person that they care for. Van Den Berg and Ferrer-i-Carbonell's analysis found that an hour of informal care is worth between £4.30 and £6.50 to the carer.^{130 131} We assume that the number of carers moves in line with the number of care users. Therefore, we assume that of the 5 million adult carers in England, approximately 50% come into contact with the system for the first time each year. Finally, we assume that 50% of the carers that have come into contact for the first time in a given year save 2 hours in searching for information as a direct result of our proposals. This implies an illustrative annual benefit of between £11 million and £16 million.

Proposal M: Additional provision of advice and support to help people arrange care and support

239. During the *Caring for our future* engagement, advice and support was also raised as an important issue in relation to personalisation. This view is supported by a base of research evidence and practice in personal budgets, which indicates that support, and advice is an essential component in enabling individuals to make choices about their care and improve outcomes.¹³²

¹²⁴ Windle, K., Netten, A., Caiels, J., Masrani, R., Welch, E. and Forder, J., *Measuring the outcomes of information and advice services: Final report*, 2010.

¹²⁵ OFT, *Choice and Competition in Public Services: A guide for policy makers*, 2010.

¹²⁶ Propper, C., Wilson, D. and Burgess, S., *Extending choice in English health care: The implications of the economic evidence*, 2006.

¹²⁷ Gaynor, M., Moreno-Serra, R. and Propper, C., *Death by market power: Reform, competition and patient outcomes in the National Health Service*, 2010.

¹²⁸ Dixon A. & Le Grand J., "Is greater patient choice consistent with equity? The case of the English NHS", *Journal of Health Services Research and Policy* 11, 2006.

¹²⁹ Baxter, K., Glendinning, C. and Clarke, S., "Making informed choices in social care: the importance of accessible information", *Health and Social Care in the Community*, 16 (2), 2008.

¹³⁰ The study was based on a Dutch sample, and reported a valuation of €10 per hour of care. We convert this into GBP at the January 2002 exchange rate of 0.617 (the sample for the study was 2001-2002).

¹³¹ Van den berg, B. and Ferrer-i-Carbonell, A., *Monetary valuation of informal care: the well-being valuation method*, 2007.

¹³² Both the Personal Outcomes Evaluation Tool (POET) survey results and the ODI Report on Support, Advocacy and Brokerage indicate that people are more likely to opt for direct payments "and stick with them" if they have had received brokerage or peer support external from the council. Evidence from the POET survey and NAO interviews with personal

240. For people receiving local authority funded packages of care, particularly personal budgets, this function is part of the care planning process. Some advice is generally provided to people whose needs are not eligible under the FACS framework or who fund their own care, but access varies across the country. There is also a potential opportunity for people to be provided with information and advice about what steps they can take to prevent or plan for future care and support needs – either financially or through considering what would suit them best at a future point of need.
241. As part of the local authority's offer to everyone in its area with care and support needs, the draft Care and Support Bill will enable people to request the assistance of their local authority in the arrangements for meeting their eligible needs for care and support, regardless of their finances. This would be subject to a reasonable charge for those who can afford it, to ensure that the local authority can meet its own costs. We propose to work with local authorities and the independent sector to consider further how self-financing services could develop alongside local authority commissioned services and current (free) services provided by many voluntary organisations and charities.
242. The voluntary sector often plays an important role if contacted by an individual. Voluntary organisations are sometimes commissioned by the local authority to provide a level of service, but anecdotally they are reported to be under significant pressure. There are few self-financing models for advice and services. Those that we are aware of tend to provide peer support and make a charge on the local authority and on the individual's personal budget (around 2%). These self-financing models are in early development and their long-term sustainability is questionable given that they are dependent on gaining some funding from local authorities.
243. The focus of this proposal is therefore to enhance personalisation and improve outcomes for those who need increased levels of support and advice in the use of their personal budget or direct payment. In particular:
- Users receiving personal budgets should have a choice of who provides the advice and support services they need;
 - To achieve this, local authorities should develop local capacity to purchase these advice and support services from external organisations;
 - Local authorities should aim to improve the advice and support services provided to users who receive support from them directly.
244. To take forward the implementation of these proposals, the Department of Health will make additional funding available to local authorities and work with ADASS and other stakeholders. This would build on the modernised duty within the draft Care and Support Bill (Proposal K). To promote the adoption of improved advice and support services following assessment, but to allow for decisions to be made at local level, we expect that, following legislation, any statutory guidance would set out what good information services should cover and look like. This would provide a mechanism by which we could guide funding towards raising the quality of information services. While we believe it to be appropriate for local authorities to retain local flexibility over funding arrangements, there is consequentially some risk that the rate of improvement may vary according to local prioritisation. Current models providing choice to users over the provision of advice and support include local authorities commissioning these services from the voluntary sector and other independent organisations.

