

<b>Title:</b> Mandatory provision of data by adult social care providers <b>IA No:</b> 9588 <b>RPC Reference No:</b> <b>Lead department or agency:</b> DHSC <b>Other departments or agencies:</b>	<b>Impact Assessment (IA)</b>
	<b>Date:</b> 08/06/2022
	<b>Stage:</b> Final
	<b>Source of intervention:</b> Domestic
	<b>Type of measure:</b> Primary legislation
	<b>Contact for enquiries:</b> Laura Green (laura.green2@dhsc.gov.uk)
<b>Summary: Intervention and Options</b>	<b>RPC Opinion:</b> RPC Opinion Status

Cost of Preferred (or more likely) Option (in 2019 prices)			
Total Net Present Social Value	Business Net Present Value	Net cost to business per year	Business Impact Target Status Qualifying provision
12.3m/3.4m	12.5m/3.6m	-2.7m/-0.8m	

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

The 2020 Office for Statistics Regulation (OSR) report highlighted gaps in our understanding of adult social care funded outside of local authority provision. The pandemic further highlighted this issue and exposed our limited ability to respond to emerging risks within the entire sector. As an interim response, social care providers voluntarily submitted data to the Capacity Tracker tool. We now need a long-term solution to obtain data from (regulated) providers to support delivery of the social care reform ambitions for the next three years and the improvements to health and social care data set out in the [Health and Social Care Data Strategy](#) and the [Adult Social Care \(ASC\) reform White Paper](#). In July 2021, OSR recognised this as a reason “to be optimistic about... ASC data.”

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

Availability of good-quality and timely data from ASC providers is essential to improve services for users, support efficient commissioning and systems assurance, and to manage national, regional and local risks. We need data from all ASC providers to get an unbiased overview of the sector at levels similar to those achieved during the pandemic. The objective of intervention is to ensure we continue to get vital information from all ASC providers in the absence of incentives to provide data.

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

Option 1 (business as usual): providers continue to input data voluntarily on a weekly basis. This option is discounted because of ~40% response rate pre-pandemic. This rose to ~ 90% during the pandemic but response rates have been falling continuously now in the absence of incentives (currently below 80%). This is eroding the quality and quantity of the data available for decision-making and service delivery, and for providers to benchmark themselves against other providers. Due to uncertainty over the level of future response rates, we have costed two BAU scenarios : Scenario A with current response rates (assumed to be 80% for care homes and 70% for home care providers) and Scenario B with pre-pandemic response rates (assumed to be 40% for care homes and 35% for home care providers). This is because we expect the current trend of falling response rates to continue if the collection remains voluntary and pre-pandemic response rates represent a reasonable lower bound for future response rates.

We have considered a range of options for using the data provisions in the Bill to mandate provider data sharing. Initially, we will mandate a subset of the current Capacity Tracker data collection. In the longer term, mandation will cover the provider data set which we are currently developing in collaboration with the sector, which will include data essential to government, local authorities and of use to providers.

Option 2 (recommended): providers are mandated to submit data to Capacity Tracker, monthly, with enforcement as a last resort. **This is the preferred option** because it will permit us to continue to get timely data from all (regulated) ASC providers in England in line with national and local policy and intervention needs, but is not as burdensome to providers as a weekly or daily data collection.

Option 3: providers are mandated to complete Capacity Tracker on a **weekly** basis (further details in Evidence Base).

Option 4: providers are mandated to complete Capacity Tracker **daily** (further details in Evidence Base).

Option 5: providers are mandated to complete Capacity Tracker **quarterly** (further details in Evidence Base).

**Will the policy be reviewed? Yes (date yet to be identified). If applicable, set review date: Month/Year**

Is this measure likely to impact on international trade and investment?	No			
Are any of these organisations in scope?	<b>Micro</b> Yes	<b>Small</b> Yes	<b>Medium</b> Yes	<b>Large</b> Yes
What is the CO <sub>2</sub> equivalent change in greenhouse gas emissions? (Million tonnes CO <sub>2</sub> equivalent)	<b>Traded:</b> n/a		<b>Non-traded:</b> n/a	

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

Signed by the responsible Minister:



Date:

28/06/2022

# Summary: Analysis & Evidence

# Policy Option 2

**Description:** Providers are mandated to complete CT on a monthly basis

## FULL ECONOMIC ASSESSMENT

We have two BAU options and have calculated the incremental costs of each option in comparison to both of these BAU costs. We present the costs compared Option 1 Scenario A followed by Option 1 Scenario B separated by a slash.

Price Base Year 2019	PV Base Year 2020	Time Period Years 5	Net Benefit (Present Value (PV)) (£m) (Scenario A/ Scenario B)		
			Low: 5.7/1.6	High: 22.1/6.2	Best Estimate: 12.3/3.4

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant)	Total Cost (Present Value)
Low	0.1	-1.2/-0.4	-5.7/-1.6
High	0.3	-4.8/-1.4	-22.1/-6.2
Best Estimate	0.2	-2.7/-0.8	-12.3/-3.4

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

The costs for this option (which represent the national cost to all providers) are mainly administrative costs, based on hourly wage and the time it takes to collect and input the data into Capacity Tracker, on a monthly basis. There is also an additional minor fixed cost of getting used to the new mandate guidance and data specification, in the first year of implementation. The cost of this option is lower than BAU options 1A and 1B due to the reduced frequency of data collection.

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

There will be some administrative costs for DHSC and partners associated with running the collection. However, these costs are already associated with the voluntary collection and we expect that any differences in administrative costs between the options will be negligible.

Other costs to business include fines in the case of non-provision of the data. The enforcement aspect is not included in the scope of this IA so is not quantified here. This would be an economic transfer from the provider paying the potential fine to the organisation receiving the penalties.

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

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

There will be no direct monetised revenue under this proposed policy. The added value will be the acquisition of good quality data from all ASC providers, to help shape effective policy. Designing good evidence-based policy has monetary benefits for the sector in the long run, but we are unable to quantify these.

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

Mandating CT data provision will reduce the risk of other pre-pandemic local data collections being reinstated, which could lead to potential duplication, added burden and costs (especially as CT allows local bodies to gather data more frequently than is mandated - thus using the same system and definitions); ensure the data available to national government, which is used to shape policies, is representative of all providers; help maintain a centralised collection, allowing providers and LAs to benchmark themselves; and ensure data is shared and accessed via appropriate channels. A monthly mandated collection, instead of weekly, also ensures we don't put a disproportionate burden on providers, and they are therefore more likely to comply and cooperate (less, though still some, risk of affecting relationships with the sector).

<b>Key assumptions/sensitivities/risks</b>	<b>Discount rate</b>	3.5
<p>The key assumptions used in this costing are as follows and are accounted for in the sensitivity testing section:</p> <ul style="list-style-type: none"> <li>- 100% response rate under mandation, which could result in an overestimation of the cost</li> <li>- Collection size is unchanged, which could result in an overestimation of the cost as it is more likely to decrease</li> <li>- The number of providers is unchanged compared with April 2022</li> <li>- No future Covid wave or other event (not considered in sensitivity testing)</li> </ul>		

### BUSINESS ASSESSMENT (Option 2)

<b>Direct impact on business (Equivalent Annual) £m:</b>			<b>Score for Business Impact Target (qualifying provisions only) £m:</b>
<b>Costs: -2.7/-0.8</b>	<b>Benefits: 0</b>	<b>Net: -2.7/-0.8</b>	
			-13.4/-3.8

### Policy Option 3

**Description:** Providers are required to submit data on a weekly basis

#### FULL ECONOMIC ASSESSMENT

<b>Price Base Year 2019</b>	<b>PV Base Year 2020</b>	<b>Time Period Years 5</b>	<b>Net Benefit (Present Value (PV)) (£m)</b>		
			<b>Low: -2.7/-6.8</b>	<b>High: -9.6/-25.6</b>	<b>Best Estimate: -5.6/-14.5</b>

<b>COSTS (£m)</b>	<b>Total Transition (Constant Price) Years</b>		<b>Average Annual (excl. Transition) (Constant Price)</b>	<b>Total Cost (Present Value)</b>
<b>Low</b>	0.1	1	<b>0.5/1.4</b>	<b>2.7/6.8</b>
<b>High</b>	0.3		<b>2.0/5.4</b>	<b>9.6/25.6</b>
<b>Best Estimate</b>	0.2		<b>1.2/3.1</b>	<b>5.6/14.5</b>

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

The costs for this option are mainly administrative costs, based on hourly wage and the time it takes to collect and input the data into Capacity Tracker on a weekly basis. The cost of this option is higher than BAU options 1A and 1B because response rates are higher under mandation than under voluntary collection and the frequency of collection is higher. There is also an additional minor transitional cost of getting used to the new guidance and data specification, in the first year of implementation.

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

There will be some administrative costs for DHSC and partners associated with running the collection. However, these costs are already associated with the voluntary collection and we expect that any differences in administrative costs between the options will be negligible. Other costs to business include fines in the case of non-provision of the data. The enforcement aspect is not included in the scope of this IA so is not quantified here. This would be an economic transfer from the provider paying the potential fine to the organisation receiving the penalties.

