National Audit Office

Report
by the Comptroller
and Auditor General

Department of Health

Care Act first-phase reforms

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Department of Health

Care Act first-phase reforms

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

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This report considers if the Department is carrying out Phase 1 of the Care Act in a way that is likely to achieve the government's objectives and be value for money.

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Contents

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Key facts

£14.4bn
local authority budgeted net spending on adult social care, 2014-15

£1.1bn
our estimate of fall in budgeted net spending on social care, 2010-11 to 2014-15

£470m
Care Act funding, 2015-16

152	local authorities with adult social care responsibility
99%	of councils very or fairly confident of achieving Phase 1 reforms by April 2015 (January 2015 stocktake)
£2.5bn	to carry out the Care Act Phase 1 and associated white paper commitments from 2013-14 to 2019-20
44%	projected increase in the number of people 65 and over, and who are in need, between 2005 and 2020
14%	fall in the number of people aged 65 or over receiving social care assessments between 2005 and 2013
30%	fall in the number of people aged 65 or over receiving social care services between 2005 and 2013
4%	of carers reported an assessment of their needs, 2010

Summary

1 Social care is personal care and practical support for people with physical disabilities, learning disabilities, or physical or mental illness. In 2012, the government set out its plan to reform care and support in the white paper *Caring for our future: reforming care and support*.[1] The objectives are to reduce reliance on formal care, to promote people's independence and well-being, and give people more control of their own care and support. The Department of Health (the Department) is responsible for achieving these objectives through the Care Act 2014, which it is doing in two phases.

2 The Care Act puts new legal responsibilities on local authorities in England and requires them to cooperate with local partners to meet them (**Figure 1** overleaf). As we have reported previously, only a small proportion of care is publicly funded. Unpaid family, friends and neighbours provide most care and support. Many adults pay for some or all of their formal care. But for many councils, adult social care is one of the biggest areas of spending. Local authorities provide universal and preventative services and usually only pay for individual packages of care for adults assessed as having high needs and limited means.[2] We estimate local authority net spend on adult social care in 2014-15 at £14.4 billion.

Scope of our report

3 This report looks at the Phase 1 changes occurring in April 2015 and the financial impact for 2015-16 of Phase 2 changes. We consider if the Department is carrying out Phase 1 in a way that is likely to achieve the government's objectives and be value for money. We have focused on the new duties to provide assessments and services to carers, and help for self-funders. We considered:

- the policy, financial and demographic contexts within which the changes are being implemented (Part One);
- the Department's arrangements to carry out the Care Act, and local authorities preparation for 2015-16 (Part Two); and
- funding which the Department has provided to introduce the Care Act in 2015-16 (Part Three).

4 We interviewed Department staff and examined Department data and interviewed stakeholders. Locally, we visited nine case study areas. Our audit approach is in Appendices One and Two.

1 HM Government, *Caring for our future: reforming care and support*, Cm 8378, July 2012.
2 Comptroller and Auditor General, *Adult social care in England: overview*, Session 2013-14, HC 1102, National Audit Office, March 2014.

Figure 1
The main changes in the Care Act 2014

The Department of Health is implementing the Care Act in two phases

Phase 1: The main changes introduced from April 2015 include duties on local authorities to:

- provide services that prevent care needs from becoming more serious, or delay the impact of their needs;
- meet a national minimum level of eligibility for a person's care and support needs;
- assess carers, regardless of how much care they provide, and meet carers' needs on a similar basis to those they care for;
- offer deferred payment or loan agreements to more people, avoiding property sales to pay for care and support;
- provide information and advice (including financial advice) on care and support services to all, regardless of care needs;
- provide an independent advocate where such support is needed;
- work with care providers to get a diverse and high-quality range of local services;
- comply with a new legal framework for protection of adults at risk of abuse or neglect;
- give continuity of care to those whose needs are being funded by the local authority who choose to move to another area;
- assess the care and support needs of children and their carers, who may need support after they turn 18, as they move to adult social care; and
- arrange and fund services to meet the care and support needs of adults who are detained in prison.

Phase 2: The main changes planned from April 2016:

- A cap (£72,000 for people aged 65 and over) on the amount someone will pay towards care and support, regardless of means, and monitored through a care account. This should encourage people who pay for their care (self-funders) to seek a needs assessment. The authority can then count their care costs towards their cap.
- An increase in the threshold, above which people start to contribute to their residential care costs, to £118,000.
- The right for people to appeal against local authority decisions about their care and support.

Source: Department of Health

Key findings

New approach to care and resource context

5 **The Department is introducing a new approach to adult social care which places new responsibilities on local authorities. We estimate Phase one of the Care Act will cost £2.5 billion to carry out from 2013-14 to 2019-20**. The government wants culture change, away from a system providing people with intensive support to one which empowers users and carers and promotes wellbeing and independence. The £2.5 billion includes some costs associated with the white paper which did not require legislation. Over half, or £1.2 billion, is for carers' assessments and services; a new entitlement and the largest single cost (paragraphs 1.2 to 1.4).

6 **Local authority budgets are falling and the proportion of savings from adult social care is rising**. The government cut its funding to local authorities by 37% in real terms between 2010-11 and 2015-16. Adult social care accounted for 15% of total savings from 2010-11 to 2011-12 but made up 40% of total savings between 2013-14 and 2014-15 (paragraphs 1.5 to 1.6).

7 **The Care Act will increase demand for assessments and services at a time when local authority provision has been falling and the number of people in need is rising**. Extended rights to carers' assessments, new entitlements to services for carers, and additional incentives for those who seem to be in need to seek assessments, including self-funders, will increase demand on local authorities. The population is ageing and the number of people over 65, and who are in need, is expected to rise by over 40% between 2005 and 2020. Better healthcare means that more ill and disabled children reach adulthood. In recent years, however, the number of carers' assessments and people receiving services has fallen, particularly for those aged 65 and over (paragraphs 1.9 to 1.11 and Figure 4).

Management arrangements and local authority readiness

8 **The Department's innovative joint governance with the sector has provided the support necessary to carry out this challenging piece of legislation**. The Department is overseeing the programme, with stakeholders on the main programme board. A programme management office, set up jointly with the Local Government Association and the Association of Directors of Adult Social Services, leads implementation. The main innovation is that stakeholders are partners, taking on responsibility and not just giving advice. This has been well received by local government and stakeholders (paragraph 2.2).

9 **The Department has consulted carefully on the Act, to understand the main risks and respond to sector concerns, and there is wide support for the Act**. Stakeholders have been involved in working groups to inform development of the policy and to produce the regulations and guidance which support the Act. The 'stocktake' survey of local authority preparation to implement the Act got a 100% response rate. Local authorities identified two big risks: cost, and uncertain additional demand from self-funders and carers. Consultation on draft guidance and regulations got 4,000 responses and the Department made changes as a result. Almost all responses to the government's consultation, and those we spoke to in our fieldwork, support the objectives of the Care Act (paragraphs 2.3 to 2.7 and 2.18).

10 The Department, working with the sector, has provided guidance materials and will give extra support to local authorities. The programme management office has organised events and meetings, and has commissioned tools and guidance. The sector has been involved in setting these materials' requirements and making sure they meet the required standards. The Department has provided funding to local authorities to support their preparation for the Care Act and has a strategy to provide increasing levels of support to those which need it (paragraphs 2.8 to 2.11).

11 The Department's tight time frame for the sector to act on final guidance and funding allocations has inhibited local implementation planning in some areas. The Department has worked with stakeholders over a long period to develop the policy, legislation and supporting regulations and guidance. The Department published its final regulations and guidance 5 months and 10 days before the Care Act was due to be introduced. The 'stocktake' surveys found that pressures on councils, compounded with uncertainty on key guidance and information, had delayed or otherwise affected Care Act preparations. For example, stakeholders and councils could not produce support material until the Department published final regulations and guidance (paragraphs 2.12 to 2.13).

12 Despite the challenging timetable, of local authorities with adult social care responsibilities, 99% were confident that they would be able to carry out the Care Act reforms from April 2015. However, it will take longer to change the culture. Most local authorities are confident that they will meet their statutory duties; for example, providing information and advice and giving carers extra support. However, it will take longer to make the culture change envisaged in the Care Act. Some local authorities will find implementation easier depending on which services they already offer, such as support for carers, and systems already in place (paragraphs 2.14 to 2.15).

Demand for local authority services

13 The Department might have underestimated the demand for assessments and services for carers. Calculating demand is complex and it is difficult to be precise. The Department considered a number of ways of estimating take up and decided to use, as a proxy, the number of people receiving Carer's Allowance, which the programme board judged was reasonable as an approach. We reviewed this and concluded that those carers who have applied for Carer's Allowance and are eligible, but do not get it due to receipt of other allowances, are as likely to seek an assessment. We estimate that this equates to a risk of some £27 million (26%) in extra assessments and services if these people also come forward (paragraphs 3.8 to 3.10).

14 Demand from self-funders is uncertain, particularly from those in the community. The Department, based on statistical modelling of national survey data and population projections, estimates that there are some 455,000 people paying for their care at home in the community. Existing research about self-funders in the community relies on limited evidence and the results suggest numbers could range from 145,000 to 249,000. The Department has not undertaken additional research to improve its understanding of the demand for assessments from self-funders in the community due to likely cost and difficulty (paragraphs 3.5 to 3.7).

Calculating the cost of the Care Act in 2015-16

15 The Department may have underestimated the cost to local authorities of extra assessments and services. To cost the additional demand for assessments and services, the Department used the median of unit costs that local authorities provided, weighted towards those which forecast more assessments than average. The programme board judged that the approach taken was reasonable. There is a risk that the Department's cost estimate does not consider local factors, such as a local authority's ability to achieve economies of scale (paragraphs 3.14 to 3.15).