Costs

245. Personal budgets are not appropriate for all new care users, for example, they are not appropriate for those receiving re-ablement services or emergency care services. In order to estimate the proportion of care users for whom personal budgets are appropriate, DH undertook a piece of analysis. This started by taking the total number of people using a service¹³³ by the types of services used. There were discussions with experts and three councils to establish the groups of care users for whom personal budgets would not be appropriate. Using data published by the Information Centre or estimates provided by the three councils involved in the work, the following

budget holders is that switching between services even with a direct payment, is not easy, and people need to advice to make the best use of the flexibility that goes with a personal budget; brokerage would help this.

¹³³ Information Centre: Adult Social Care Activity Data.

groups were excluded from the total number of people using services: those using re-ablement; emergency crisis services; professional support only; and equipment only.

246. The DH analysis suggests that personal budgets are appropriate for between 60% and 90% of new care users. This group would therefore benefit from this additional advice and support. In addition, existing care users may have a change of circumstance that means their care package is substantially changed – this group of people may also need advice and support services. Based on our knowledge of the social care system and a discussion with a couple of councils, we have assumed that this may be the case for 10% to 20% of existing care users. Taking these factors into account we estimate that anywhere between 350,000 and 600,000 individuals may access a new personal budget each year.
247. The evidence on the costs of advice and support services provided by external organisations following assessment is patchy. Discussions with a few local authorities who have developed or are developing these services confirm that costs do vary across authorities, both in terms of the anticipated hours of support needed and the hourly rate charged. Based on this limited evidence, we have assumed that the average cost per person is around £210 per person for about 12 hours of support. There are estimates for the costs of advice and support from other sources, which range from £100¹³⁴ to £292¹³⁵ to £410¹³⁶, but the quality of these estimates varies. We do not know exactly how many people would choose to take up the offer of advice and support – using evidence from current experience we have assumed that, over the medium term, up to 40% of care users would choose to do so.¹³⁷
248. On this basis, and building in some sensitivity analysis, the cost of providing 40% of personal budget holders with advice and support from the independent sector is estimated to be around £40 million to £60 million per year nationally. These figures include an allowance for administration costs but not training. We would expect uptake of these services, and therefore costs, to start at a low level and to increase over time. Therefore, costs would be phased over a number of years.
249. In addition, there will be set-up costs of between £5 million and £10 million for additional recruitment and training. This assumes that, in order to deliver these services, an additional 1,300 to 2,300 staff will be required (this assumes staff contact time with care users is 30 hours a week for 45 weeks a year and on average individuals require 12 hours of advice and support) with training costs of £1,000¹³⁸ per person and recruitment costs of £4,700¹³⁹ per person.
250. We are not able to make a detailed assessment of the costs for advice and support for self-funders at this stage as further development work is needed, although it is envisaged that costs will be met by individuals. However, there will be costs to DH associated with the development work identified. At this stage, for illustration, we have estimated these to be of the order of £200,000. This cost estimate comprises staff resources to take forward the work (one FTE post over the course of the project would be £70,000) and resources to work with stakeholders and costs for dissemination (a DH estimate of £130,000 to gather evidence from and run stakeholder events and to disseminate findings through various means).

Benefits

251. Evidence suggests that those who receive advice and support services as a result of these proposals will accrue benefits. There is substantial evidence to suggest for some people, information

¹³⁴ ADASS Personal Budget Survey, March 2011.

¹³⁵ Glendinning, C. et al, *Evaluation of the Individual Budgets Pilot programme*, IBSSEN, York, 2008.

¹³⁶ Office for Disability Issues, *Richmond case study: Support Planning and Brokerage Demonstrator Project*, 2011.

¹³⁷ Early experience from where users were given a choice of taking up a personal budget suggest that younger people (those aged 18-64) are more likely to do so although some older people will too. Therefore we have assumed that the proportion taking up advice and support from an independent advisor will match the proportion of users who are aged 18-64 i.e. 40% (based on data published by the Information Centre on users receiving services).

¹³⁸ This assumes each person receives around 5-10 days training at a cost of £100 to £150 per day based on advertised training costs – see <http://www.northamptonshire.gov.uk/en/councilservices/business/training/tc/Pages/CostsofTrainingCourses.aspx> and <http://www.actionforadvocacy.org.uk/articleServlet?action=display&article=1924&articletype=38> and discussions with a few councils.

¹³⁹ CIPD, Annual Survey Report 2007 – figures updated to 2010-11 prices.

must be complemented with advice and support services, such as brokerage.^{140 141 142} This is particularly true for people with care needs, who may lack capacity to access, process and act on an often complex and expansive range of information.