<b>BENEFITS (£m)</b>	<b>Total Transition (Constant Price) Years</b>		<b>Average Annual (excl. Transition) (Constant Price)</b>	<b>Total Benefit (Present Value)</b>
<b>Low</b>	n/a		Optional	<b>Optional</b>

<b>High</b>	n/a		Optional	<b>Optional</b>
<b>Best Estimate</b>	n/a		n/a	<b>n/a</b>
<b>Description and scale of key monetised benefits by 'main affected groups'</b>				
There will be no direct monetised revenue under this proposed policy. The added value will be the acquisition of good quality data from all ASC providers, which will help shape effective policy. Designing good evidence-based policies will have longer-term monetary benefits for the sector but we are unable to estimate these.				
<b>Other key non-monetised benefits by 'main affected groups'</b>				
Mandating weekly data collection would provide us with frequent data from all providers, however, this could be viewed as an excessive burden on providers, particularly in the context of moving to 'Living with Covid' and other pressures on the sector such as workforce capacity issues. It risks affecting the constructive relationship between DHSC and providers/stakeholders and exacerbating the pressure felt by providers. Mandating CT data provision will reduce the risk of other pre-pandemic local data collections being reinstated, which could lead to potential duplication, added burden and costs; ensure the data available to national government, which is used to shape policies, is representative of all providers; help maintain a centralised collection, allowing providers and LAs to benchmark themselves; and ensure data is shared and accessed via appropriate channels.				
<b>Key assumptions/sensitivities/risks</b>			<b>Discount rate</b>	3.5
The key assumptions used in this costing are as follows and are accounted for in the sensitivity testing section:				
<ul style="list-style-type: none"> <li>- 100% response rate under mandate, which could result in an overestimation of the cost</li> <li>- Collection size is unchanged, which could result in an overestimation of the cost as it is more likely to decrease</li> <li>- The number of providers is unchanged compared to April 2022</li> <li>- No future Covid wave or other event (not considered in sensitivity testing)</li> </ul>				

### BUSINESS ASSESSMENT (Option 3)

<b>Direct impact on business (Equivalent Annual) £m:</b>	<b>Score for Business Impact Target (qualifying provisions only) £m:</b>
Costs: 1.2/3.1   Benefits: 0   Net: 1.2/3.1	5.8/15.3

## Policy Option 4

**Description:** Providers are mandated to complete CT on a daily basis

### FULL ECONOMIC ASSESSMENT

Price Base Year 2019	PV Base Year 2020	Time Period Years 5	Net Benefit (Present Value (PV)) (£m)		
			<b>Low: -44.7/-48.9</b>	<b>High: -172.5/-188.4</b>	<b>Best Estimate: -96.8/-105.7</b>

<b>COSTS (£m)</b>	<b>Total Transition (Constant Price) Years</b>		<b>Average Annual (excl. Transition) (Constant)</b>	<b>Total Cost (Present Value)</b>
<b>Low</b>	0.1		<b>9.5/10.4</b>	<b>44.7/48.9</b>
<b>High</b>	0.3		<b>36.8/40.3</b>	<b>172.5/188.4</b>
<b>Best Estimate</b>	0.2		<b>20.7/22.6</b>	<b>96.8/105.7</b>

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

The costs for this option are mainly administrative costs, based on hourly wage and the time it takes to collect and input the data into Capacity Tracker on a daily basis. This cost is higher than BAU options 1A and 1B due to both increased response rates and increased frequency of data collection. There is also an additional minor fixed cost of getting used to the new guidance and data specification, in the first year of implementation.

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

There will be some administrative costs for DHSC and partners associated with running the collection. However, these costs are already associated with the voluntary collection and we expect that any differences in administrative costs between the options will be negligible. Other costs to business include fines in the case of non-provision of the data. The enforcement aspect is not included in the scope of this IA so is not quantified here. This would be an economic transfer from the provider paying the potential fine to the organisation receiving the penalties.

<b>BENEFITS (£m)</b>	<b>Total Transition (Constant Price) Years</b>		<b>Average Annual (excl. Transition) (Constant)</b>	<b>Total Benefit (Present Value)</b>
<b>Low</b>	Optional		Optional	<b>Optional</b>
<b>High</b>	Optional		Optional	<b>Optional</b>
<b>Best Estimate</b>	n/a		n/a	<b>n/a</b>

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

There will be no direct monetised revenue under this proposed policy. The added value will be the acquisition of good quality data, which will help shape effective policy. Designing good evidence-based policies will have monetary benefits for the sector, in the long run, however we are unable to estimate them.

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

Mandating daily data collection would provide us with very timely data from all providers, however, this could be viewed as an excessive burden on providers as we move to 'Living with Covid' and risks affecting the constructive relationship between DHSC and providers/stakeholders, with significant negative impacts on future policy implementation. Mandating CT data provision will reduce the risk of other pre-pandemic local collections being reinstated, which could lead to potential duplication, added burden and costs; ensure the data available to national government, which is used to shape policies, is representative of all providers; help maintain a centralised collection, allowing providers and LAs to benchmark themselves; and ensure data is shared and accessed via appropriate channels.

<b>Key assumptions/sensitivities/risks</b>	<b>Discount rate</b>	3.5
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The key assumptions used in this costing are as follows and are accounted for in the sensitivity testing section:

- 100% response rate under mandate, which could result in an overestimation of the cost
- Collection size is unchanged, which could result in an overestimation of the cost as it is more likely to decrease
- The number of providers is unchanged compared to April 2022
- No future Covid wave or other event (not considered in sensitivity testing)

#### BUSINESS ASSESSMENT (Option 4)

<b>Direct impact on business (Equivalent Annual) £m:</b>			<b>Score for Business Impact Target (qualifying provisions only) £m:</b>
<b>Costs: 20.7/22.6</b>	<b>Benefits: 0</b>	<b>Net: 20.7/22.6</b>	
			103.4/112.9

#### Policy Option 5

**Description:** Providers are mandated to complete CT on a quarterly basis

#### FULL ECONOMIC ASSESSMENT

Price Base Year 2019	PV Base Year 2020	Time Period Years 5	Net Benefit (Present Value (PV)) (£m)		
			Low: 7.4/3.2	High: 28.5/12.5	Best Estimate: 15.9/7.0

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value)
Low	0.1	-1.6/-0.7	-7.4/-3.2
High	0.3	-6.2/-2.7	-28.5/-12.5
Best Estimate	0.2	-3.4/-1.5	-15.9/-7.0

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

The costs for this option are mainly administrative costs, based on hourly wage and the time it takes to collect and input the data into Capacity Tracker on a quarterly basis. These costs are lower than BAU options 1A and 1B due to reduced frequency of data collection, despite increased response rates. There is also an additional minor fixed cost of getting used to the new guidance and data specification, in the first year of implementation.

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

There will be some administrative costs for DHSC and partners associated with running the collection. However, these costs are already associated with the voluntary collection and we expect that any differences in administrative costs between the options will be negligible. The reduced frequency of data collection would not meet the needs of local authorities and risks them reintroducing local collections to meet their data needs, which could lead to potential duplication and additional burden to providers. Other costs to business include fines in the case of non-provision of the data. The enforcement aspect is not included in the scope of this IA so is not quantified here. This would be an economic transfer from the provider paying the potential fine to the organisation receiving the penalties.

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

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

There will be no direct monetised revenue under this proposed policy. The added value will be the acquisition of good quality data, which will help shape effective policy. Designing good evidence-based policies will have monetary benefits for the sector, in the long run, however we are unable to estimate them.

<b>Other key non-monetised benefits by 'main affected groups'</b>	
Quarterly collection would reduce the burden on providers but would also significantly reduce the timeliness of data available to DHSC, local authorities and others, which would mean we were less able to respond and support providers where needed.	
<b>Key assumptions/sensitivities/risks</b>	<b>Discount rate</b> 3.5
The key assumptions used in this costing are as follows and are accounted for in the sensitivity testing section:	
<ul style="list-style-type: none"> <li>- 100% response rate under mandate, which could result in an overestimation of the cost</li> <li>- Collection size is unchanged, which could result in an overestimation of the cost as it is more likely to decrease</li> <li>- The number of providers is unchanged compared to April 2022</li> <li>- No future Covid wave or other event (not considered in sensitivity testing)</li> </ul>	

**BUSINESS ASSESSMENT (Option 5)**

<b>Direct impact on business (Equivalent Annual) £m:</b>	<b>Score for Business Impact Target (qualifying provisions only) £m:</b>
Costs: -3.4/-1.5   Benefits: 0   Net: -3.4/-1.5	-17.0/-7.4

**Evidence Base**

**Problem under consideration and rationale for intervention**

1. The COVID-19 pandemic brought into sharp focus the need for better data and information in Adult Social Care. Prior to the pandemic, the quality and quantity of data on key areas such as capacity, workforce and the number of people in receipt of care were very poor. All but a small amount of the data available to DHSC was captured through aggregate annual returns from local authorities covering only LA commissioned care and only became available 6 months after the year end. The data did not cover individuals who fund their care privately or who receive unpaid care; these were almost entirely absent from our understanding of how the care system was operating. Although some organisations did collect data from the ASC sector at provider and local level, the data collections were (and remain) un-standardised and do not provide a comprehensive or consistent picture of the whole sector. These and other data gaps were highlighted by the Office for Statistics Regulation (OSR) in their 2020 review of adult social care data.
2. During the pandemic, providers were incentivised by the Infection Control and Testing Fund (ICTF) to voluntarily submit data into the Capacity Tracker tool on a daily basis, which became weekly as we moved to 'living with Covid'. The ICTF ended on 31 March 2022. Without this incentive and with the move to 'Living with Covid', completion rates of the Capacity Tracker have begun to fall, and we expect this trend to continue. Therefore we need a long-term solution that allows us to collect information from all regulated adult social care providers.
3. In February 2021, we published the Integration and Innovation White Paper, which outlined how we want to improve data across health and social care. The Health and Social Care Data Strategy set out our vision for ensuring that service users have access to high quality, timely and transparent data to improve outcomes and for all people to be a partner in their care. In the ASC reform White Paper we have publicly committed to developing and implementing a range of data development projects over the next three years to underpin our ambitions for reform of the system.