16 The Department has learned from the problems it encountered in modelling the cost of Phase 1 and has improved its approach for Phase 2. The Department did not define clearly enough some of the data needed; nor did it use quality measures such as a range controls. The Department did not allow sufficient time to check the consistency and reliability of the data. The Department, with its partners has improved the approach it is taking to model the costs of Phase 2, using a sample-based approach and improving quality assurance (paragraphs 3.16 to 3.17).

Distribution of funds to local authorities

17 There is variation in the extent to which individual councils might have been over or underfunded. The Department has used various methods to distribute funds to local authorities. These include the formula used to fund clinical commissioning groups; the Adult Social Care Relative Needs Formula; and funding by prison population. As an indication of risk, the median gap between funds provided and local authorities' cost estimates may be 0.2% of spending on adult social care but varying up to 4% of spending. This will be affected by issues with the quality of the data provided by local authorities and their local spending decisions as well as by how well the formulae used match the need (paragraphs 3.26 to 3.29).

18 A significant proportion of the funding which the Department is providing for the Care Act's new burdens is not new money. The Department assumes that £174 million (40%) of Care Act funding will come through the Better Care Fund, from money previously allocated to clinical commissioning group budgets and existing local authority capital grants. Local authorities negotiate their allocations with local health partners. Local areas had to confirm funding for the Care Act in their Better Care Fund plans, and explain how duties would be met. This is not being monitored (paragraphs 3.23 to 3.25).

19 If demand or costs exceed expectations, pressures will fall first on individual local authorities. The Department may not have sufficient information and does not have a contingency fund to avoid impacts on services. The Department is working with the sector to monitor and respond to actual demand coming from the Care Act in 2015-16. However, the metrics do not cover fully costs incurred by local authorities. The Department plans to use data collected in the first three months to support its bid for the next spending review. Otherwise, options for the government could include changes to the regulations, additional guidance, peer-to-peer support and sector-led improvement. In the short term local authorities may have to cut or reduce services (paragraphs 3.30 to 3.33).

Conclusion on value for money

20 The Department has managed the introduction of Phase 1 of the Care Act well, with an innovative joint approach with the sector, ongoing involvement of stakeholders and open sharing of data and documents. Consequently, 99% of local authorities were confident that they would be able to carry out the Care Act reforms from April 2015. We judge therefore that the programme has been implemented well and the approach shows good practice from which other programmes could learn. However, with the level of demand so uncertain, the Department's cost estimates and chosen funding mechanisms put local authorities under increased financial risk. In a challenging financial environment, with pressures on all services, local authorities may not have sufficient resources to respond if demand exceeds expectation. In response, local authorities could delay or reduce services in the short term, risking legal challenge and potentially creating extra burden for individuals, their families and carers, who in turn might seek help elsewhere that is not suited to their needs. This is a longer term risk to value for money which needs to be managed and goes against the culture change envisioned by the Act. As the Department carries out Phase 2 of the Act, it needs to monitor carefully the adequacy of funding each local authority has for Care Act new burdens.

Recommendations

21 There are many positive elements in the way the Department has worked collaboratively with the adult social care sector to carry out the Care Act, which should provide lessons for future policy changes. Our recommendations are designed to help the Department minimise the impact of new burdens in the Act on individual local authorities.

a **As the Care Act rolls out, the Department needs to know quickly if individual local authorities are struggling, and respond**. The Department should work with the sector to monitor both the cost of, and demand for, services. The Department should also set out the options to help local authorities minimise the effect of increased demand and cost on service quality. We expect that the Department will need to continue to monitor both phases from 2015-16 until the pattern of demand stabilises.

b **The Department should report to Parliament whether it has achieved the government's objectives**. The Department has a strategy in place to monitor and evaluate the benefits of the reforms being introduced. The Department should include in its timetable a report to Parliament on progress towards achieving the government's objectives.

c **The Department should work with the sector to improve its data and reduce the level of uncertainty in its assumptions for Phase 2**. The Department should research the numbers of self-funders in the community. The Department should continue to work with the sector to improve the quality of data on demand and cost.

d **In the longer term the Department should maximise the time and resources available to carry out Care Act Phase 2, and any other changes which it may plan**. The Department should maximise the time that local authorities and other stakeholders have to carry out the government's changes. The Department should also be transparent about the source and amount of all extra funds it intends local authorities to have; for example, the amount available to each authority from the NHS through the Better Care Fund.

Part One

New approach to adult social care

1.1 The government set out its plan to reform care and support in the 2012 white paper *Caring for our future: reforming care and support*.[3] The Care Act 2014 is a significant part of a new approach but it is happening during a time of financial constraints and increasing need. In this part we set out:

- the white paper's objectives;
- the cost of the Care Act; and
- the resource context, including trends in population and care provision.

Objectives

1.2 The 2012 white paper describes the care system as reactive to crises and lacking clarity, consistency, and enough information and support for users and carers. It sets out a new approach based around two principles:

- "to prevent, postpone and minimise people's need for formal care and support… built around the simple notion of promoting people's independence and wellbeing"; and
- "people should be in control of their own care and support".

The white paper gives the government's vision for care and support reform as "I" statements; experiences it would like users, carers and families to have:

- "I am supported to maintain my independence for as long as possible".
- "I understand how care and support works, and what my entitlements and responsibilities are".
- "I am happy with the quality of my care and support".
- "I know that the person giving me care and support will treat me with dignity and respect".
- "I am in control of my care and support".[4]

3 HM Government, *Caring for our future: reforming care and support*, Cm 8378, July 2012.
4 See footnote 3.

1.3 Through the Care Act, the Department aims to achieve the government's vision (**Figure 2** overleaf). The Department wants to empower people who use care and support, their families, and carers, to be able to find help, and maintain their independence. Local authority information, advice and assessments become services in their own right, rather than routes to publicly-funded intensive care and support.

Cost of the Care Act

1.4 The Care Act puts new responsibilities on local authorities in England. The Department estimates it will cost local authorities £470 million in 2015-16 to carry out (see Part Three). We estimate that that Care Act Phase 1, including the cost of white paper-related activities which did not require legislation and central programme spend, will cost £2.5 billion to implement from 2013-14 to 2019-20 (**Figure 3** on page 15). The largest cost is £1.2 billion for carers' assessments and services, a new entitlement. Care Act Phase 2 costs for assessing self-funders also begin in 2015-16.

Resource context

1.5 The Department is rolling out the Care Act at a time of falling budgets. We reported previously that the government cut its funding to local authorities by 37% in real terms between 2010-11 and 2015-16.[5] Difficulties faced by local authorities in meeting their budgets include demand for adult and children's social care; ability to make planned savings that are large enough and to the agreed timetable; and meeting pay costs and the costs of redundancy programmes.[6]

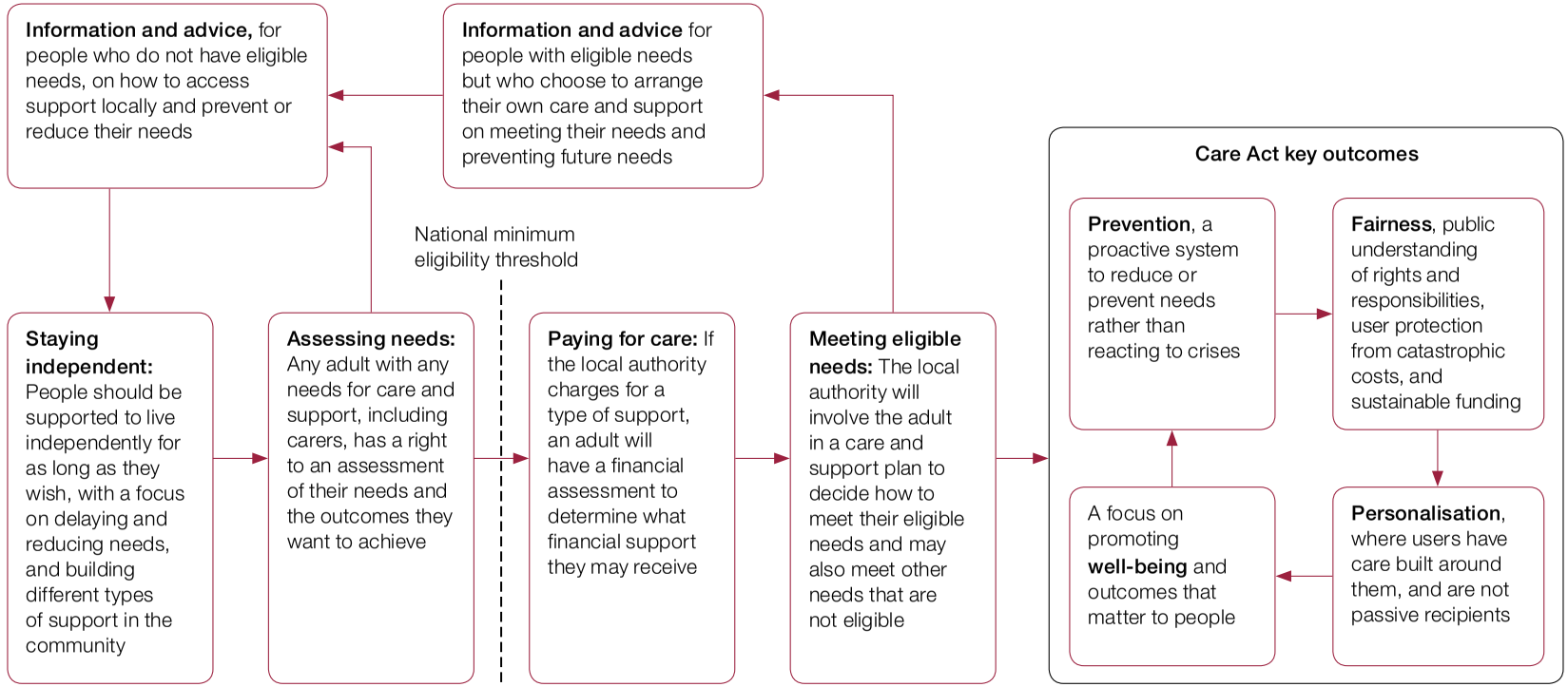
1.6 Local authorities have tried to protect spending on adult social care, which accounted for 41% of total spend in 2010-11, but have been less able to do so over time. Between 2010-11 and 2014-15, budgeted net spending on adult social care fell by £1.1 billion (7.8%) to £14.4 billion. However, the focus of local authority spending reductions has changed. Adult social care accounted for only 15% of total savings from 2010-11 to 2011-12 but made up 40% of total savings between 2013-14 and 2014-15. The impact is also uneven. Local authorities with big reductions in spending power have been less able to protect spending on key services.[7]

1.7 Authorities have made savings through efficiencies and reducing activity, but efficiency savings may be lessening. If funding continues to fall, local authorities will have to use different approaches. The government emphasises service transformation projects that increase integration with other local bodies. Recently, we reported that the Department for Communities and Local Government had not yet estimated local authorities' capacity to carry out widespread service transformation. Nor has it estimated the potential savings, how long this would take, or the effect on service users.[8]

5 Comptroller and Auditor General, *Financial sustainability of local authorities 2014*, Session 2014-15, HC 783, National Audit Office, November 2014.
6 Comptroller and Auditor General, *The impact of funding reductions on local authorities*, November 2014.
7 See footnote 5. Owing to changes in local authorities' responsibilities for schools, education spending is excluded from our analysis.
8 See footnote 5.