252. Hatton and Waters' survey finds that brokerage was the most positively commented on process associated with personal budgets. The survey also found that those who received advice and support from someone independent of the council or NHS reported better outcomes.¹⁴³ This finding is supported by findings from the case studies in the Office for Disability Issues (ODI) support planning and brokerage demonstrator project.¹⁴⁴
253. A review of evidence by the Social Care Institute for Excellence (SCIE)¹⁴⁵ noted that brokerage and support is needed but the support infrastructure is not yet sufficiently well developed in the UK. Emerging evidence indicates that support is more successful when it is independent of the service system. Support brokers should provide a task-focused service and be trained and regulated. A further evaluation of support planning and brokerage found that such services are associated with a higher proportion of care users taking up direct payments, better awareness of personal budgets and improved choice.¹⁴⁶ Glendinning et al found that individual budget holders reported greater satisfaction with the services they use because the personalised approach allowed them to select solutions that fitted their care needs and preferences.¹⁴⁷
254. In summary, complementary inputs, such as brokerage support, are important facilitators of the information proposals.¹⁴⁸ These benefits will depend on the efficacy of the models developed.
255. The benefits of the development work on advice and support for self-funders is to identify whether and what sustainable models can be developed to provide this service.

Support and representation (advocacy)

Proposal N: Make clearer the duty for local authorities to share information with individuals, carers and families

256. Feedback from the *Caring for our future* engagement suggested that the participation of family and carers is hampered by them not having access to up-to-date information such as care plans for those that they are caring for. To address this we could make clearer and potentially extend in legislation the local authority duty to share information with care users, carers and family. The proposed new duties to consult with the individual during an assessment, and to provide care and support plans, could be augmented to include explicit requirements to consult or share information with carers and families (subject to the consent of the individual and with some necessary safeguards in place). This could be largely facilitated through the improvements proposed to local authority web-based information (Proposal L) and development of the ability to provide online access to assessment and care plan information to the care user, and with their consent, to their carer and/or family.

¹⁴⁰ Scourfield, P., (2010), "Going for brokerage: a task of 'independent support' or social work?", *British Journal of Social Work*, 40(3), April 2010.

¹⁴¹ Baxter, K., Glendinning, C. and Clarke, S., "Making informed choices in social care: the importance of accessible information", *Health and Social Care in the Community*, 16 (2), 2008.

¹⁴² ADASS, LGA, IDeA, *Transforming adult social care: access to information, advice and advocacy*, 2010.

¹⁴³ Hatton, C. and Waters, J., *The National Personal Budget Survey*, Lancaster University and In Control, Lancaster, 2011.

¹⁴⁴ Office for Disability Issues, *Final report from the support planning and brokerage demonstration project*, May 2011.

¹⁴⁵ SCIE, *The implementation of individual budget schemes in adult social care*, 2009.

¹⁴⁶ Campbell, N., Cockerell, R., Porter, S., Strong, S., Ward, L. and Williams, V., *Independent Living Strategy, Support Planning and Brokerage*, Office for Disability Issues, 2011.

¹⁴⁷ Glendinning, C. et al, *Evaluation of the Individual Budgets Pilot programme*, IBSEN, York, 2008.

¹⁴⁸ Scourfield, P., 'Going for Brokerage: A Task of 'Independent Support' or Social Work?', *British Journal of Social Work*, 40, 2010.

Costs

257. This duty reinforces good practice, which is applied in some areas but not all – we do not know how widespread these practices are. If this best practice is applied in all cases, there may be an initial low cost for local authorities, users and their families in engaging with and understanding the process of assessment. However, in the long run, there may also be reduced costs as a result of users and their families being better informed and better supported to get the right care and support at the right time. We cannot be certain about the level of these costs but, for illustrative purposes, the initial costs to councils are likely to be no more than £3 million to £6 million. We cannot be certain what the additional costs per assessment of this approach would be and to how many people this would apply. However, we have assumed for illustrative purposes that in order to fulfil this duty, the existing costs of assessment are increased by 5% to 10% for about 20% of new care users who are assessed. We estimate that the current costs of assessment per person are around £450. This is a central estimate for the cost of an assessment, and is based on discussions with local authorities about the processes and time involved in carrying out different types of assessments. We estimate that about 700,000 new care users are assessed each year.¹⁴⁹

Proposal O: Develop and disseminate best practice models for support and representation services

258. Advocacy services have been in place for more than 30 years, often providing support for people who lack mental capacity, and who have no one to act on their behalf. These services will continue to play a vital role in supporting the most vulnerable people in society¹⁵⁰ and we need to ensure that these services fit with the new focus of information and advice services and re-examine and increase the evidence base around their benefits as well as how cost effective they can be. Therefore, we propose to commission a review of current evidence, to be used to facilitate discussion with stakeholders in the field.