4. To deliver these ambitions, we are reviewing current data collections and publications, ensuring they have a clear purpose and are proportionate. We will also continue to share data, as we have done throughout the pandemic, so that sector partners and other stakeholders continue to have the data and local intelligence they need to operate effectively and to deliver improved outcomes for those receiving care and support. The data projects outlined in these publications (such as the implementation of digital social care records) will help to reduce the administrative burden of providing information and free up more time to care. In July 2021, the OSR highlighted this as one of the reasons “to be optimistic about...social care data.”
5. The mandation provision in clause 99 of the Health and Care Act 2022 is the key enabler to ensure that we continue to have robust ASC data flows. This provision will apply to all regulated providers of adult social care in England. In the short term (over this financial year), they will be required to complete the Capacity Tracker, though to a lower frequency than during the pandemic. To reduce the transition costs for providers, we will be mandating a subset of the data items already included in the Capacity Tracker collection and giving providers a reasonable notice period before mandating additional data where possible.
6. In the absence of data mandation under this provision, there is a very high risk that DHSC and other national, regional and local actors would lack the data and other information that is needed to monitor and support the sector, for example to continue to recover from the effects of the pandemic. This includes understanding capacity and risk in the wider care system, judging when and how to target support to providers and ultimately helping to deliver the best quality of care to individuals across the care system. Our plans for improving data across health and social care also underpin our ambitions for reform.
7. As we move to Living with Covid, understanding and collecting data from the ASC sector remains crucial as the government delivers on its ambitions for ASC reform, including charging reform. Data from ASC providers on workforce pressures and care home occupancy will be vital to the successful implementation, monitoring and evaluation of these reforms.
8. We have already taken steps to reduce the burden of data provision as we have moved into Living with Covid by removing multiple data items from Capacity Tracker and will continue to review, refine and reduce further. Between March and May 2022, we removed around 30% of the data fields. This included most of the infection prevention and control data collection that was put in place for the pandemic, such as staff movement restrictions, staff pay while isolating, block-booking of agency staff and providing staff accommodation. We have also reduced collection of data on testing, visiting, resources and training, and are further reviewing the remaining items in Capacity Tracker with a view to still further reductions.
9. In the longer term, we plan to replace the current data collection with a more robust provider data set and to develop more efficient and useful ways of sharing the data across the sector. The aim of the new collection is for the right data to be captured once, to be used and shared with all those that need it, including providers, local authorities, the Care Quality Commission (CQC), other key organisations and national government, such as Civil Contingencies Secretariat (CCS). This will add real value in providing a full overview of the sector and its challenges while reducing duplication of data collection. The new collection will look to build on feedback received from providers and other

stakeholders and on existing successful automated data sharing processes, through Application Programming Interfaces (APIs), between Capacity Tracker and other external data systems such as LG Inform, the Market Insight Tool, or the SitGen dashboard in Cabinet Office.

10. We are building on the close engagement with the sector that we developed during the pandemic, to carry out an extensive engagement programme with sector stakeholders, including providers, local authorities and health and care arms-length bodies. This aims to identify and agree key data needs and to explore and implement opportunities to streamline current data collections. The main output will be the creation of a provider-level minimum data set which will be progressively introduced from April 2023. We will review the frequency of data collection from providers when this dataset is ready for implementation. We will provide a full assessment of the impact of this longer-term provider data collection ahead of its introduction.
11. A key enabler for this new data collection is the digital enablement programme of the care sector that is currently being led by NHS Transformation. In December 2021, the Department of Health and Social Care published People at the Heart of Care, which set out a vision for reform of the adult social care system as well as setting out Government's intention to invest at least £150m to drive rapid digitisation in the sector. This investment in digitising care providers will greatly improve the efficiency of the sector and reduce the data collection burden on care staff, for example, by enabling a move away from manual record keeping and data collection to automated systems. The recently published Data saves lives: reshaping health and social care with data sets out how the other steps we are taking to reduce data collection burden, including the new Data Alliance Partnership which is working to reduce burden by, for example, streamlining data collections and encouraging data sharing.

### **Rationale and evidence to justify the level of analysis used in the IA (proportionality approach)**

12. The Impact Assessment for the Health and Care Bill did not include an assessment of the potential burdens placed on providers because the details of the data which would be mandated for collection using these powers were yet to be determined. We committed to producing an impact assessment once we had details of how the enabling powers might be used. This impact assessment delivers on that commitment by considering the costs of the Capacity Tracker collection which providers will be mandated to complete in the first instance.
13. Social care providers are currently completing Capacity Tracker on a voluntary basis. The Capacity Tracker collection has been co-developed with a range of ASC sector stakeholders, including providers and local authority representatives, and with their involvement, has evolved over time as data needs change. This has ensured that stakeholders can help to minimise the burden on providers while also meeting the data needs of all users.
14. We base our estimate of the cost to providers of completing the data collection on two main cost components: the time taken to collect and prepare the data for upload, and the time taken to input the data into Capacity Tracker. These are the key costs that providers have told us they face when submitting data into Capacity Tracker.
15. To estimate the time taken to collect and prepare data for input, we commissioned colleagues in the Capacity Tracker Support Team in the NHS North of England Commissioning Support Unit (NECS) to conduct a short survey of providers who called the support centre between 28 April-5 May 2022. Providers were asked approximately

how long it takes them to collect and prepare the information and how long it takes them to upload/input the data, and what method they use to upload their data to Capacity Tracker i.e. bulk upload or input directly to each page. We received responses from 106 domiciliary care providers and 397 care homes, which we have used as a basis for our assumptions on the length of time it takes to prepare to complete the collection. Whilst this sample may not be representative of all care providers (for example, those who call the support centre may take longer to complete the collection than others, hence their need to call for support), this allowed us to quickly gather data from a large number of providers which we could use as evidence to support our assumptions.

16. To estimate the time spent inputting the data, we were able to use Google Analytics data on the average time providers spend on each of the pages of the Capacity Tracker portal.
17. Regarding set-up costs and most transition costs, we assumed that these are sunk costs outside the scope of this policy and impact assessment because providers are already submitting data via Capacity Tracker and have been doing so throughout the pandemic. Whilst we are aware of approximately 350 locations that have either not set up capacity tracker, or have never submitted data, these make up less than 1.5% of locations and therefore would not have a substantial impact on costs. Examples of set-up costs include training and purchasing equipment.
18. The only transition cost that we include recognises that providers will need to familiarise themselves with the specification of the mandatory data collection when that is published, to ensure they are providing the necessary data. We will engage with a wide range of provider, local authority and other sector stakeholders in the design of this specification – as we do now and have done throughout the pandemic.
19. To calculate the total cost to providers, we then multiply the total time taken to complete the collection per year by the number of CQC-registered providers (taken from the CQC-registry) and the hourly pay rate for managerial staff (taken from Skills for Care data). Where we have made assumptions in this costing, we have used assumptions that are likely to overestimate the cost to providers so that our estimate is an upper bound for the cost to providers.
20. There will be some administrative costs for DHSC and partners associated with running the collection. However, these costs are already associated with the voluntary collection under BAU and we expect that any differences in administrative costs between the options will be negligible given standard validation and analysis that has been curtailed for weekly and daily collection would be reinstated/increased for less frequent collections. Therefore, we have not quantified these costs.
21. We have not quantified the benefits of collecting data from social care providers via a mandatory collection, because they are very difficult to monetise. Having good-quality and timely data allows us to understand capacity and risk in the care system, target support to providers and inform adult social care policy decisions and therefore helps us to improve outcomes for care providers and care users. The theory of change needed to realise these benefits is very complex and each stage is difficult to quantify. Instead, we provide case study examples of the benefits of collecting data using Capacity Tracker to demonstrate why it is important to continue gathering data from social care providers on a frequent basis (see section on monetised and non-monetised costs and benefits of each option).

22. We have used a five-year appraisal period for calculating the Equivalent Annual Net Direct Cost to Business (EANDCB) and the Net Present Value (NPV) because this is the period after which the associated enforcement regulations must undergo statutory review. Our longer-term provider data collection is likely to be in place within these five years, so we do not expect the collection in its current form to still be in place at the end of the appraisal period, but we do not know when this transition will occur. We expect the costs of this new collection to be similar to or lower than the costs of the current collection. We will complete another impact assessment if the collection changes substantially such that a new assessment is needed.

## **Description of options considered**

23. Option 1: Business as usual: providers continue to input data voluntarily. This option is discounted because of ~40% response rates pre-pandemic. These rose to ~ 90%, during the pandemic, after data submission was linked to access to the Infection Control and Testing Fund (ICTF). With the end of the ICTF and the move to 'Living with Covid', response rates have been falling (currently ~ 80%). This is eroding the quality of the data available for decision-making, benchmarking etc. Due to uncertainty over future response rates, we cost two scenarios of BAU: Scenario A with current response rates and Scenario B with pre-pandemic response rates. This is because we expect response rates to drop if the collection remains voluntary and pre-pandemic response rates represent a reasonable lower bound for future response rates.
24. Option 2 (Preferred): providers are required to complete Capacity Tracker on a monthly basis, with enforcement as a last resort. This will be mandated through new provisions in the Health & Care Act.
25. This is the preferred option because it ensures that we continue to get timely and representative data from all (registered) providers of adult social care in England but helps to balance the data provision burden for providers against the information requirements of local, regional and central government.
26. Option 3: Providers are mandated to complete capacity tracker on a weekly basis. As option 2, but on a weekly basis – this was discounted because it would be burdensome on providers in a non-emergency situation.
27. Option 4: providers are mandated to complete capacity tracker on a daily basis. As option 2, but on a daily basis – this was discounted because of the burden on providers in a non-emergency situation.
28. Option 5: providers are mandated to complete capacity tracker on a quarterly basis. As option 2, but on a quarterly basis. This was discounted because it would not provide data at the frequency required by local, regional and central government to allow them to provide targeted support to providers or have the necessary oversight over the system.