Figure 2
Care Act policy objectives

Care Act marks a culture change

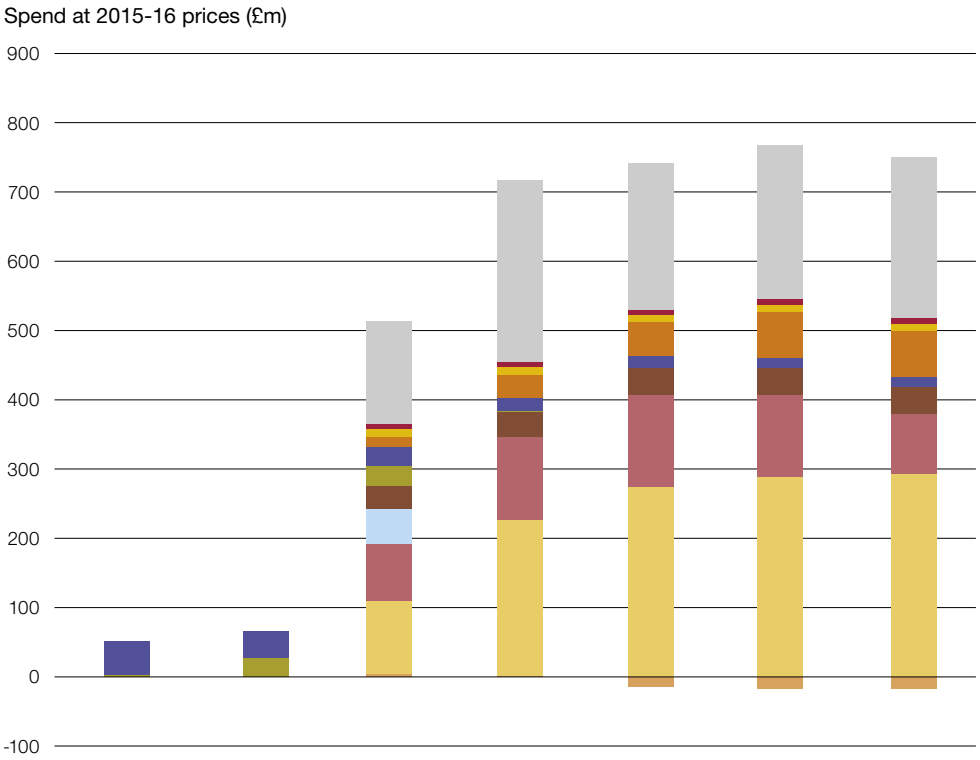


Source: Department of Health

Figure 3

Care Act costs 2013-14 to 2019-20

The Department has provided £512 million in 2015-16 of which £470 million is allocated to local authorities. The largest cost arises from greater demand for assessments and services



	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Costs of self-funder assessments (Phase 2)			146.0	260.0	210.0	220.0	230.0
Safeguarding and market oversight	0	0	8.2	8.1	8.1	8.1	8.1
Prisons	0	0	11.2	10.3	10.3	10.3	10.3
Advocacy	0	0	14.5	34.6	49.5	67.1	67.1
Other work streams	49.0	37.6	28.0	18.1	17.2	13.8	13.8
Department of Health programme management	2.5	28.2	28.7	1.5	0	0	0
Continuity of care and eligibility	0	0	32.7	35.2	38.7	38.7	38.7
Better Care Fund capital	0	0	50.0	0	0	0	0
Deferred payment agreements	0	0	83.5	121.1	132.1	118.5	87.3
Carers	0	0	104.6	224.0	275.1	289.3	292.8
Legal reform	0	0	4.7	2.3	-13.6	-17.2	-17.2

Notes

1 Costs of self-funder assessments from Department of Health, *Response to the consultation on funding formulae for implementation of the Care Act in 2015-16*, December 2014

2 Programme management and other work stream costs, from internal Department of Health documents, are not directly attributable to specific new Care Act duties.

3 All other cost estimates from Department of Health impact assessments.

Source: National Audit Office analysis of Department of Health data

1.8 To promote service transformation and make ongoing efficiencies, the government introduced the Better Care Fund from 2015-16. The main Fund objective is to improve outcomes, for adults with health and social care needs, by joining up NHS and local government services. We have highlighted the risk that service transformation, such as the Better Care Fund, may take time to achieve benefits.[9]

Population and trends in care provision

1.9 The need for care is rising. The population aged 65 and over in England is expected to rise by between one fifth and one quarter in all regions by mid-2022.[10] The number aged 65 and over, and who are in need, is expected to rise by over 40% between 2005 and 2020 (**Figure 4**). Better healthcare also means that more ill and disabled children reach adulthood and more ill and disabled young adults live longer.[11]

1.10 The number of people getting care assessments and services has fallen. Authorities could be diverting new clients to the voluntary sector, providing preventative services or tightening eligibility.[12] The number of contacts from new clients fell from a high in 2010-11 but then rose to 2,163,000 in 2013-14, up 4% from 2012-13 and the highest number recorded in the last ten years.[13] However, the number of new clients assessed or receiving services has fallen faster for those aged 65+ (Figure 4).

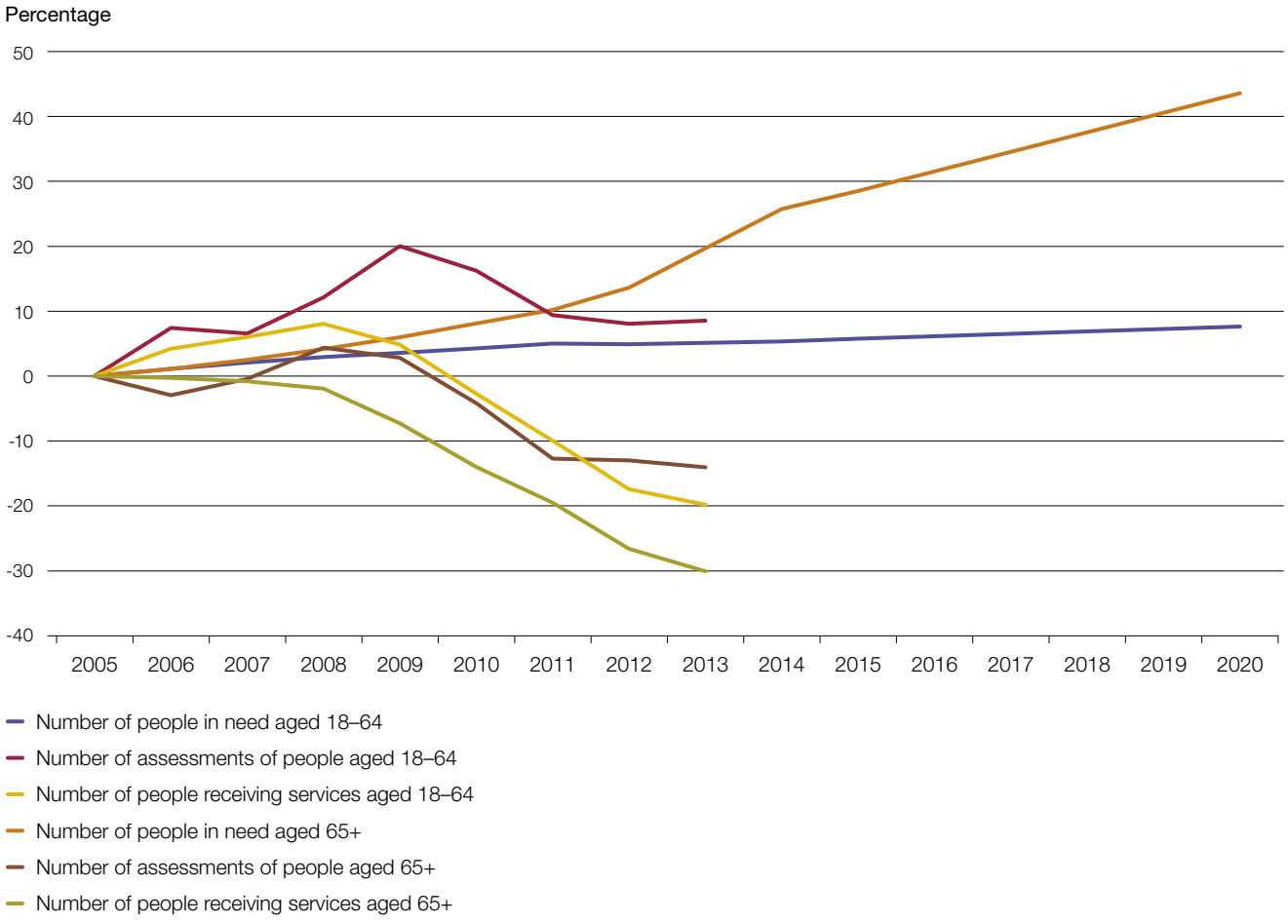
1.11 The demand for local authority services is likely to increase as a consequence of the Care Act (see Part Three). The Care Act extends the rights of carers to be assessed to be equivalent to the rights of those they care for. The Care Act also provides a new entitlement for support to meet carers' eligible needs. It also gives local authorities a duty to give information and advice to all. The right to an assessment for all those who appear to be in need remains in place, but self-funders are now more likely to approach local authorities in preparation for measures being introduced in 2016-17. In particular, the cap (£72,000 for people aged 65 and over) on the amount someone will pay towards care and support, regardless of means, and monitored through a care account.