259. We would work with the field to develop and disseminate best practice and potential business models that might draw on other funding mechanisms for voluntary sector and peer provision of advocacy. If, as a result of this work, it was agreed there was a need for more evidence, there would be additional costs for commissioning research and evaluation.

Costs

260. Costs would fall to DH and would be no more than £600,000 if we assume the cost of evidence gathering to be no more than £100,000 (based on advice from a DH expert) and that the resources required within DH and the sector do not exceed two full time equivalents for a year (£150,000). We cannot be sure what further work will be required beyond this first stage, but for illustrative purposes, we have estimated that other costs do not exceed £350,000. We cannot be clear at this stage exactly what will be required but these other costs may include a range of activities including gathering evidence, analysing options, evaluating different approaches and dissemination of findings.

261. Once these best practice models have been developed, there will be a cost to local authorities to implement them. We have not attempted to cost this here as it will be dependent on the types of models developed.

Benefits of Proposals N and O

262. Advocacy is generally considered useful and beneficial for care users and patients; but its value has been hard to quantify and its quality is seen as variable. As part of an evidence review and research commissioned by the ODI, improved choice and control was identified as a primary desired outcomes of independent advocacy.¹⁵¹ A range of generic outcomes and benefits which were identified in interviews with providers and users can be subsumed within this primary outcome. Some examples include greater participation in decision-making and improved social wellbeing and

¹⁴⁹ Information Centre, Adult Social Care Activity Return 2010-11.

¹⁵⁰ *Advocacy: Voice and the Protection from Crime and Abuse*. Voice Ability's memorandum to the Department of Health Review, following events at Winterbourne View Hospital, March 2012.

¹⁵¹ Davies, L., Townsley, R., Ward, L. and Marriott, A., *A framework for research on costs and benefits of independent advocacy*, Norah Fry Research Centre at University of Bristol, 2009.

psychological health. Other potential benefits included reductions in the number of people inappropriately placed in residential care with associated cost savings.

263. Making available evidence and tools to local authorities on good practice will enable them to take evidence-based decisions locally on whether and how to make improvements to their support and information services. It is possible that further research to evaluate different approaches and practices may be needed.

Summary of costs of Option 2 (Implement Proposals J – O)

Table 9:

Proposal	Agent	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total	Average annual
J. Directory of service providers													
Transition Cost	DH	0.25	0.25	0	0	0	0	0	0	0	0	0.5	
L. Improve councils' web-based information and advice													
Capital Transition Cost	DH	0	0	20	12.5	0	0	0	0	0	0	32.5	
Recurrent Costs	LA	0	0	0	0	12.5	12.5	12.5	12.5	12.5	12.5	75	7.5
M. Additional advice and support for users													
Transition Cost	DH	0	0.1	0.1	0	0	0	0	0	0	0	0.2	
Transition Cost	LA	0	2.5	2.5	2.5	0	0	0	0	0	0	7.5	
Recurrent Costs	LA	0	0	7.5	20	32.5	50	50	50	50	50	310	31
O. Work with sector on best practice advocacy and peer support													
Transition Cost	DH	0	0.35	0.25	0	0	0	0	0	0	0	0.6	
Total													
Capital Transition Cost	DH	0	0	20	12.5	0	0	0	0	0	0	32.5	
Transition Cost Total	LA	0	2.5	2.5	2.5	0	0	0	0	0	0	7.5	
Transition Cost Total	DH	0.25	0.7	0.35	0	0	0	0	0	0	0	1.3	
Recurrent Cost Total	LA	0	0	7.5	20	45	62.5	62.5	62.5	62.5	62.5	385	38.5
Recurrent Cost Total	DH	0	0	0	0	0	0	0	0	0	0	0	0
Costs Grand Total		0.25	3.2	30.4	35	45	62.5	62.5	62.5	62.5	62.5	426.3	

264. The duty for local authorities to share information with individuals, carers and their families may have some initial low costs. For illustrative purposes, the initial costs to local authorities are likely to be no more than £3m to £6m.

V. RISKS

265. A recent Audit Commission report identified the need for local authorities to manage the risks of fraud and abuse as personal budgets and direct payments are scaled up.¹⁵² However, current levels of abuse are low and occurrences rare. Personal budgets will be linked to the drawing up of care and support plans, which will have a statutory basis and will set out both the eligible needs and the outcomes to be achieved. This will ensure that outcomes can be monitored and any risks assessed and managed.

266. It is proposed that local authorities will be funded to take forward the proposals for a local web-based portal and for improving advice and support to plan care and put it in place. However, as

¹⁵² Audit Commission, *Protecting The Public Purse*, November 2011.

discussed above, while it is appropriate for local authorities to retain local flexibility over how funding is prioritised, this could mean a certain degree of variability in improvements in information services.