## **Policy objective**

29. With the end of the ICTF and the move to 'Living with Covid', response rates are slowly falling. The objective of this policy is to ensure that we continue to receive data from all ASC providers as set out in the Health and Care Act 2022.
30. Data from ASC providers is needed to monitor the care sector, understand system capacity and associated risk in the care system, identify when and how to target support to providers, with the ultimate aim of helping provide the best quality care to individuals across the care

system. The requirements of sector reform, such as the introduction of Charging Reform and assessing the Fair Cost of Care, and of key risks to effective and safe provision of care, such as workforce absence and shortages, mean that it is imperative that we continue to collect data from across the sector.

31. The key indicators for success will be that we continue to get critical information from providers of adult social care and that we rarely have to resort to our enforcement powers to encourage compliance.

## Summary and preferred option with description of implementation plan

32. Our preferred option is to mandate a monthly data collection to balance the data provision burden on providers against the information requirements of local, regional and central government.
33. Mandation will allow us to maintain a comprehensive and unbiased overview of care provision in England by requiring all providers to submit a single standardised set of data, regardless of size or location (although there will be differences as appropriate for care homes and domiciliary care providers). The provision of data by adult social care providers is critical to supporting efficient and effective commissioning, monitoring and assurance, and the management of risks at all levels, with the overall aim of helping deliver the best possible service for social care users. This policy will also help to manage and potentially reduce the burden on providers from data collections by local authorities, CQC and others.
34. The preferred option will be given effect through primary legislation – clause/section 99 in the Health and Care Act 2022. This will be enforced by regulations which will be laid under clause/section 100 and will provide SofS with a discretionary power to impose a financial penalty on private providers who, without reasonable excuse, do not comply or provide false or misleading information. **These enforcement regulations will come into force at a later date and are not part of the scope of this impact assessment.** The enforcement regulations provide discretionary powers to impose a financial penalty as a last resort on persistent offenders. We plan to complete a separate impact assessment for the enforcement regulations.
35. Mandating ASC provider data provides a statutory backstop to collect data from all regulated providers of adult social care in England to help us fill data gaps around unmet need, understand more about self-funders, support government policy and better manage emergency situations, and support local and regional work. Our ambition is for a long-term sustainable culture of good data discipline between the department and the sector such that we rarely have to resort to our legal powers to get access to information.
36. These arrangements are due to come into effect from July 2022, with enforcement due to commence from November 2022. There is sufficient flexibility in both provisions as they set out the high-level actions that need to be taken, but the detail about what is collected and when is to be set out separately in writing and can change as necessary through co-design with sector representatives. That said, we do not intend to make regular changes to data requirements, and will give a reasonable notice period before making any changes. The enforcement powers are discretionary and are intended to be used only as a last resort.
37. The data initially mandated for collection from July 2022 will cover care home bed vacancies and homecare service users; workforce resourcing including absences;

vaccination for Covid-19 and flu (seasonal) including the upcoming autumn Covid-19 booster campaign; and visiting in care homes.

38. DHSC will be directing NHS Digital to carry out the data collection function, and the NHS Business Services Authority to carry out the enforcement function. Both functions will be subject to oversight and review, following the now well-established governance processes for provider data collection put in place in the early months of the pandemic. These include full review of all data proposed to be collected by provider representatives from the Care Providers Alliance (CPA), Home Care Association (HCA), National Care Forum (NCF), Care Association Alliance (CAA) and Care England as well as the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Care Quality Commission (CQC), Department for Levelling Up, Housing and Communities (DLUHC), DHSC, NHS England and NHS Improvement (NHSEI) and NHS North of England Commissioning Support Unit (NECSU) that make up the Data Advisory Group. NECSU and DHSC Regional Teams will also continue to provide support – ongoing through regular webinars, FAQs and helpdesks as well as bespoke support as needed.
39. Data will be collected through the Capacity Tracker system which has been used to collect regular data from providers throughout the pandemic and was used by some local authorities prior to the pandemic to measure capacity. Using the system with which providers are already familiar will reduce the burden to providers because they will not have to transition to a new system to complete the mandatory collection. In the longer term, we are engaging with the sector to develop a provider-level minimum dataset. We will provide a full assessment of the impact of this longer-term provider data collection ahead of its introduction.

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

**Table 1: Gross costs of Option 1 (business as usual), scenarios 1A and 1B and incremental costs of each option compared to options 1A and 1B**

<b>Gross costs of BAU</b>						
	Scenario A			Scenario B		
	Central	Low	High	Central	Low	High
BAU	<b>£3.8m</b>	£1.8m	£6.8m	<b>£1.9m</b>	£0.9m	£3.4m
<b>Incremental costs above BAU</b>						
	Scenario A			Scenario B		
	Central	Low	High	Central	Low	High
Option 2: Monthly Data	<b>-£2.7m</b>	-£1.2m	-£4.8m	<b>-£0.8m</b>	-£0.4m	-£1.4m
Option 3: Weekly Data	<b>£1.2m</b>	£0.5m	£2.0m	<b>£3.1m</b>	£1.4m	£5.4m
Option 4: Daily Data	<b>£20.7m</b>	£9.5m	£36.8m	<b>£22.6m</b>	£10.4m	£40.3m
Option 5: Quarterly Data	<b>-£3.4m</b>	-£1.6m	-£6.2m	<b>-£1.5m</b>	-£0.7m	-£2.7m

**Options 1A and 1B, business as usual (BAU): providers continue to input data voluntarily on a monthly basis**

40. To calculate the annual cost to providers we take the following steps:
- Calculate the number of providers completing CT by taking the number of providers who would be mandated to complete CT (from the CQC registry as the policy applies to all CQC-registered Adult Social Care providers) and multiplying this by the expected response rate.
  - Calculate the time taken to upload per month per provider by adding together the time taken to upload to CT for each of the required pages and the time taken to prepare/collect the data.
  - Convert the time taken per month to a yearly figure in hours.
  - Multiply by the time taken per year by the number of providers completing CT to calculate the time taken for all providers.
  - Multiply the hours taken during the first year by the hourly pay to calculate the total cost for the first year.

41. For each option, we apply 3 different scenarios to take into account the uncertainty around how much time providers take to fill in the data collection tool. The central estimates are based on web analytics, surveys on a sample of providers and anecdotal evidence from providers.

**Table 2: Low, Central and High estimates for the time taken to collect and report data**

	Central	Low	High
Reading the specification for mandatory data collection (mins)	30.0	15.0	45.0
Time to complete capacity tracker direct upload pages (min) - Care homes	2.0	1.5	2.4
Time to complete capacity tracker direct upload pages (min) - Other providers, including domiciliary care	1.1	0.8	1.3
Time taken to collect and prepare information (mins) - Care homes	15.0	6.0	30.0
Time taken to collect and prepare information (mins) - Other providers, including domiciliary care	10.0	5.0	15.0

42. We cost two alternative BAU scenarios to account for the uncertainty around future response rates in the absence of mandation. Whilst current response rates are around 75% for care homes and 70% for domiciliary care, these have been slowly falling since April 2022 and we have reason to believe they may decrease over time. Providers are aware that mandation is going to be introduced which may have kept response rates high in anticipation of the collection becoming mandatory. We therefore also include an option with response rates of 40% for care homes and 35% for domiciliary care which is similar to pre-pandemic response rates. Some local areas were using CT before the pandemic and therefore 40% represents a reasonable lower bound for where CT response rates could fall to in the absence of mandation.

### Monetised costs

**Table 3: Costs of Business as Usual Options 1A and 1B (voluntary weekly collection)**

<b>Option 1 - continue weekly voluntary collection</b>		Transition cost in millions (year 1)	Annual cost in millions (nominal)
Scenario A - BAU with current response rates	<b>Central</b>	<b>£0.0m</b>	<b>£3.8m</b>
	Low	£0.0m	£1.8m

	High	£0.0m	£6.8m
Scenario B - BAU with lower response rates	<b>Central</b>	<b>£0.0m</b>	<b>£1.9m</b>
	Low	£0.0m	£0.9m
	High	£0.0m	£3.4m

### Benefits of collecting data from ASC providers

43. As explained above, we have not been able to quantify the value of receiving data directly from ASC providers, but the following case studies and testimonials demonstrate why this data is beneficial. Teams in DHSC have been using this data to monitor and evaluate their policies and target support where needed. This is beneficial for:
- care providers** because they receive the support they need;
  - local authorities** and **Clinical Commissioning Groups** because they are able to access data for providers in their areas and use this to target the support they provide; and
  - care users** because it allows us to monitor and evaluate the impact of policies and improve the quality of social care provision.

#### **Example 1: DHSC’s Adult Social Care Covid-19 Vaccines Team (case study from April 2021)**

*“The data has allowed us to **monitor** uptake nationally and at regional and local levels, and across a wide range of care settings. This means we have been able to take data informed decisions in conjunction with stakeholders to design support which targets low uptake areas of the sector.*

*We have been able to **evaluate** the impact of actions that have been taken, so we know what makes a material difference to getting the ASC sector vaccinated. We can see in real time if targeted interventions to drive uptake in specific areas is effective, and can adjust these interventions accordingly.*

*This data has allowed us to **inform** the public on progress of vaccine roll-out, giving accurate and up-to-date statistics which are published weekly on the NHS website.”*

#### **Example 2: DHSC’s Regional Assurance Team**

*“One key benefit identified by multiple team members has been the accurate picture of designated settings displayed by the Tracker: this unique feature has been described as ‘invaluable’ both in saving time and providing a consistent point of truth, and important for monitoring whether existing plans were practical and where additional help might be required. A number of the team also used the Tracker for an exercise in which they explored Covid-positive discharges to care settings, many of which were subsequently found to be designated settings, thereby driving improvements in both reporting and understanding of DHSC guidance.*

*More recently, the Capacity Tracker has provided the team with up-to-date information on vaccination rollout and uptake, which has been similarly helpful in allowing localised progress to be easily followed and compared with regional and national averages, ensuring that any problems in this crucial area could be quickly identified. Data such as that on PPE has also facilitated timely support where required by providers and local authorities.”*

#### **Example 3: Oxfordshire County Council (case study from November 2021)**

Oxfordshire County Council uses Capacity Tracker to give them a clear understanding of the status, capacity and capabilities of care providers in the county. They feed the data into the

council's bespoke dashboard to help senior staff gain an understanding of the current position with care providers and indicates what support providers require across the County.