9 Comptroller and Auditor General, *Planning for the Better Care Fund*, Session 2014-15, HC 781, National Audit Office, November 2014.
10 Office for National Statistics, *Subnational Population Projections*, *2012-based projections*, May 2014.
11 Comptroller and Auditor General, *Adult social care in England: overview*, Session 2013-14, HC 1102, National Audit Office, March 2014.
12 See footnote 11.
13 Health & Social Care Information Centre, *Community Care Statistics: Social Services Activity*, England, 2013-14, Final Release, December 2014.

Figure 4

Forecast change in population and people in need of care in England

The number of people in need, particularly aged over 64, is rising, but numbers getting care assessments and services have fallen



Source: National Audit Office analysis of data from *Projecting Older People Population Information; Projecting Adult Needs and Service Information*; Health and Social Care Information Centre data on assessments and packages of care; and Office for National Statistics population data (all data for England only)

Part Two

Implementation and local authority readiness

2.1 The Department supports the local government sector to carry out the Care Act. In this part we examine:

- how the Department managed authorities carrying out the first phase of the Care Act;
- the support it gave them; and
- the main risks to successfully carrying out the Act.

Managing implementation

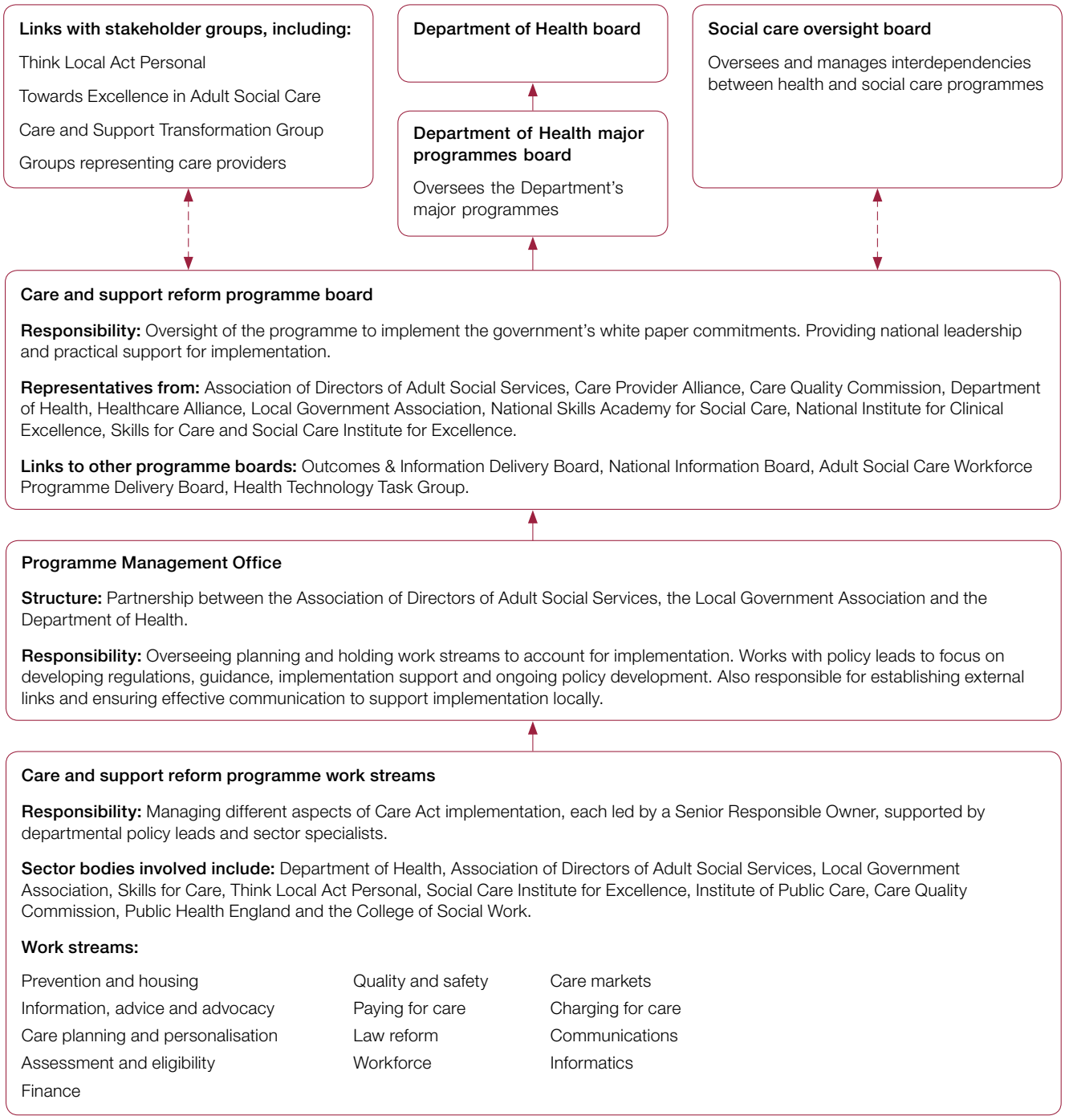
2.2 Our work has showed that failing to consult with delivery partners early brings a high risk of programme failure. We have found no consistent approach to drawing on local authorities' experience early.[14] For the Care Act, from early on, the Department established innovative arrangements. The Department has overseen the programme, with key stakeholders as members of the main programme board and implementation through a programme management office, working with the Local Government Association and the Association of Directors of Adult Social Services (**Figure 5**). Stakeholders have been partners responsible for delivery, not just giving advice. Stakeholders and the sector have received this well, and the Department has been able to maximise its understanding of the issues.

14 Comptroller and Auditor General, *Central government's communication and engagement with local government*, Session 2012-13, HC 187, National Audit Office, June 2012.

Figure 5

Programme structure for implementing the Care Act

The Department involved stakeholders through the governance arrangements



Source: Department of Health

Consulting the sector

2.3 The Department has consulted stakeholders from early on, prior to the 2012 white paper, involving them in working groups to inform development of the policy and later to develop the regulations and guidance which support the legislation. The Department has also been open with stakeholders about its data and assumptions and has made a number of key programme documents available through the Local Government Association's website.

2.4 The Department also held formal consultations, including on the draft regulations and guidance for Phase 1 changes in 2015-16, including several consultation events, which attracted over 4,000 replies.[15] The Department has responded to concerns and did extra research including:

- a pilot with 27 local authorities to test the new eligibility criteria; and
- research into section 18(3) of the Care Act, part of which has been delayed to examine the potential impact on the supplier market (section 18(3) requires local authorities to meet needs for those requiring any type of care).

The Department held a formal consultation in February and March 2015 for Phase 2 changes in 2016-17 and is analysing the results.

2.5 The Department, Local Government Association and Association of Directors of Adult Social Services have regularly surveyed local authorities with social care responsibilities to assess progress. This 'stocktake' has a 100% response rate. This gives the Department and its partners a clear picture of the main risks and allowed them to target support where needed.

2.6 The Department has worked with sector bodies, and seconded social care finance officers, to estimate the cost of new duties. In July 2014, the Department worked with partners (Local Government Association, Association of Directors of Adult Social Services, the County Councils Network and London Councils) on a scenario modelling exercise. The Department asked local authorities to use a model to estimate likely demand for, and cost of, extra assessments for self-funders and carer assessments and support. The model was based on one developed by Lincolnshire County Council. The model was completed either partly or completely by 79% of councils. In response, the Department changed its funding estimates. It increased funding for carer support by £35.2 million and reduced funding for deferred payment agreements by £25 million.

2.7 Most stakeholders and local authorities we interviewed understood and supported the Care Act objectives. The Department found from consultation on the Care Act draft regulations and guidance that "almost all consultation responses recognised the opportunity provided by the Care Act, and were supportive of the ambition and principles espoused within the Act, regulations and guidance".[16]

15 Department of Health, *Response to the consultation on draft regulations and guidance for implementation of Part 1 of the Care Act 2014*, Cm 8955, October 2014.
16 See footnote 15.

Support to the sector

2.8 The programme management office has organised a range of events and local meetings, and commissioned tools and guidance for the sector. The sector has worked on setting the requirements for these materials and in making sure that they meet the required standards, such as having accurate technical content. For example, the Social Care Institute for Excellence has developed materials to support local authority staff, social workers and others involved in assessment and eligibility. The sector has also organised specialist support to local authorities where required, for example to undertake a detailed review of their plans. Skills for Care, in partnership with the College of Social Work, has developed learning and development resources. The materials are online and cover these areas:

- **Guidance on key areas of reform**

  General duties, identifying needs, assessments, safeguarding, person-centred care, integration and partnerships.

- **Learning and development**

  Learning resources, specialist legal training materials, tools to support workforce planning.

- **Enablers**

  Self-assessment, costing, communications, informatics, support for care providers.

2.9 The stocktake surveys and results of our case study visits showed local authorities found the guidance material to be helpful. However, some local authorities felt overwhelmed by the volume of material and the timescales in which the Department and stakeholders produced it. Some materials, for example on workforce training, could not be completed until after the Department had agreed and published the final regulations and guidance in October 2014.