267. Even if all the proposals for information are implemented, there is still a risk that they may not work together to become that catalyst that ultimately drives up the quality of information for users and their carers, particularly in a context that is likely to see continuing pressures on funding in the next few years. However, we would expect to mitigate these risks by working with ADASS and other stakeholders to ensure implementation at the local level.
268. If it works well, there remains a risk that the framework for information and advice still needs to be underpinned by real services that support choice and the care that people want to access. Good information systems that would raise public expectations could be problematic if not underpinned by the availability of appropriate and improved services. This risk could be mitigated by the work being taken forward on strengthening the role of local authorities in facilitating a diverse and vibrant market to deliver a range of high quality and responsive services and other proposals to improve the quality of services more generally. These proposals are discussed in the corresponding Impact Assessment “Quality, care providers and the workforce.”
269. There is a slight risk associated with changing the treatment of earned income. Those with smaller incomes will be better off in residential care, since they will not have to fund their living expenses as they would in domiciliary care. In reality, the extent to which this would affect an individual’s choice is likely to be limited, deciding whether to use residential or domiciliary care is much more likely to be based on an individual’s needs. In addition, local authorities act as a gatekeeper to publicly funded residential care, preventing individuals from accessing care according to their financial preference.

VI. SPECIFIC IMPACT TESTS

One-In One-Out

270. The proposals discussed within this Impact Assessment do not fall within the scope of the Government’s “One-In One-Out” (OIOO) rule which states that “no new primary or secondary UK legislation which imposes costs on business or civil society organisations can be brought in without the identification of existing regulation with an equivalent value (in terms of net costs to business) which can be removed.”
271. These proposals do not involve any additional regulatory measures that impose costs on business or civil society. The changes to the law proposed in the draft Care and Support Bill relate to the responsibilities of local authorities and other public sector partners for the planning and commissioning of adult social care services and for meeting the needs of their local population.

Wider impact on business and small firms

272. The primary objective of the proposals set out in the White Paper is to support people who use care and support and their carers to maintain their health, wellbeing and independence for as long as possible. As part of the overall objective of improving quality of care and experience, proposals are also intended to strengthen and enhance the social care market.
273. Proposal J to make a directory of services available and Proposal L to improve local authorities’ web-based information and advice services both have the potential to impact on small firms providing care and support services. A charge on suppliers for inclusion in a service directory could act to limit the number of small suppliers who may wish (or can afford) to engage. The current and developing self-financing models look to address this by making any charges proportionate to the size of the organisation concerned. This aspect will be covered within the further work to explore the robustness of self-financing delivery models with stakeholders and the current private and independent sector organisations currently working in the field.
274. Proposals to support personalisation may have positive implications for small businesses in that they could increase the number and range of small and micro providers. The development of

personal budgets has led to an increase in the opportunities for micro-providers responding to niche markets as care becomes more personalised.¹⁵³

Competition

Integration

275. The January 2012 Future Forum report on Choice and Competition noted that the Forum had heard many people saying that competition and integration are opposing forces. However, in practice, both the Future Forum and the King's Fund/Nuffield Trust work have argued that these two mechanisms are not necessarily in opposition and, indeed, can be seen to represent complementary or mutually reinforcing forces given appropriate conditions.

276. Consequently, the Future Forum workstream reports on integration, choice and competition contained recommendations to reduce potential conflicts and reinforce the potential for competition to promote integration. These recommendations were supported by the work of the King's Fund/Nuffield Trust. Four of the ten elements of the latter's proposed enabling framework to support integration over a five to ten year timeframe would contribute to this objective:

- Align financial incentives by allowing commissioners flexibility in the use of tariffs and other contract currencies;
- Support commissioners in the development of new types of contracts with providers;
- Ensure clarity on the interpretation of competition and integration rules;
- Set out a more nuanced interpretation of patient choice.

277. In its response, Government noted that the NHS Future Forum had said it should make its position clearer and guard against the dangers of competition being an end in itself, and set out to improve its plans as follows:

- Monitor's core duty will be to protect and promote the interests of patients – not to promote competition as if it were an end in itself;
- There will be new safeguards against price competition, cherry picking and privatisation;
- There will be stronger duties on commissioners to promote (and Monitor to support) care that is integrated around the needs of users – e.g. by extending personal health budgets and joint health and social care budgets, in light of the current pilots;
- The NHS Commissioning Board will promote innovative ways to integrate care for patients and care users.