*“We pull the information from the Capacity Tracker and populate the dashboard. This is done daily. The dashboard provides all the key indicators in one easy-to-analyse product. Of course, that accuracy is dependent on users inputting data on a regular basis, and that the data is accurate. The dashboard reveals information such as current vaccination status for care home and agency staff. We are now using the dashboard to monitor the uptake of the Covid-19 vaccination booster and the flu vaccination.”*

This highlights the importance of receiving regular data from providers through Capacity Tracker. The full case study on how Capacity Tracker data underpins intelligence and insight for decision-makers and Oxfordshire County Council is published [here](#), alongside other case studies from local government, providers and Clinical Commissioning Groups [here](#).

#### **Example 4: Kirklees health and care system (case study from November 2020)**

Kirklees Care Homes have been utilising Capacity Tracker since before the outbreak of Covid-19. Utilising the Capacity Tracker has supported the Kirklees system (Local Authority and the two Clinical Commissioning Groups, Greater Huddersfield and North Kirklees) to be able to closely monitor care home activity and inform regarding market sustainability.

The new Business Continuity features of the Capacity Tracker enabled the Local Authority and Clinical Commissioning Groups to identify those providers who were in need of the most support.

Those providers who had identified themselves as Red or Amber are contacted first by the contracts team in order to identify and understand the challenges being faced by these providers.

The full case study on use of Capacity Tracker in Kirklees is published [here](#).

Whilst the value of collecting data from providers has been clearly demonstrated during the pandemic, this case study shows how Capacity Tracker was useful for supporting care homes at a local level before the outbreak of Covid-19. This supports the continued use of Capacity Tracker as we exit from the emergency situation during the pandemic.

44. Although we do receive data from other sources, such as annual workforce data via Skills for Care (SfC), these collections do not cover the entire sector and/or have relatively low coverage (SfC coverage is c.50% of providers and workforce) and do not provide data with the frequency needed to provide rapid responses to changes in the sector as nearly all are published annually.

#### Non-monetised costs

45. Response rates have started to decrease after the recent removal of financial incentives, and it is likely they will decrease further, so we do not have coverage from the entire sector with voluntary collection. The quality of the data collected will be affected and may not be representative of the sector. For example, the data might be affected by selection bias: those providers who do not complete CT may be those we most need data on, or those providers which are under the most pressure might be less likely to have the resources to complete the data collection.
46. Poor data quality will prevent policy teams in DHSC from designing evidence based and relevant policies. This could have negative impacts on:

- a. **care providers** because they might not receive the support they need;
- b. **local authorities** and **Clinical Commissioning Groups** because they would not be able to access good quality data for providers in their areas and therefore will not be able to target the support they provide; and
- c. **care users** because it will prevent accurate monitoring and evaluating of the impact of policies and impede the improvement of the quality of social care provision.

47. If Capacity Tracker fails to provide reliable and useful data to LAs, CCGs and providers, it is likely that other local collections may be re-instated and we return to a pre-pandemic situation where data collections are duplicated and the data provision burden on providers is exacerbated.

**Option 2 (preferred): providers are required to complete Capacity Tracker on a monthly basis**

48. For the other options, we use the same methodology as for BAU but we assume a response rate of 100% because all providers would be required to complete CT under mandation.

49. We also calculate a one-off transition cost based on the time taken to familiarise themselves with the guidance specifying the mandatory data collection, multiplied by the hourly pay and number of providers.

50. Monetised costs: the annual cost of option 2 is lower than under BAU Options 1A and 1B because the frequency of collection is lower. There is also the additional transition cost to adapt to mandation which does not apply under BAU.

**Table 4: Costs of mandated monthly data collection (Option 2)**

<b>Option 2 - mandate a monthly collection (preferred)</b>	Transition cost in millions (year 1)	Annual cost in millions (nominal)	
<b>Gross costs of Option 2</b>			
Central	<b>£0.2m</b>	<b>£1.1m</b>	
Low	£0.1m	£0.5m	
High	£0.3m	£2.0m	
<b>Incremental costs compared to Option 1</b>			
Scenario A - BAU with current response rates	<b>Central</b>	<b>£0.2m</b>	<b>-£2.7m</b>
	Low	£0.1m	-£1.2m
	High	£0.3m	-£4.8m
Scenario B - BAU with lower response rates	<b>Central</b>	<b>£0.2m</b>	<b>-£0.8m</b>
	Low	£0.1m	-£0.4m
	High	£0.3m	-£1.4m

51. Non-monetised costs: collecting data on a monthly basis means we have less timely data than BAU Options 1A and 1B which means local and national government will not be able to react as quickly to changes in the sector.

**Non-monetised benefits**

52. Mandating data collection ensures we receive an unbiased overview of the whole sector because all providers are required to respond. In the absence of mandation, it is likely that

our data collection will be biased towards parts of the sector which are better able to submit data, for example large providers or those who are already digitised.

The case studies above demonstrate why it is beneficial to have data from the whole sector. Both local and national government use the data from capacity tracker to target support to those providers who need it.

53. Gathering regular and complete data from the sector will also allow monitoring and evaluation of the implementation of ASC reform, including charging reform. Timely data on the provider market and workforce pressures will reduce implementation risks for these policies.
54. Collecting data monthly means that the burden on providers will be lower and is proportional given that we are no longer in an emergency situation.

#### Benefits of a single central and standardised data collection

55. This intervention builds on principles developed at the start of the pandemic when, in a [joint letter](#) to all registered adult social care providers, the Care Provider Alliance, the Care Quality Commission, DHSC, NHS England and NHS Improvement agreed to only ask them for information once, via Capacity Tracker (CT), and to establish mechanisms to share that information appropriately between themselves, with local authorities, CCGs and other local bodies, in order to prevent duplication of data burdens on providers. This resulted in a single data collection, which produced timely and reliable data throughout the pandemic, and also increased data transparency, allowing providers and LAs to benchmark themselves.
56. Prior to the widespread adoption of Capacity Tracker, data was collected multiple times by various actors, especially local authorities, leading to duplication and added burden on providers. In setting up Capacity Tracker as the core data collection tool for the pandemic, local authorities agreed to suspend many of their collections and not introduce new ones as new needs arose, for example for Covid vaccination data. While it is not clear the extent to which this has been maintained across all areas, this policy seeks to embed and widen this use of a single standardised and nationally consistent data collection for use by multiple local and national users.
57. The mandation of Capacity Tracker as the data standard in the short term means that providers have the benefit of continuity and will only face the cost of transition to a new collection once, when the provider-level minimum data collection is launched.
58. Without mandation and in the absence of financial or other incentives to providers, there is a risk that the CT collection becomes unreliable (due to low response rates). It is also possible that local authorities, CCGs and other local bodies create or reinstate local data collections to meet their internal data needs. This would increase the burden on providers and impose additional costs on the sector, including transition costs to a different system. The net result would be a return to the fragmented, non-standardised data landscape noted unfavourably by OSR, while also removing any possibility of benchmarking against the wider system. However, these costs cannot currently be quantified as we lack information on the sector's appetite to take this route.
59. By continuing our engagement with the sector via the Capacity Tracker data collection, we are also maintaining a basis for the longer-term aim of a provider-level minimum data set. This is currently being developed in collaboration with sector stakeholders, including providers, local authorities and health and care arms-length bodies. We plan to progressively introduce this from April 2023, as a new mandatory and standardised data

collection that can meet the data needs of all stakeholders, support health and care integration and be managed in line with the principles of good data governance. We will be able to quantify the benefits of this new collection when it replaces Capacity Tracker with the benefit of the data gathered via the sector-wide consultation exercise which is currently underway.

60. We have not been able to quantify the value of this centralised data collection, but the following case studies and testimonials demonstrate why it is beneficial.

#### **Example 5: Reaping the rewards of using the Capacity Tracker across the East Midlands**

“We were originally using our own portal, as Capacity Tracker did not provide all the data we needed and were asking providers to fill in this portal. However, as the Capacity Tracker developed, we realised we were duplicating data and no longer needed our own portal. Capacity Tracker had progressed to a place where it provided everything that we wanted and needed, and eventually provided a more consistent picture of the data.”

“Between us all, when beginning to collaborate at the start of the pandemic, we had no idea of the true amount of care and residential homes that we had. We had many different numbers – in fact, each organisation had different figures, so there was never a true list. The Capacity Tracker gives us this confidence and supports us to continue working collaboratively. There is so much information available from the tool and it is still growing. Looking ahead, we will use it for purposes other than Covid-19 because it works so well.”

“In summary, we would recommend the Capacity Tracker as it is a great tool that can work in collaboration with other more personalised systems that CCGs and local authorities use, or those used by the providers and partners we work alongside, which means that it can work for everyone.”

The full case study on use of Capacity Tracker is published [here](#).

#### **Example 6: Use of Capacity Tracker at Telford and Wrekin CCG and Shropshire CCG**

*Once the immediate threat of COVID subsides, do you think you will ever go back to your local system?*

“I don’t believe so. We’ve now got to the position where everyone likes it, and they are using it very well. We’ve also seen the benefits it provides. I can’t see us reverting to the old system when we have 100% of the care homes in our area now using Capacity Tracker”

The full case study on use of Capacity Tracker is published [here](#).