2.10 The Department and sector partners have put in place a strategy to provide additional support to local authorities which need it. The Department is using the stocktake survey, together with ongoing analysis of risks, the specialist support available to councils and other contacts to judge whether additional support is required. The Department, largely with its partners including peer-to-peer support and sector-based improvement activities, will provide increasing levels of support depending on the issues to be addressed. This includes help to build capacity and capability, generic support materials and specific help for individual councils if needed.

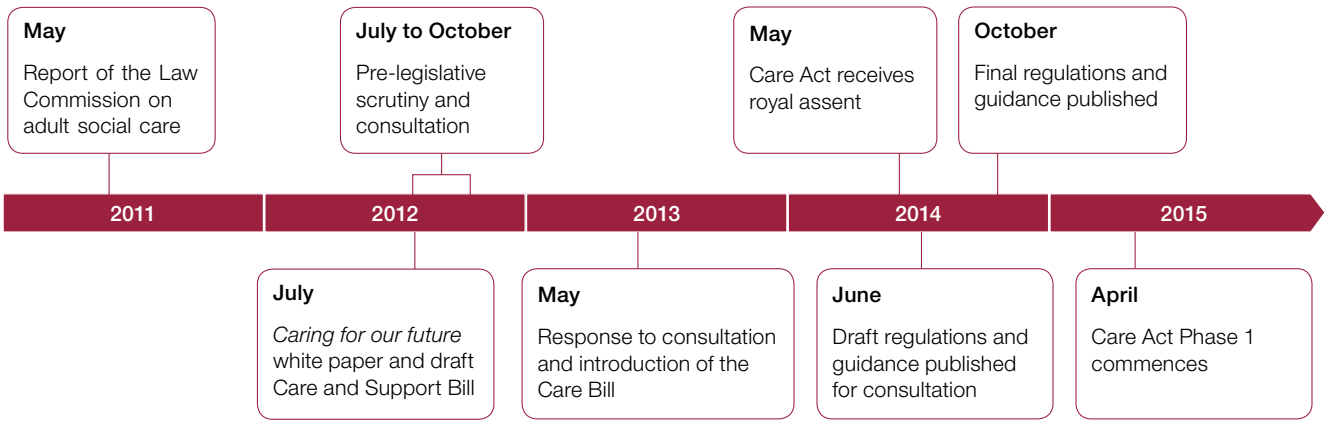
2.11 The Department provided funding in 2013-14 and 2014-15 for regional support, based on the existing Association of Directors of Adult Social Services' regional sector-led improvement networks, and in 2014-15 for change management resources in local authorities. The Department has also provided £30 million in 2015-16 to help local authorities develop the capacity and communications needed for the reforms being introduced in 2016-17. Our case study local authorities found the regional networks were helpful. However, feedback from the stocktakes suggests that authorities felt the Department needed to ensure greater coordination across regional networks to share good practice. The Department plans to invest in networks to enable sharing of practice both locally and nationally.

Timetable for implementation

2.12 The Care Act puts several new duties on local authorities and makes other duties clearer. For example, having to provide information and advice for anyone regardless of need, an extended entitlement to a carers' assessment, and the duty to shape adult social care markets. These changes have been developed over a long period and were made quickly once the Care Act received royal assent (**Figure 6**). As noted in paragraph 2.3 the Department has involved stakeholders, including the local government sector, in the development of both the policy and the regulations and guidance which support the Act, as well as consulting formally on the detail. The sector has therefore had time to prepare for the changes. Nevertheless, the speed of introducing the Act, and uncertainty over the detail, has inhibited local authorities' planning.

Figure 6
Timescale for carrying out the Care Act

Local authorities had a short time to carry out the Care Act



Source: National Audit Office

2.13 Uncertainties over and delays in the final regulations and guidance have featured in all three stocktakes undertaken to date. The Department for Communities and Local Government asked that local authorities should have at least six months to prepare. The Department published its final regulations and guidance 5 months and 10 days before the Care Act was due to take effect. The January 2015 stocktake reported that "a significant number of councils flagged that the delay in publishing regulations, guidance and tools was a significant area of concern, inhibiting implementation locally".[17] A common issue raised during our fieldwork was poor clarity in some guidance. Also, that the Department had not given enough information about the changes to regulations and guidance after consultation. The Department published its response to the consultation on the guidance, including key changes, and argues that changes were relatively minor and it was impractical to produce a complete version of the guidance with all changes highlighted, as it has 500 pages. However, while this may have made their job difficult, local authorities have worked to be ready to meet their statutory duties from April 2015.

Readiness of local authorities

2.14 Despite the speed of introducing the Act, in the January 2015 stocktake, 99% of local authorities reported that they were confident that they could carry out the Care Act reforms from 1 April 2015. In practice it meant that local authorities could manage their new statutory duties from April 2015. Some local authorities are better placed to introduce the Act. For example, the January stocktake reported that 12% of councils would not have a contingency plan for provider failure in place for April 2015. A significant number of local authorities would not have finance and IT systems up and running, and local authorities had expressed concerns about the time frame for staff training.[18] The stocktake also reflects the changes local authorities made. We saw examples in our fieldwork of changes made, or changes already in place, which support the Care Act (**Figure 7** overleaf).

2.15 Local authorities and stakeholders agree that it will take longer for them and service users to adapt to the change in culture, as envisaged in the Care Act (paragraph 1.3).

17 Department of Health, Association of Directors of Adult Social Services and the Local Government Association, *Care Act Implementation Results of Local Authority Stocktake*, January/February 2015.
18 See footnote 17.

Figure 7
Local authority readiness

Some local authorities are prepared to introduce the Care Act through changes made or approaches already taken

Durham: Implementation has been centred on introducing e-marketplace software for April 2015. The authority developed software after consultation and considering national policy documents. Functions include advice and information, eligibility checker, online assessments, directory of services, online care plans and access to care accounts. The software should prevent a significant proportion of the population from developing dependencies.

Devon: The carers' health and well-being check is a joint health and social care project. It uses the skills and knowledge of community health professionals and the voluntary sector to identify carers and access services. The project has resulted in higher-than-average carer identification.

Wakefield: The council has a deferred payment scheme. Health and social care partners work closely. As an 'integration pioneer' NHS and council staff and the voluntary sector are trialling 'connecting care closer to home' in three GP surgeries which started in 2014.

Source: National Audit Office fieldwork visits

Monitoring and evaluation

2.16 The Department has expressed the government's outcomes in the 2012 white paper as "I" statements (paragraph 1.2). The programme board has approved a strategy, which provides a framework for monitoring and evaluating the benefits of the reforms.

2.17 The Department plans to monitor the activities associated with each "I" statement. Where possible, the Department plans to use existing data collection mechanisms to create a baseline to judge the Care Act impacts. The Health and Social Care Information Centre collects and publishes information about adult social care. It has consulted on changes to data requirements from 2015-16 including safeguarding, user and carer surveys, deferred payment agreements and short- and long-term support and announced the first set of data change in March 2015. The Department has identified the Personal Social Services Survey of Adult Carers in England as one of several data sources to measure how supported carers and users feel to maintain their independence. The Department has also identified gaps, for example on advocacy, where data are unavailable. The Department has not yet set targets, identified which measures are likely to show statistically significant improvements, or determined the cost of new metrics to the Department and local partners.

Risks to implementation

2.18 Through sector and stakeholder consultation, the Department understands the main risks to carrying out the policy. In the stocktakes, local authorities are increasingly identifying uncertainty about demand from carers and self-funders as the greatest risks to implementation (**Figure 8** overleaf).

2.19 All councils offer carer assessments, but the number of assessments for carers has fallen since 2010, when 4% of carers were assessed.[19] The Care Act entitles carers to receive information and advice, to be assessed and, if appropriate, to access services, which should reverse this trend. The Care Act incentivises self-funders to approach local authorities before the 2016 cap on care costs comes into effect. Previously, either the self-funder would not have approached their local authority or, having made contact, may have chosen not to be assessed.