278. In summary:

- Competition and integration are widely seen to be potentially opposing principles;
- There is some evidence that in practice, competition can be a force for both fragmentation and integration;
- A number of initiatives are being prepared to help avoid fragmentation and optimise integration;
- These initiatives will need to be closely monitored and their results brought together to understand their individual and overall impact on improving integrated care outcomes.

Information, advice and support

279. The proposals on information, advice and support need to be viewed in the wider context of other themes within the White Paper and policy considerations. Also important will be the local implementation arrangements through local authorities and their own organisational responsibilities for developing a diverse and responsive care market to meet their population's needs.

280. Within this wider context, Proposals J and L for a directory of services linked to or including information related to the quality of care may have particular implications for micro and small service providers:

- A charge on suppliers for inclusion in a service directory could act to limit the number of small suppliers who may wish (or can afford) to engage and thereby restrict their ability to compete.

¹⁵³ Community Catalysts - <http://www.communitycatalysts.co.uk/micro-enterprise-help-for-micro-providers/>

To mitigate this we would like to see the business models for service directories to allow for proportionate charging models that would support greater involvement of smaller suppliers in the private and voluntary sectors. Any 'kite marking' and links to directories would seek to ensure that they provide a comprehensive coverage of services, including those from smaller suppliers.

- On the benefits side, a provider's inclusion on such a service directory, linked to and from both the national and local authority levels will provide a significant opportunity for small and micro providers to advertise their services and provide the basis for a greater level of competition.

Human rights

281. We have not identified any negative impact on human rights as a result of our proposals. Several of the proposals are likely to have positive implications for human rights, in particular proposals to improve the quality and availability of information about the support on offer and proposals to extend and improve personalised care and support to care users and carers. For example, in terms of earned income, the Joint Committee on Human Rights (JCHR) recommended in their recent report:

"There appears to be an anomaly in the charging policy for residential care which creates a significant work disincentive, thus impeding access to independent living. The Government also appear not to recognise the extent to which people living in residential care are able to engage in paid work. We urge the Government to take action to remove this disincentive as soon as possible."

282. By addressing this concern, we are contributing positively to individuals' ability to live an independent life, according to their desired outcomes.

Other impacts

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

ANNEX A: Further Explanation of Incentives created around the treatment of earned income

Most individuals in residential care will have limited assets to pay for care, and therefore will have to pay out of earned income, if they have any. If they do not have earned income they still receive care, since the local authority provides a safety net. Individuals in local authority supported residential care are therefore financially no better off from working, thus the charging rules act as a disincentive to work.

This is illustrated in the table below. Person A earns £10,000, whereas Person B does not work. They have the same £6,000 benefits, neither have assets above the lower capital threshold. Therefore, Person A has £16,000 of income that could be charged for care, whilst Person B has £6,000. Both receive care worth £30,000, but are allowed to keep around £1,000 through the personal expenses allowance (PEA). Therefore, Person A has £15,000 of their income taken for care costs, whilst Person B has £5,000. Both are left with their PEA of £1,000, despite Person A earning £10,000. Person A has no additional funds in their pocket from working.

Person C illustrates that an individual has to earn a large amount before they benefit from working. Person C earning £30,000 per year, receiving benefits of £2,000 per year, is able to afford all of their £30,000 care costs. They are £2,000 better off than Person B, but they receive no financial support from the local authority.

Table 1

	Person A	Person B	Person C
Earned Income	£10,000	£0	£30,000
Benefits	£6,000	£6,000	£2,000
Assets to pay for care (above the lower capital limit of £14,250)	£0	£0	£0
Assessable assets for care	£16,000	£6,000	£32,000
Value of care received	£30,000	£30,000	£30,000
Personal Expenses Allowance	£1000	£1000	£1000
Charged income for care	£15,000	£5,000	£30,000
Support from LA	£15,000	£25,000	£0
Money in pocket	£1,000	£1,000	£2,000

ANNEX B: INTEGRATION CASE STUDIES

Care Navigators

A literature review carried out for the Department found the following:

“The term Care Navigator is used interchangeably with that of Wayfinders or Community Navigators. Whichever term is used, these are (usually) volunteers or voluntary organisational employees who provide ‘hard-to-reach’ or vulnerable people with emotional, practical and social support; acting as an interface between the community and public services, signposting individuals to appropriate interventions. The structure and processes of the interventions vary across localities and are dependent on population need (Age Concern and Help the Aged, 2009; Windle et al, 2009).

Prior literature emphasises the role of the care navigator as essential in facilitating appropriate service integration: ‘Connecting primary care, community-based providers and the formal health service system into a seamless network that is responsive to changing community and client needs requires flexible adaptive models..one such approach is that of a Care Navigator’ (Anderson and Larke, 2009; p21).