#### **Example 7: Benefits of Using the Capacity Tracker in Mid and South East Essex**

“Prior to the tracker being in place, we also tried to collect business continuity information ourselves, but this was really difficult. The business continuity reports on the Capacity Tracker have enabled us to monitor use of PPE and therefore to be more proactive in approaching those providers reporting low levels of PPE. Therefore, if the care homes keep all the information updated it will reduce the level of calls being made to them.”

The full case study on use of Capacity Tracker is published [here](#).

**Option 3: providers are required to complete Capacity Tracker on a weekly basis**

61. The cost of this option is higher than BAU because response rates are higher under mandation, despite having the same collection frequency. There is also an additional transition cost for providers to familiarise themselves with the collection.

62. Mandating a weekly collection has a higher cost to providers than a monthly collection (under option 2) because the collection frequency is higher. This means that we get more timely data and would be able to provide targeted support and make policy decisions more rapidly. However, as we move out of an emergency situation, this cost to providers may be seen as disproportionate. This may affect the constructive relationship between DHSC and the sector which would have negative impacts on the implementation future policies.

**Table 5: Costs of mandated weekly data collection (Option 3)**

<b>Option 3 - mandate a weekly collection</b>	Transition cost in millions (year 1)	Annual cost in millions (nominal)	
<b>Gross costs of Option 3</b>			
Central	£0.2m	£5.0m	
Low	£0.1m	£2.3m	
High	£0.3m	£8.8m	
<b>Incremental costs compared to Option 1</b>			
Scenario A - BAU with current response rates	<b>Central</b>	£0.2m	£1.2m
	Low	£0.1m	£0.5m
	High	£0.3m	£2.0m
Scenario B - BAU with lower response rates	<b>Central</b>	£0.2m	£3.1m
	Low	£0.1m	£1.4m
	High	£0.3m	£5.4m

**Option 4: providers are required to complete Capacity Tracker on a daily basis**

63. The cost of this option is higher than BAU because there are higher response rates and the frequency of collection is higher.

64. Providers were asked to submit data daily during the pandemic which gave us very timely data and enabled us to respond quickly to the state of the sector. This placed a significant burden on providers which would no longer be proportionate now we are not in an emergency situation.

65. Mandating a daily collection will put a significant burden on providers and is likely to affect the constructive relationship between DHSC and the sector. This would have negative impacts on the implementation future policies and DHSC might face significant amounts of resistance from stakeholders.

**Table 6: Costs of mandating daily data collection (Option 4)**

<b>Option 4 - mandate a daily collection</b>	Transition cost in millions (year 1)	Annual cost in millions (nominal)
<b>Gross costs of Option 4</b>		

Central		£0.2m	£24.5m
Low		£0.1m	£11.3m
High		£0.3m	£43.7m
<b>Incremental costs compared to Option 1</b>			
Scenario A - BAU with current response rates	<b>Central</b>	£0.2m	£20.7m
	Low	£0.1m	£9.5m
	High	£0.3m	£36.8m
Scenario B - BAU with lower response rates	<b>Central</b>	£0.2m	£22.6m
	Low	£0.1m	£10.4m
	High	£0.3m	£40.3m

**Option 5: providers are required to complete Capacity Tracker on a quarterly basis**

66. The cost of this option is lower than BAU and the preferred option (Option 2) due to the lower frequency of data collection.

67. However, this would not provide us with data at the frequency needed by local and national government. For example, as the collection is the only source of COVID-19 and flu vaccination data for the adult social care workforce, the Department and NHSE would not be able to quickly detect any changes in vaccination rates or target support where most needed to drive uptake; as the flu season runs September to March there only would only be three data points each season. The Department and local systems would also not be able to react quickly enough to business continuity issues arising in the sector such as workforce pressures. As a by-product local government would be extremely likely to stand up their own collections and /or contact providers directly, creating additional burdens for providers.

**Table 7: Costs of mandating a quarterly collection (Option 5)**

<b>Option 5 - mandate a quarterly collection</b>	Transition cost in millions (year 1)	Annual cost in millions (nominal)	
<b>Gross costs of Option 5</b>			
Central	£0.2m	£0.4m	
Low	£0.1m	£0.2m	
High	£0.3m	£0.7m	
<b>Incremental costs compared to Option 1</b>			
Scenario A - BAU with current response rates	<b>Central</b>	£0.2m	-£3.4m
	Low	£0.1m	-£1.6m
	High	£0.3m	-£6.2m
Scenario B - BAU with lower response rates	<b>Central</b>	£0.2m	-£1.5m
	Low	£0.1m	-£0.7m
	High	£0.3m	-£2.7m

**Sensitivity testing (ST)**

68. The options set out above are based on the assumptions that:

- a. the number of providers stays constant
- b. the collection size stays constant

69. In order to test the sensitivity of the model to these assumptions, we have calculated the impact of the following situations, under the option 2 central scenario assumptions:

- a. ST1.A: the collection size increases by 20%
- b. ST1.B: the collection size decreases by 20%
- c. ST2.A: the number of all providers decreases by 5 %
- d. ST2.B: the number of all providers increases by 5 %
- e. ST2.C: the number of providers changes with the 21/22 growth rates (the number of nursing care homes decreases by 1%, non-nursing care homes decreases by 2% and other types of providers increases by 8%)

70. Whilst we have applied these sensitivity tests to our preferred option, these assumptions have also been used to calculate the gross costs of the BAU option and the other options. Therefore, the conclusions drawn from the sensitivity testing on option 2 (i.e. that the change in annual cost is proportional to changes in collection size and provider number) would also apply to the other options.

### Collection size

71. The collection size is susceptible to change when the longer-term provider data collection is set up. The size of the collection will reflect the various needs of different stakeholders and the information on burden to providers that we will collect during the consultation phase. In order to quantify the potential effect of these changes, we have costed two different scenarios.

#### ST1.A

72. To calculate the impact of an increase in the collection size, we apply the same method as for Option 2 with central estimates, but we increase the time taken to gather and upload the data by 20% and we add a transitional cost to gather the additional data for the first time (10 hours) and to read the new data specification (30 min).

73. In this scenario, the transition cost is substantially higher due to the 10 hours accounted for to gather the data for the first time. The annual cost difference, however, is proportional to the change in collection size.

#### ST1.B

74. For the impact of a decrease in the collection size by 20%, we reduce timings by 20% and add a one-off transitional cost to adapt to the new data specification.

75. In this scenario, the difference to Option 2 Central is proportional to change in collection size.

**Table 8: Transition and annual costs of the preferred option (option 2)**

	Transition cost in millions (year 1)	Annual cost	
		Cost in million (nominal)	Change to Option 2Central
Option 2 Central	£0.2m	£1.1m	NA
Option 2 Central – ST1.A	£4.3m	£1.4m	20%
Option 2 Central – ST1.B	£0.4m	£.9m	-20%

### Number of providers

#### ST2.A

76. To calculate the impact of a decrease in the number of providers, we apply the same method as for Option 2 with central estimates, but we decrease the number of providers by 5% (across all three categories of providers: non-nursing care homes, nursing care homes and other care providers). We calculate the impact for one year only. The impact for following years will be the same.

77. In this scenario, the difference to Option 2 Central is proportional to the change in the number of providers.

**ST2.B**

78. To calculate the impact of an increase in the number of providers, we apply the same method as for Option 2 with central estimates, but we increase the number of providers by 5% (across all three categories of providers: non-nursing care homes, nursing care homes and other care providers). We calculate the impact for one year only. The impact for following years will be the same.

79. In this scenario, the difference to Option 2 Central is proportional to the change in the number of providers.

**ST2.C**

80. This scenario applies the 21/22 growth rates to the first year, for each provider group:  
 a. nursing care homes decreases by 1%  
 b. non-nursing care homes decreases by 2%  
 c. other types of providers increases by 8%

81. We calculate the impact for one year only. The impact for following years will be the same.

82. In this scenario, the difference to Option 2 Central is minimal (1% increase).

**Table 9: Annual costs and change in costs of preferred option (Option 2)**

	Annual cost	
	Cost in million (nominal)	Change to Option 2 Central
Option 2 Central	£1.1m	
Option 2 Central – ST2.A	£1.1m	-5%
Option 2 Central – ST2.B	£1.2m	5%
Option 2 Central – ST2.C	£1.2m	1%

**Direct costs and benefits to business calculations**

83. Given that all of the costs listed in the section on ‘monetised and non-monetised costs and benefits’ relate to businesses, see section above for the direct costs and benefits to business.

**Risks and assumptions**

**Risks**

84. In the event of another Covid-19 wave (or similar public health emergency), there may be an urgent need to increase the volume and frequency of mandated data collection. If this is likely to significantly increase the data collection burden on providers, we would also review the support given to providers at that time.

85. There may also be a need to increase the collection size in future, for example by adding new data items to allow monitoring of ASC reform policies. We have considered the impact of increasing the collection size by 20% in our sensitivity analysis, but it is possible that the collection size may need to increase by more than 20% as data needs change. Any change to the collection would be co-developed with the sector to ensure it meets the data needs of local and national government and providers themselves. Providers will be given sufficient notice of any change to the collection and if it changes substantially such that the impact on providers would be very different, another impact assessment would be conducted.

86. In this impact assessment we have assumed that all providers will comply with the mandatory data requirements. However, there is a risk that some providers do not submit the required data and therefore we would have to take enforcement action. This could result in increased costs to those providers due to fines for non-compliant providers and reduces the benefits because we would not have complete coverage of the ASC sector. The enforcement of this policy is not due to commence until November and a separate impact assessment will be conducted which considers the impact of enforcement action.