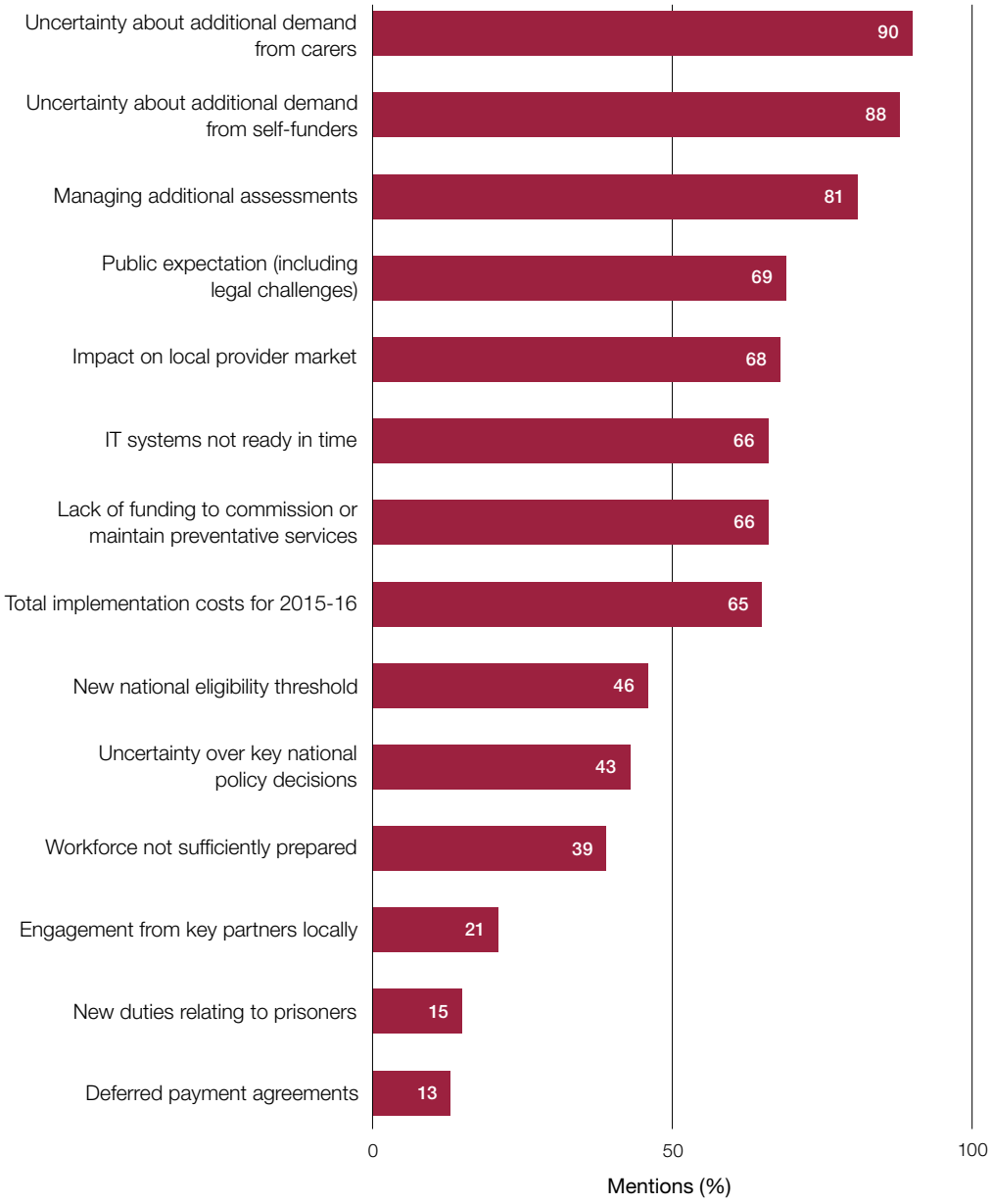
2.20 While almost all councils have indicated they are confident with their own preparations (paragraph 2.14 and Figure 7), the majority continue to cite uncertainty about demand and concerns about whether their budgets will be sufficient. We consider the cost of these risks, and the Department's funding available to mitigate them, in Part Three.

19 Health and Social Care Information Centre, *Survey of carers in households – England 2009-10*, page 9.

Figure 8

Risks to implementation of Phase 1 of the Care Act

Local authorities have identified uncertainty about the additional demand from self-funders and carers as presenting the greatest risks to implementation



Notes

1 Survey completed 13 January to 3 February 2015 by all 152 authorities with responsibility for adult social care.

2 Result show topics mentioned by councils who were asked to outline key risks to Care Act delivery in 2015-16.

Source: Department of Health, Association of Directors of Adult Social Services and the Local Government Association, *Care Act Implementation Results of Local Authority Stocktake*, January 2015.

Part Three

Funding

3.1 The Department has allocated £470 million to local authorities to carry out the Care Act in 2015-16. The largest parts comprise:

- £124.9 million for supporting new entitlements for carers;[20] and
- £116 million for assessing self-funders.

3.2 In this part we examine how the Department is funding new burdens for carers and self-funders including:

- estimating the extra cost;
- distributing funding to local authorities; and
- monitoring demand for assessments and services.

Estimating the extra cost of carers and self-funders

3.3 The Department has used different data to calculate the total extra cost of assessing and providing services for carers, and assessments for self-funders (**Figure 9** overleaf). As well as national data, the Department collected data from local authorities, using its costing model.

Population estimates

Carers

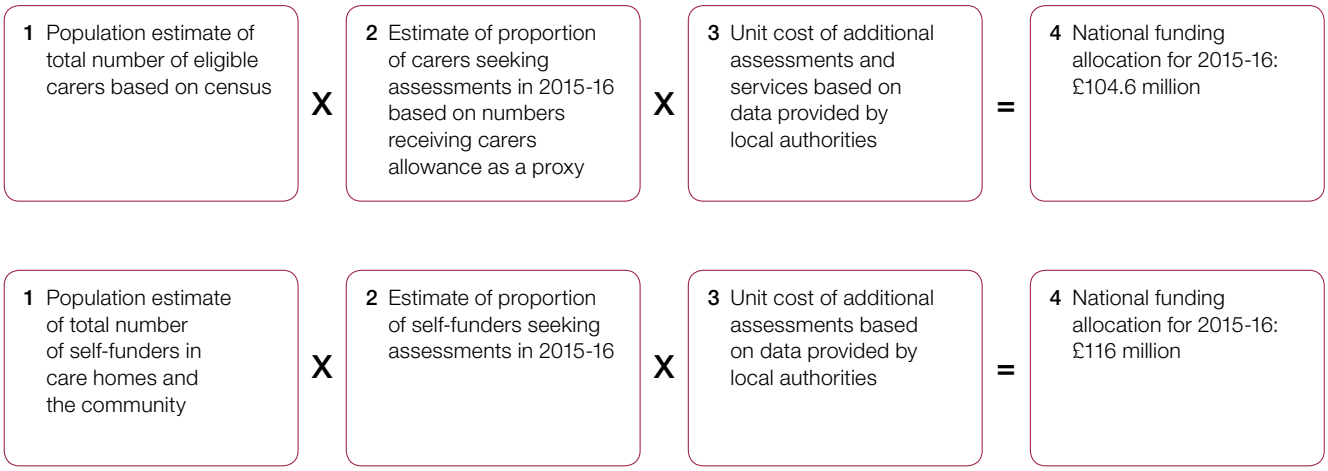
3.4 In its impact assessment, the Department estimated initially that there are 1,360,000 carers eligible to be assessed. This is based on the number of people who provide 50 hours or more of care from the 2011 census for England and Wales, including under-18s. The equivalent figure, who may be eligible for assessment in England only, excluding under-18s, is 1,250,000. **Figure 10** on page 29 shows several carer population estimates from the Department for Work & Pension's surveys and administrative data. The Department's figure is a mid-range estimate of the population eligible for assessment.

20 Includes £20.3 million of funding for 'general pressures' across Care Act implementation.

Figure 9

The Department's method for estimating 2015-16 funding for carers and self-funders

The Department has combined estimates of population and take-up with local authority unit costs to arrive at total funding allocations for 2015-16



Note

1 Funding allocation figures taken from Department of Health, *Response to the consultation on funding formulae for implementation of the Care Act in 2015-16*, December 2014.

Source: National Audit Office analysis of Department of Health, Impact assessment 6107, *The Care Act 2014: Regulations and guidance for implementation of Part 1 of the Act in 2015-16*, October 2014 and other internal Department of Health documents

Self-funders

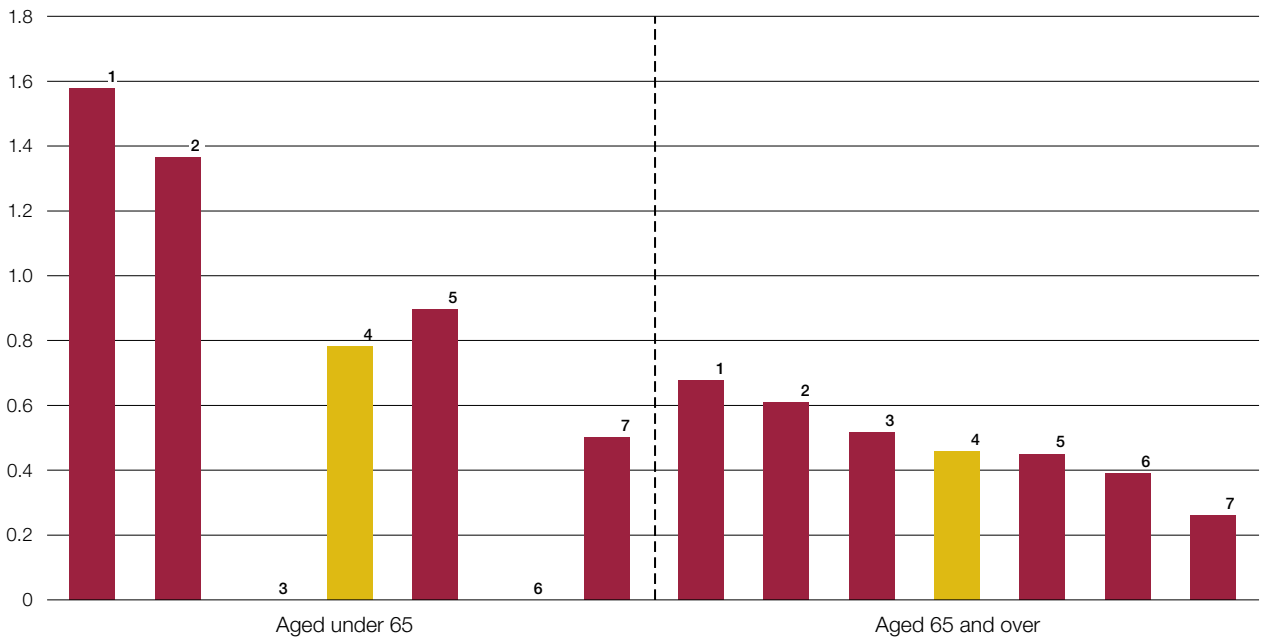
3.5 The Department estimates that there are 154,000 self-funders in residential care. This is consistent with other large scale research into numbers of people in care homes.

3.6 The Department also estimates that there are some 455,000 people paying for their care at home in the community. Alternative research into self-funders at home suggests a population range of 145,000 to 249,000. However, this is limited, based on modelling and small-scale surveys, and is inadequate to give a national estimate. The Department did not commission primary research and has relied on the results of statistical models which use national survey data and population projections.

3.7 Many local authorities are not confident that they know the number of self-funders receiving homecare in the community. The Department collected data from local authorities about the number of self-funders, using its scenario model. This suggested a population of around 249,000. The Department suggested to local authorities that, where no better data exists, they assume that the number of self-funders receiving homecare in the community is in the same proportion as those in residential care. More than half of councils who provided estimates (54%) adopted this assumption.