The overarching role necessarily differs with their location (e.g., secondary, primary or community care) and the user themselves: ‘If we want to be successful you have to deal with every patient in a way that’s appropriate for them. Some can just run with a name and a number, but the elderly are not able to go out on their own. The patient navigator should be able to use their own judgement’ (Anderson and Larke, 2009; p740). Nevertheless, despite disparate implementation, the core role incorporates needs assessments, education, collaboration, communication, support, co-ordination and follow-up of care along the relevant pathway.

There are few robust randomised evaluations of the social care navigator model and the majority of these are drawn from secondary or primary care navigators across North America. One of these trials explored the role of care navigators in connecting patients to primary care after a psychiatric crisis and found that the intervention group was statistically more likely to access care (62.4 per cent vs 37.6 per cent, $p < 0.001$) (Griswold et al, 2010). Further successful outcomes recorded through case-controlled or qualitative trials included: a greater knowledge as to those resources available to support their care pathway, better and more appropriate access to service provision and financial assistance, better perceived emotional support, improved quality of life and a ‘smoothed’ experience – that is users did not perceive the different service boundaries as barriers to receiving appropriate, integrated and timely care (Wilcox et al 2010, Campbell et al 2010, Cameron et al 2009, Lemak 2004).” (Windle, 2011)

An evaluation of a care navigator pilot project implemented in Kent was carried out by Windle et al (2009) as part of the wider national evaluation of the Partnerships for Older People Projects (POPPs). The POPPs evaluation concentrated on costs and outcomes. Fixed and variable costs were collected from the care navigator project and care users completed a standardised questionnaire before and after the intervention that measured changes in users’ relating to: health-related quality of life; quality of life per se; and type and extent of service use across health (secondary and primary) and social care. In measuring health-related quality of life, the changes seen in the intervention group were compared with a quasi-control group drawn from the British Household Panel Survey.

Table 1 summarises the individual-level impact of the care navigation pilot in Kent, and is based on conservative assumptions of zero improvement in quality of life after the first year of the intervention. We have also conservatively assumed zero impact on the demand for primary and secondary care. Windle et al’s (2009) analysis identified potential savings on primary and secondary care and increased benefit take-up. However, the finding could not be unambiguously attributed to the care navigation intervention. Moreover, subsequent analysis by Nuffield Trust (2011), using an alternative control group, did not find statistically significant reductions in the spend on primary and secondary care services in a number of POPPs interventions.

Owing to the use and location of Care Navigators (within VSO), there may well be an increase in use of those services provided by the third sector (e.g., befriending support, shopping, volunteer transport etc). However, during the Kent pilot phase, service use within this care sector was not recorded. These additional costs are therefore absent from our analysis.

Care Navigators made at least three visits to each user and for the purposes of this analysis, we have assumed an average of three visits to the user in one year, plus one follow-up visit in the following year. Based on analysis by Windle et al (2009), we estimate that care navigation costs approximately £140 per person in the first year, and £50 per person in the second. Similarly, based on Windle et al (2009), we estimate that each individual receiving care navigation experiences a QALY gain of 0.1 in the first year of the intervention.

Table 1: Costs and Benefits associated with Care Navigators provision (2010/11 prices)¹⁵⁴

	Year 1	Year 2
Costs		
Unit Cost	£142	£47
Benefits		
QALY gain	£5,820	
Net Benefit	£5,678	-£47

Table 2 shows the costs and benefits associated with rolling out the care navigator scheme across the country and includes estimated start-up costs in the year prior to intervention based on analysis from Windle et al (2009). These figures are for illustrative purposes only as we do not know the extent to which care navigation occurs across England. We assume that care navigation is offered to those older people with needs covered by the substantial and critical FACS eligibility criteria. Moreover, we assume that 12% of these people would be unlikely to take up the offer of this service. Finally, we assume that the stock of people with substantial and critical needs are offered care navigation over the first three years of implementation.

We have assumed that the service is provided to people who meet the critical and substantial FACS criteria in 2015/16 onwards. We assume that everyone will benefit within three years and from Year 2, care navigators will support new care users as well (flow). The number of care users is estimated using the Department of Health's modelling on future demand of services.

There was no information on potential take up rate and therefore we assumed a 12% non-take up rate based on the model provided to support the recent Dilnot report.¹⁵⁵

Start up costs occur in Year 0. These figures were based on the National evaluation of the Personal Health Budgets, a similar intervention to the POPPs programme requiring early administrative and management activity.¹⁵⁶

Table 2: Cost and Benefits associated with Care Navigation Services at an England Level (2010/11 prices, £million)

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	NPV
Number of recipients		225,000	370,000	370,000	150,000	155,000	155,000	160,000	165,559	170,064	
Costs											
Cost of the Intervention (£m)	7	30	60	60	35	25	25	25	£24	£23	£300
Benefits											
QALY gain		1,300	2,100	2,050	800	850	850	850	£855	£866	£10,450
Net Benefit	-7	1,250	2,000	2,000	800	800	800	800	£832	£842	£10,150

As noted above, these figures are for illustrative purposes only. Care navigation services are already established in some localities.