**Table 10: Assessment of assumptions**

<b>Assumption</b>	<b>Rationale and likely impact</b>
Managerial staff complete capacity tracker	<p>Providing data is likely to fall under the remit of managerial and/or administrative staff rather than care staff, although this may not always be the case. This means that we may have overestimated the cost to providers as managerial staff have the highest hourly pay rate.</p> <p>Reducing hourly wage by £2 results in a 14% decrease in the cost, under Option 2 Central assumptions.</p>
100% of providers complete capacity tracker when it is mandatory	<p>Under mandation, all providers would be required to complete Capacity Tracker. Whilst the achieved response rate may be lower (providers may occasionally miss the window for providing data or choose to ignore the mandation) we use 100% because that is the maximum burden that the policy imposes on providers. This means that we may have overestimated the cost to providers if a 100% response rate is not achieved.</p> <p>Reducing response rates to 80% results in a decrease on the total cost to providers by 20%, under Option 2 Central assumptions.</p> <p>There is a particular risk of lower compliance during the first few months of the mandatory data collection because the associated enforcement regulations are not due to commence until November. We do not know what the impact of this will be, but we expect that the response rates after mandation is introduced will be at least as high as under BAU Option 1 Scenario A because it is unlikely they would drop below current levels as a result of the collection becoming mandatory.</p>
Response rates in the absence of mandation will be 80% for care	<p>This is based on average weekly response rates in Capacity Tracker over the last 4 months, under the current voluntary collection.</p>

<p>homes and 70% for other care providers</p>	<p>We have not seen a large decline in response rates since the removal of Infection Control Funding at the end of March, as shown in the chart below.</p> <p><b>Figure 1: CT response rates over time, January to April 2022</b></p> <table border="1"> <caption>Data for Figure 1: CT response rates over time, January to April 2022</caption> <thead> <tr> <th>Date</th> <th>Care homes (%)</th> <th>Home care (%)</th> </tr> </thead> <tbody> <tr><td>04/01/2022</td><td>85</td><td>75</td></tr> <tr><td>11/01/2022</td><td>90</td><td>78</td></tr> <tr><td>18/01/2022</td><td>88</td><td>78</td></tr> <tr><td>25/01/2022</td><td>85</td><td>78</td></tr> <tr><td>01/02/2022</td><td>82</td><td>78</td></tr> <tr><td>08/02/2022</td><td>88</td><td>79</td></tr> <tr><td>15/02/2022</td><td>88</td><td>79</td></tr> <tr><td>22/02/2022</td><td>86</td><td>79</td></tr> <tr><td>01/03/2022</td><td>85</td><td>76</td></tr> <tr><td>08/03/2022</td><td>85</td><td>77</td></tr> <tr><td>15/03/2022</td><td>87</td><td>80</td></tr> <tr><td>22/03/2022</td><td>85.9</td><td>78.8</td></tr> <tr><td>29/03/2022</td><td>85</td><td>76</td></tr> <tr><td>05/04/2022</td><td>84</td><td>79</td></tr> <tr><td>12/04/2022</td><td>82</td><td>76</td></tr> <tr><td>19/04/2022</td><td>80</td><td>68</td></tr> <tr><td>26/04/2022</td><td>83</td><td>75.1</td></tr> </tbody> </table> <p><b>Source: <u>Adult social care in England, monthly statistics: May 2022</u></b></p> <p>However, it is likely that response rates have remained high in anticipation of the mandation of data provision. If mandation does not occur, it is likely that response rates will return to pre-pandemic levels of 40-50%.</p> <p>We have taken account of this by also costing Option 1 Scenario B to show what the BAU costs would be if response rates did return to pre-pandemic levels.</p>	Date	Care homes (%)	Home care (%)	04/01/2022	85	75	11/01/2022	90	78	18/01/2022	88	78	25/01/2022	85	78	01/02/2022	82	78	08/02/2022	88	79	15/02/2022	88	79	22/02/2022	86	79	01/03/2022	85	76	08/03/2022	85	77	15/03/2022	87	80	22/03/2022	85.9	78.8	29/03/2022	85	76	05/04/2022	84	79	12/04/2022	82	76	19/04/2022	80	68	26/04/2022	83	75.1
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<p>One person from each provider must read the specification for the mandatory data collection and this takes an average of 30 minutes</p>	<p>The full guidance which providers need to read has not yet been completed so we don't know how long it will be, but we have included this cost to recognise that providers will need to dedicate some time to this activity. Guidance on certain data items has been issued to help providers prepare and we have used this as a basis of our assumptions. We have also included low and high options of 15 and 45 minutes.</p>																																																						
<p>In the central scenario, we assume that the collection size stays constant</p>	<p>Feedback from providers tells us that it takes them longer to complete capacity tracker just after a change to the collection. We do not know how many times the collection will change because this will be dependent on future data needs.</p> <p>In the cost and benefits section we present scenarios ST1.A and ST1.B. ST1.A presents a situation in which the collection size is increased by 20% and the provider requires 10 hours to collect the data for the first time. This scenario presents a transition cost which is over 20 times that of Option 2 Central. The annual cost for this scenario is only 20% higher, which is proportional to the increase in the collection size.</p>																																																						

<p>The time taken to complete the Capacity Tracker collection will remain approximately the same as it is now</p>	<p>We do not know how the collection will change in future. It is more likely that the collection will decrease in length than increase in length as we transition to 'Living with COVID'. However, there may be a need to increase its length in future, for example in the winter flu season or if there is a new COVID variant.</p> <p>In the cost and benefits section, we present scenarios ST1.A and ST1.B, which set out increases/decreases of the collection by 20%.</p> <p>In the event of a 20% decrease in the collection size, the annual cost will reduce by 20%, compared to Option 2 Central.</p>
<p>All providers use direct upload</p>	<p>Whilst we are aware that the bulk upload feature is used, and by up to as many as 60% of providers (from soft intelligence from NECS), we have been unable to collect enough data to be able to model bulk uploads in a reasonable way. With the small amount of data we were able to collect on bulk upload providers, the time per location spent on uploading was reported to be lower than those using direct upload. Following this, by using an assumption that only direct upload is used, we provide a conservative overestimate of costs. It also follows that, since direct upload is an option, these providers would only use the bulk upload feature if it was saving them time, strengthening the argument that this is an overestimate.</p>
<p>Google Analytics data on the time it takes to fill in CT represents a typical week for all providers</p>	<p>We have Google Analytics data on the time taken to complete Capacity Tracker in a particular week (4-10 April 2022) and have used this as the basis of our calculation. This may be an overestimate because there was a change to the collection on 4 April which reduced the amount of information required from providers, and therefore these assumptions may have been an overestimation of the amount of time spent filling in CT because feedback from providers tells us that it takes longer to complete the collection when there has been a change. This means we might be overestimating the costs to providers.</p>
<p>The number of CQC registered providers will not change significantly from the number in April 2022</p>	<p>As we are unable to forecast how the number of providers will change over time, we have assumed a constant number of providers.</p> <p>In the cost and benefits section, we provide some sensitivity analysis around the number of providers. We present the change in costs for the 1<sup>st</sup> year of implementation in the case where all provider categories increase or decrease by 5%. We also present the case where the 21/22 growth rates apply to the first year of implementation (nursing care homes decreased by 1%, non-nursing care homes decreased by 2% and other types of providers increased by 8%). This last scenario results in a 1% increase in the annual cost.</p> <p><b>Figure 2: Changes in number of care providers over time</b></p>

	<table border="1"> <caption>Estimated Wage Data from Graph</caption> <thead> <tr> <th>Date</th> <th>CH nursing</th> <th>CH non-nursing</th> <th>Other (including dom care)</th> </tr> </thead> <tbody> <tr> <td>2020-12-01</td> <td>4300</td> <td>11000</td> <td>10800</td> </tr> <tr> <td>2021-01-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2021-02-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2021-03-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2021-04-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2021-05-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2021-06-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2021-07-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2021-08-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2021-09-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2021-10-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2021-11-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2021-12-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2022-01-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2022-02-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2022-03-01</td> <td>4300</td> <td>11000</td> <td>11000</td> </tr> <tr> <td>2022-04-01</td> <td>4300</td> <td>10700</td> <td>12000</td> </tr> </tbody> </table>	Date	CH nursing	CH non-nursing	Other (including dom care)	2020-12-01	4300	11000	10800	2021-01-01	4300	11000	11000	2021-02-01	4300	11000	11000	2021-03-01	4300	11000	11000	2021-04-01	4300	11000	11000	2021-05-01	4300	11000	11000	2021-06-01	4300	11000	11000	2021-07-01	4300	11000	11000	2021-08-01	4300	11000	11000	2021-09-01	4300	11000	11000	2021-10-01	4300	11000	11000	2021-11-01	4300	11000	11000	2021-12-01	4300	11000	11000	2022-01-01	4300	11000	11000	2022-02-01	4300	11000	11000	2022-03-01	4300	11000	11000	2022-04-01	4300	10700	12000
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<p>Managerial wages will be steady into the future</p>	<p>Skills for Care data (found through the <a href="#">interactive dashboard</a><sup>1</sup>) on historic trends suggests that real wages for managerial social care staff have been steady in the past. We assume this trend would continue.</p> <p>Reducing hourly wage by £2 results in a 14% decrease in the cost, under Option 2 Central assumptions.</p>																																																																								
<p>Any large-scale event such as a Covid wave would bring in extra funding/assistance</p>	<p>Our analysis does not account for a potential increase in user numbers or a dramatic increase in data needed or the frequency needed. Whilst this may occur due to, for example another Covid wave, in the past this has been accompanied by an extension of ICF funding to incentivise data collection, and as such, we would expect this to extend to such events in future. In this scenario, there might be a need to move to policy option 3 or 4 for more regular updates, but cost would be mitigated.</p>																																																																								
<p>No need to train anyone new to fill in CT or replace equipment at any point</p>	<p>Since the data is already being collected, there has been no assessment of the cost of becoming familiar with the capacity tracker system, or costs of setting up or buying the hardware necessary. Whilst this is true for the present, it may be necessary in the future to train someone else in using the system, or replace existing IT stock. Given the social care staff turnover rate, it is likely that new people will periodically need to be trained in using the CT software. This would likely be a small amount of time, however, by assuming this does not occur our estimated costs would be slightly underestimated.</p>																																																																								

<sup>1</sup> To find managerial pay first click the green “Press here to view more data from the report” button two times, then go to the “pay” button at the top of the page. From here graphs can be filtered by staff type and to show real and nominal pay over time.