Figure 10
Carer population estimates for England

The Department used a mid-range estimate of eligible carers



Notes

1 Number caring for 20 hours or more. Survey of carers in households 2009-10; Health and Social Care Information Centre.

2 Number caring for 20 hours or more. Census 2011; Office for National Statistics.

3 Number caring for 20 hours or more. English Longitudinal Study of Ageing 2006. No data for those aged 18-64.

4 Number caring for 50 hours or more. Census 2011; Office for National Statistics.

5 Number caring for 20 hours or more. Family Resources Survey, United Kingdom 2007-08; Department for Work & Pensions.

6 Number caring for 50 hours or more. English Longitudinal Study of Ageing 2006. No data for those aged 18-64.

7 Number caring for 35 hours or more. Department for Work & Pensions administrative data on Carer's Allowance, February 2014 (receipt or underlying entitlement for at least one year).

8 All figures are for people aged 18 or over in England.

Source: National Audit Office estimates for England

People seeking assessments and services in 2015-16

Carers

3.8 Calculating demand is complex and it is difficult to be precise as it involves anticipating the behaviour of people who may not already be in contact with public services. Before the Care Act, carers who provided a 'substantial amount of care on a regular basis' could request an assessment and local authorities had to inform them about this right.[21] NHS information Centre (now the Health and Social Care Information Centre) research in 2010 indicated that 6% of carers said they had been offered a carer's assessment and 4% received an assessment.[22]

3.9 The Department considered a number of ways of estimating, as a proxy, potential future demand from carers:

- The Department asked local authorities for their own estimates of uptake but the data was unsuitable (see paragraph 3.16).
- The Department looked at the proportion of carers caring for someone in receipt of local authority support who would be likely to request an assessment. The Department calculated the number of people aged 18 to 64 who currently receive Carer's Allowance and from the Census 2011, the number of people caring for 50 hours per week or more. The Department also used this information to estimate the number of people aged 65 and over who would request an assessment. The programme board approved this approach.

3.10 We reviewed the Department's approach and concluded that it was as reasonable to include people who had applied for and are eligible for Carer's Allowance but who are not entitled to it (as they receive other allowances, such as incapacity benefit or state pension). The Department for Work & Pensions publishes data on the number of people in this position. Using this data, in place of the Department's method, could add an extra £27 million (26%) in 2015-16, at a cost of £387 per carer in extra assessments and services, if these additional people come forward.[23]

3.11 Of the total number of potentially eligible carers, the Department has assumed that 75% will request an assessment in 2015-16, rising to 100% in 2017-18. The Department examined evidence on take-up rates of income-related benefits for the disabled and elderly population, which showed a range between 61% and 92%. Without any other reliable measure, the Department's assumption on how quickly these new entitlements will be taken up appears prudent.

21 Carers (Recognition and Services) Act 1995 or the Carers and Disabled Children Act 2000.
22 Health and Social Care Information Centre, *Survey of carers in households – England 2009-10*, page 9.
23 This estimate uses data from Department for Work & Pensions about the number of carers in February 2014 who had an underlying entitlement to Carer's Allowance for at least a year.

3.12 Of the eligible carers seeking assessment, the Department has assumed around 50% will get a personal budget and 15% respite care. The Department calculated these rates based on the arithmetic mean of local authority estimates. In its calculation, the Department included local authorities that did not provide all the data needed and two local authorities that reported a take-up rate of more than 100%. Both of these factors are likely to have distorted the Department's overall estimate.

Self-funders

3.13 Research on self-funders does not cover the likelihood of them seeking an assessment. Using the same logic as for carers, the Department assumed that 80% of the total estimated population of self-funders will request an assessment. Without any other reliable measure and given the uncertainty around the self-funder population, this assumption appears prudent.

Cost of assessments and services

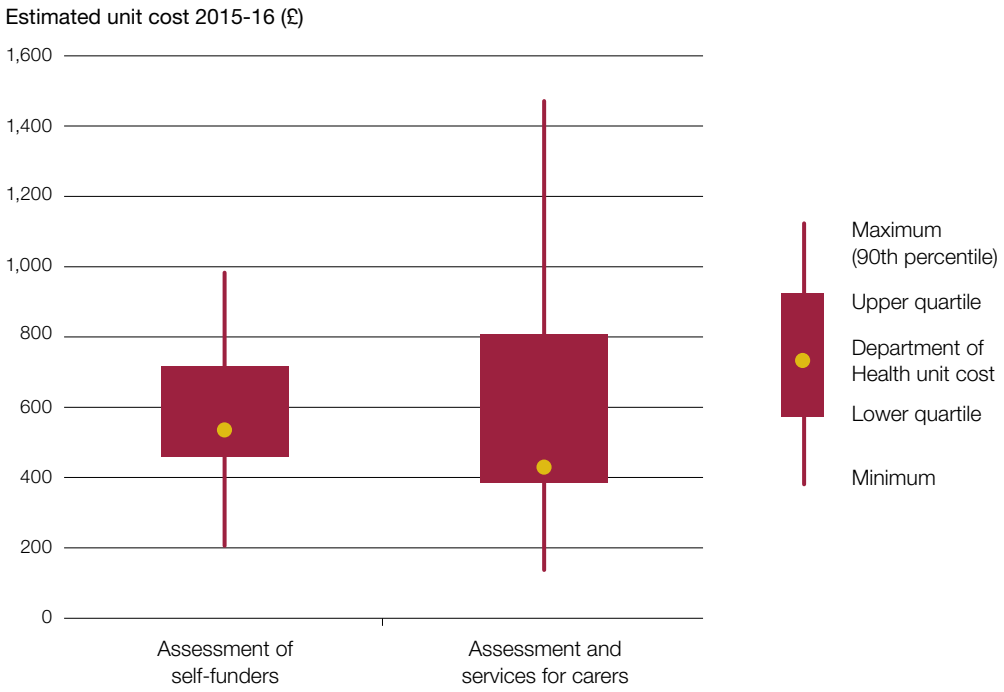
3.14 To calculate the total cost of extra assessments and services for carers and self-funders, local authorities gave the Department, using the costing model, the unit cost of each assessment and service for 2015-16. The unit costs of assessments and services spanned a wide range (**Figure 11** overleaf).

3.15 The Department therefore used the median of costs that local authorities reported, weighted towards authorities that forecast that they will do more assessments than average. Local authorities with higher levels of work tended to report lower unit costs for assessments and services (**Figure 12** on page 33). This may be because such councils can achieve economies of scale or other factors affecting cost, such as local labour market conditions. The Department's estimate of unit costs may not sufficiently consider local cost variation and may have underestimated the total costs of additional assessments and services. This is important as failure through insufficient resources would happen in individual local authorities, rather than the system as a whole.

Figure 11

Range of local authority unit cost estimates for assessing self-funders and carer assessments and services

The Department has used a weighted median of costs that local authorities reported



Notes

1 Dot represents weighted median. Maximum capped at 90th percentile.

2 Data submitted by local authorities using the costing model. Unit cost of self-funders based on data from 119 local authorities and unit costs for carers for assessments and services from 93 local authorities.

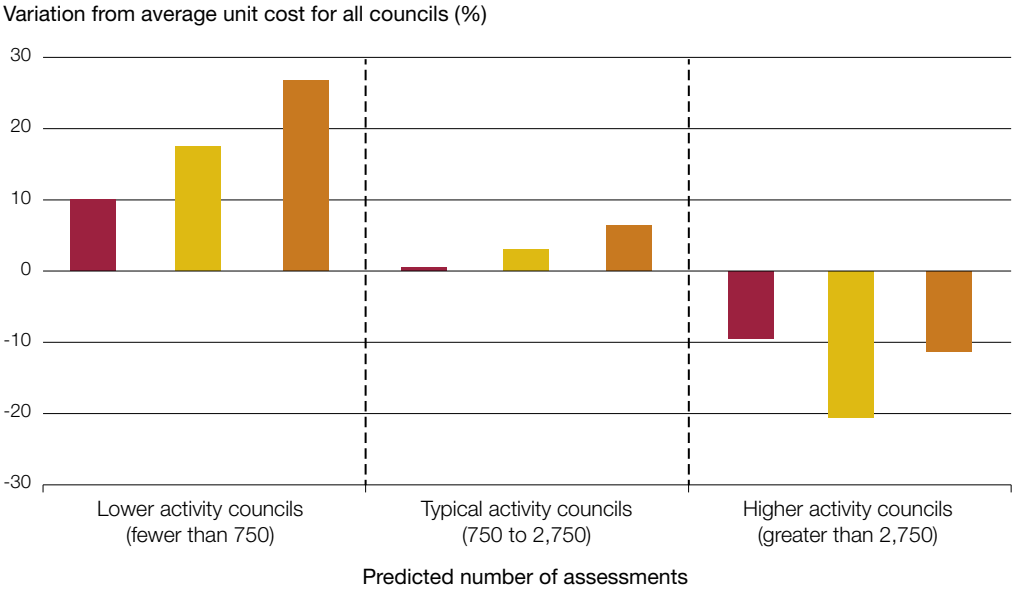
3 Unit cost of assessment and services for carers provided by authorities combined with Department of Health assumptions of take-up rate of personal budgets and respite care.

Source: National Audit Office analysis of Department of Health data

Figure 12

Variation in councils' reported unit costs for carers

Local authorities predicting higher levels of work tend to report lower than average unit costs for assessments and services



Notes

1 Activity level based on planned number of assessments.

2 Based on data from 86 councils.

Source: National Audit Office analysis of Department of Health data

Scenario modelling

3.16 The Department has based several estimates of cost and demand from the Care Act on data it collected from local authorities. It has done this using a model that Lincolnshire County Council developed and which the Department adapted for its needs including additional tools and data. Lincolnshire County Council designed the model, based on its particular circumstances and data, to help test the impact of different scenarios, for example the effect of changes in demand. The model was not, however, designed to aggregate nationally. The model also has drawbacks:

- **Unclear guidance**

  The labelling of the expected number of carers likely to come forward and the associated guidance did not clarify whether this was for 2015-16 alone or for the three years up to 2017-18. Local authority estimates of the number of carers likely to come forward varied significantly but the Department could not be sure whether estimates were for a single year or not. The Department acknowledges that this lack of clarity led it to use Carer's Allowance data instead.