¹⁵⁴ Unit costs and HRQoL changes were provided by Karen Windle, in analysis based on data collected during the national POPP evaluation.

¹⁵⁵ Forder, J. and Fernandez, J.-L., Analysing the costs and benefits of social care funding arrangements in England: technical report, PSSRU, University of Kent, 2009.

¹⁵⁶ Jones, K. et al., *The cost of implementing personal health budgets*, 2011.

The evidence from the Kent evaluation suggests, however, that if reducing systemic barriers to integration makes integrated services more cost-effective to implement locally, there can be significant benefits to individuals.

Integrated Case Management (ICM)

Integrated case management "...is a collaborative process which: assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health, social care, educational and employment needs, using communication and available resources to promote quality cost effective outcomes" (Case Management Society UK). The practice of care management or case coordination includes: case finding, assessment, care planning, care-coordination and case closure.

Although there has been some positive evidence on the effect of case management, it is difficult to assess the exact impact due to heterogeneity of the implementation of the intervention across the country and variation in the local context (Kings Fund, 2011). As Øvretveit (2011) notes, "a change found to have little effect in one place may work somewhere else." Overall, Purdy (2010) observes that the evidence for case management is "promising but mixed".

Therefore, we present indicative costs based on one case coordination intervention in Brent, which was evaluated extensively (Windle et al, 2009).

Table 3 presents the impact of the care coordination intervention in Brent at the individual level. These costs are based on the conservative assumption that there are no cost-savings to commissioners as a result of the intervention. Windle et al's before-after analysis shows that utilisation of primary, secondary and social care fell for those care users receiving the intervention; however, there was no control group against which to compare these findings. Moreover, we assume that there is not a preventative impact of active case management, so any benefits occur in the year of the intervention.

Table 3 Costs and Benefits associated with Case Management provision (2010/11 prices)¹⁵⁷

Costs	£
Unit Cost	2,182
Benefits	
QALY Gain	3,300

The intervention also incurred start-up costs, as outlined in Table 4:

Table 4 Start up Costs associated with Case Management provision (2010/11 prices, thousands)¹⁵⁸

	Year 0 (£000)	Year 1 (£000)
Set up costs (Adverts, IT, office expenses)	36	0
Evaluation	102	67
Dissemination	11	27
Training	4	0

Table 5 shows the costs and benefits associated with rolling out the care coordination scheme across the country. These figures are for illustrative purposes only as we do not know the extent to which care management occurs across England, and we do not propose to mandate any particular model of intervention.

¹⁵⁷ Unit costs and HRQoL changes were provided by Karen Windle, in analysis based on data collected during the national POPP evaluation

¹⁵⁸ Setup costs were provided by Karen Windle, in analysis based on data collected during the national POPP evaluation.

We assume that care management is offered to those older people with relatively low social care need (an inability to perform one or two activities of daily living (ADL)). We assume 10% of these people will not accept the intervention. Finally, we assume that the current stock of people aged over 65 with one or two ADL failures would be offered the case management intervention over the first three years.

Table 5: Cost and Benefits associated with Case Management Services at an England Level (2010/11 prices, £million)

	2014 -15	2015 -16	2016 -17	2017 -18	2018 -19	2019 -20	2020 -21	2021 -22	2022 -23	2023 -24	2024 -25	2025 -26	NPV
Number of Recipients ('000s)	0	580	921	925	352	360	368	374	387	398	405	410	
Cost of Intervention (£m)	23	1,236	1,876	1,820	669	661	653	641	641	637	626	613	
QALY Gain (£m)	0	1,849	2,837	2,753	1,012	1,000	988	970	970	964	947	927	
Net Benefit	-23	613	961	933	343	339	335	329	329	327	321	314	5144

Case management also has the potential to improve people's experience of the health and social care systems. Hudson and Moore (2006) find that integrated case management can positively impact on people's experience. Sheaff et al's (2009) survey agrees, citing the following perceived impacts:

- Case management improved access to health care, levels of psychological support and communication with health professionals.
- Patients valued the contact time that their case manager provided
- Patients' confidence improved as they knew their case manager was contactable at any time.
- Leighton et al's (2008) evaluation of the community matron service found the following:
 - 65% rated the service as 'excellent', 27% as 'very good'
 - Improved independence and confidence among patients, and relief among carers
 - Particular value was placed on the reliability of the service, the improvement in communications and the perceived reduction in admissions.

We have not been able to monetise these benefits.