## Impact on small and micro businesses

87. The provision of social care is undertaken by a large number of private companies. Of these, approximately 70% have a staff count of 49 staff or less and would therefore be classified as small or micro businesses.

**Table 11: Percentage of providers recorded as small or micro businesses**

	% of all providers who provided CT data on 26 April 2022
Micro (< 9 staff)	11%
Small (< 49 staff)	59%
Other	30%

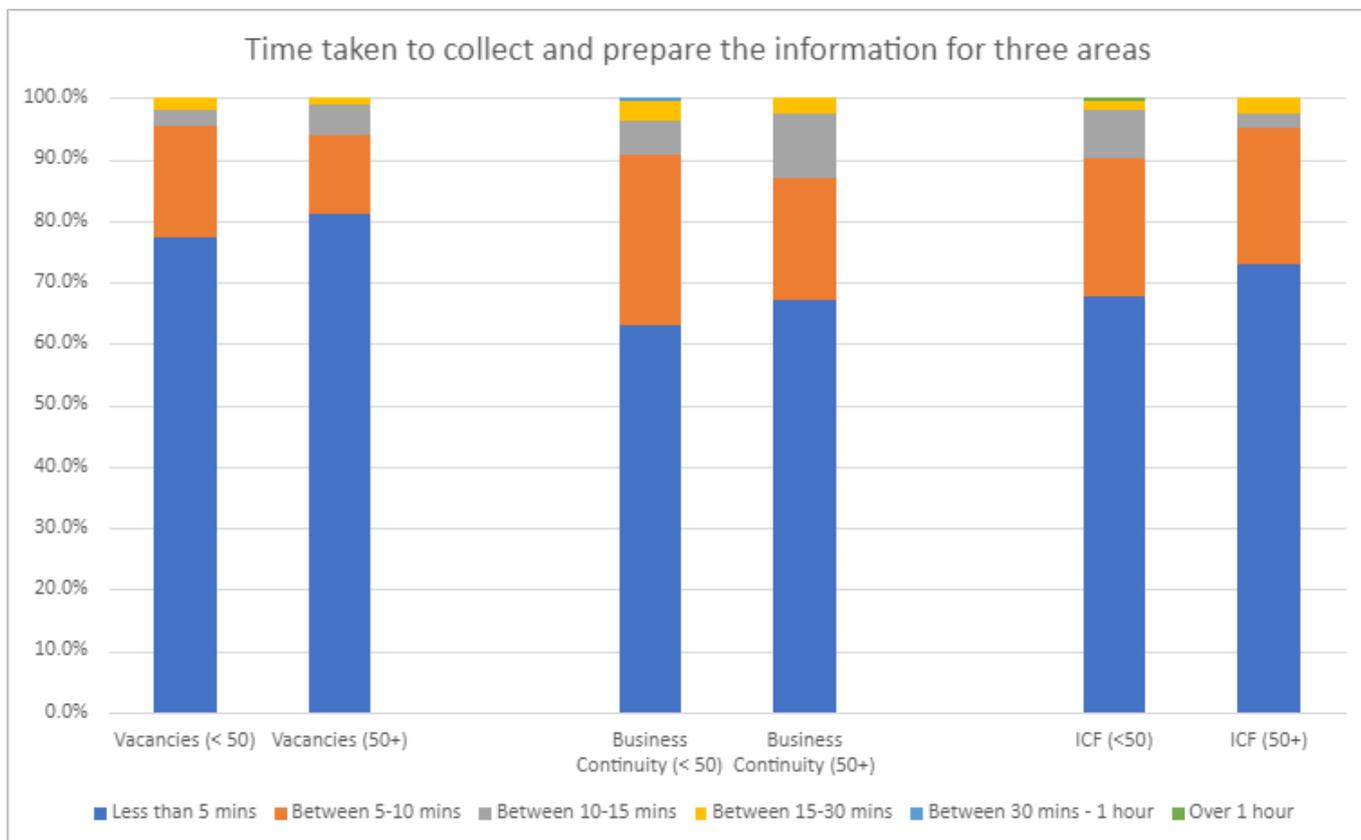
88. This means that exempting small and micro businesses (SMBs) is not a viable option as only 30% of providers would be required to provide data, which would only provide a partial picture of the care sector and market, and therefore defeat the purpose of a mandatory collection.

89. Exempting SMBs may also impact negatively on those businesses, as failing to collect data from such providers would mean that future policy decisions made from the data would not take into account the situation of SMBs, and thus may fail to meet their needs.

90. Mitigation measures, such as less frequent data collection, or collecting less data from SMBs would also render much of the rest of data collection ineffective.

91. Following data collected by NECS support team, the time of data collection for locations with 49 or less staff was not significantly different from the time taken by larger providers. This suggests that the burden on SMBs is not disproportional. The graph below shows the responses from locations on the time taken to collect and prepare the information for capacity tracker for the three key areas of vacancies, business continuity and Infection Control Fund (ICF). This is split by respondents with 49 or less staff, and those with 50 and above.

**Figure 3: Time taken to prepare information for capacity tracker as reported by providers with 49 or fewer staff and those with 50 or more staff**



92. Since the data is already provided by SMBs currently in a voluntary system, we can see that the costs of setting up systems in which to collect the data have already been accounted for.

93. It is also worth noting that soft intelligence from NECS suggests any changes to the data collected in future will be less burdensome on those who do not use the bulk upload function of capacity tracker. This means that any future changes to data collection would also not be overly burdensome for SMBs.

94. Given that it is not reasonable to exempt or mitigate SMBs from the collection of data, due to their large market share, and that information gathered suggests that the burden on SMBs would not be disproportional, the policy will apply to small and micro businesses, with no mitigation.

### **Wider impacts (consider the impacts of your proposals)**

95. This policy may have indirect equalities impacts due to the fact that the additional data from social care providers can be used to improve outcomes in social care. The collection includes data on the social care workforce, which could be used to benefit social care workers, for example, by evidencing staff shortfalls and thus allowing measures to be put in place to prevent staff burnout. The social care workforce has disproportionate representation of female workers (82%) and workers from black, Asian and other ethnic minority backgrounds (21%)<sup>2</sup> compared with the UK population, so this could be disproportionately beneficial to people who share these protected characteristics on average, compared with people who do not.

<sup>2</sup> Source: Skills for Care, ASC Workforce Statistical Appendix 2021 [ASC-Workforce-Statistical-Appendix-2021.xlsx \(live.com\)](#). Figures broken down by ethnic background are not published at the England level.

96. We have considered whether these policies will have differential impacts in rural and urban areas and assess that this is unlikely to be the case because providers in both rural and urban areas are already completing Capacity Tracker and therefore have the required equipment and infrastructure (e.g. internet connection).
97. We assess that the environmental impact of all of these options will be negligible because care providers already have the equipment and software necessary to submit data to capacity tracker, given that it has been a requirement for them to do so in order to receive Infection Prevention and Control Funding during the pandemic. Whilst providers use computers/laptops/tablets to complete the data collection, we do not anticipate that using these for a few minutes a month to complete Capacity Tracker will have a significant carbon impact given that the providers would be using these devices for other purposes.
98. We have assessed that these options are unlikely to affect competition in the adult social care market. They do not directly or indirectly limit the number or range of suppliers and do not reduce their ability to compete because they apply to all adult social care providers. Individual provider level data from Capacity Tracker is not published so these options would not mean that providers are able to access commercially sensitive data about their competitors.
99. A justice impact test (JIT) is not required in this case because this impact assessment relates only to making the provision of data mandatory and not to the enforcement of this mandation, which will come into force at a later date.

## **A summary of the potential trade implications of measure**

100. There is no impact on international trade and investment.

## **Monitoring and Evaluation**

101. The associated enforcement clauses, which are yet to come into force, include a requirement for a statutory review every five years with a report published. This will review the enforcement of data mandation and therefore the scope of this review is likely to include an evaluation of the mandation itself. We will specify evaluation plans for this once the enforcement regulations are in place. Key evaluation metrics are likely to be the proportion of providers completing the data collection, and the number of enforcement actions taken.
102. The objective of this policy is to increase the provision of data from adult social care providers so we will monitor and evaluate its effectiveness by tracking response rates to Capacity Tracker. We have historical data on response rates throughout the COVID-19 pandemic so we will be able to compare response rates after this policy comes into force to historical levels. We have seen response rates decrease as we have moved into Living with Covid, particularly since the end of the ICTF (31 March 2022) and expect these to continue to plateau or decrease further until mandation begins in July (exact date tbc), so would compare response rates after data provision becomes mandatory to those immediately before it comes into force.
103. There is uncertainty around what response rates would be in the absence of mandation, which would be the counterfactual for evaluation of this policy. We therefore plan to compare response rates to both the response rates before mandation and response rates pre-pandemic, as we have done in costing the BAU option.
104. The data collection will also continue to be subject to oversight and review, following the now well-established governance processes for provider data collection put

in place in the early months of the pandemic. These include full review of all data proposed to be collected by provider representatives from Care Providers Alliance (CPA), Home Care Association (HCA), National Care Forum (NCF), Care Association Alliance (CAA) and Care England as well as Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Care Quality Commission (CQC), Department for Levelling Up, Housing and Communities (DLUHC), DHSC, NHS England and NHS Improvement (NHSEI) and NHS North of England Commissioning Support Unit (NECSU) that make up the Data Advisory Group.