- **Respite care**

  The model did not specify the types of services that should be included under respite care, the definitions and costs of which can vary significantly by local authority. This may have contributed to the significant variation in unit costs reported by local authorities (**Figure 13**).

- **Quality controls**

  The model did not include standard quality control features normally included in large-scale data collection exercises, such as range control, to prevent estimates well outside of expected ranges.

- **Assumptions**

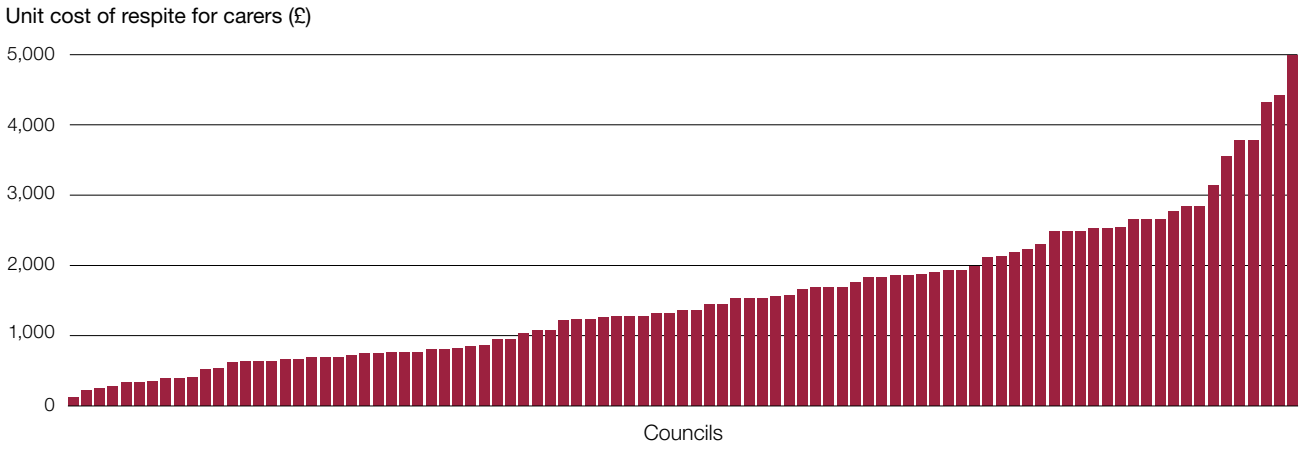
  The model makes important assumptions based on limited evidence, for example that councils will continue to use the same staff mix with no extra supervision or line management cover.

Each of these factors is likely to vary significantly by local authority, according to local management decisions, and the model does not allow for this. The result is to have increased the level of uncertainty about the estimated cost of the reforms.

3.17 The Department sent the model to all 152 local authorities responsible for adult social care. Of those, 119 (78%) completed the model at least in part, with 86 supplying all the data required. The Department allowed local authorities 20 working days to complete the model, and five days for two local authority secondees to collate and quality assure the data. This was insufficient time to ensure data consistency and reliability. The Department, with its partners, has learned from this and has improved the approach it is taking to model the costs of Phase 2, using a sample-based approach and improving quality assurance.

Figure 13
Local authority unit cost estimates of respite care for carers

Local authority unit cost estimates show a significant variation



Note

1 Based on data from 93 councils.

Source: National Audit Office analysis of Department of Health data

Distribution to councils

3.18 From the total of £470 million, the Department has distributed £240 million to local authorities for early assessments of self-funders and for carers in 2015-16 (**Figure 14** overleaf).[24] The calculation the Department has used to decide how much each local authority should get is different from its calculations to determine the total extra cost discussed above.

Funding formulae

3.19 To distribute funding for assessing self-funders, the Department developed a new formula. This is because the cap on care costs puts new duties on local authorities, for which there are no comparative data. The 'Cap Additional Assessment Formula' estimates relative incidence of:

- self-funders in residential care using data collected from local authorities, compared with data from the 2011 census; and
- self-funders in the community using modelling of social care needs from the English Longitudinal Study of Ageing.

24 Includes £20.3 million of funding for 'general pressures' across Care Act implementation.

Figure 14
Distribution of funds for introducing the Care Act

Intended use	Total (£m)	Distribution method
Revenue		
New entitlements for carers	69.4[1]	Allocated as part of Better Care Fund using NHS England formula for distributing funding to clinical commissioning groups
National minimum eligibility threshold, information and advice, advocacy, safeguarding and other measures	54.6	
New carers' rights	35.2	Formula grant allocated as part of the Carers and Care Act Implementation Grant using Department of Health Adult Social Care Relative Needs formula
General pressures across Care Act implementation	20.3	
Early assessments of self-funders	116	Allocated as a grant under Section 31 of Local Government Act 2003 using 'Cap Additional Assessment Formula'
Capacity building for Phase 2 reforms	20	
Communications for Phase 2 reforms	10	
For care and support in prisons	11	Allocated to prisons using 2013 population data from the National Offender Management Service
Deferred payments	84	Allocated with Revenue Support Grant using 'Deferred Payment Allocation Formula'
Capital		
IT and costs associated with transition to the capped cost system	50	Allocated from Better Care Fund using Adult Social Care Relative Needs Formula
Total	**470.5**	

Note

1 Includes funding from the Better Care Fund, based on assumption that Care Act funding follows the same distribution as Better Care Fund funding. The actual distribution in the Better Care Fund is negotiated locally.

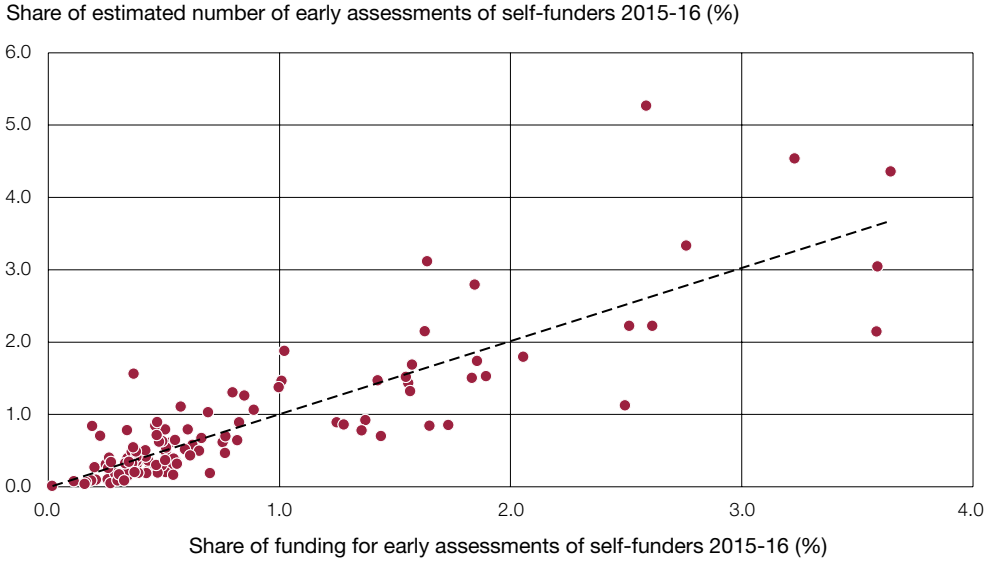
Source: Department of Health, *Response to the consultation on funding formulae for implementation of the Care Act in 2015-16*, December 2014

3.20 Without direct evidence, a modelling-based approach cannot give enough assurance over overall number of self-funders in the community. However, it does indicate the relative proportions of self-funders in local communities. This allows the Department to make reasonable conclusions about funding distribution. We can see this when comparing the variation in council estimates of assessments of self-funders and funding distribution (**Figure 15**).

Figure 15

Variation in council estimates of assessments of self-funders compared to funding distribution

There is a clear relationship between councils' estimates of demand and the Department's funding distribution using the Cap Additional Assessment Formula



Notes

1 Funding for self-funders derived from Local Government Finance Settlement, 19 December 2014.

2 Data from 119 local authorities who provided data using the costing model.

3 Variation in the Department's share of funding for early assessment of self-funders in 2015-16 predicts 73% of the variation in council estimates of the number of self-funders they expect to assess in 2015-16.

Source: National Audit Office analysis of Department of Health data

3.21 To distribute funding for new entitlements for carers the Department applies:

- the clinical commissioning group formula for Better Care Fund allocations; and
- the Adult Social Care Relative Needs Formula, to calculate allocations from the Carers and Care Act Implementation Grant.

3.22 Both are established formulae that use population data, such as size, age, gender, and levels of deprivation, to predict the funding needed to address health and social care needs locally. This gives a reasonable indicator of the distribution of carers and therefore local demand for carers' assessments and services.

Better Care Fund

3.23 A significant proportion of funds for the Care Act are not completely within the control of either the Department or local authorities. The Department assumes that in 2015-16, £124 million of revenue funding,[25] including £69.4 million for new carer rights (Figure 14),[26] and £50 million of capital funding will come from the Better Care Fund. This is not new money; revenue funds come from clinical commissioning group budgets for secondary healthcare. Capital funding is from existing Department of Health grants to local authorities.[27] The Department linked Care Act funds with the Better Care Fund to promote integration and joint approaches to care between local authorities and the NHS.

3.24 The Department has not ring-fenced Care Act money within the Better Care Fund. Each local authority must negotiate its allocations with health partners locally and therefore does not have complete control over funding for their new burdens. The September 2014 stocktake identified a risk in around a fifth of authorities, particularly if there are wider financial challenges, that Better Care Fund spending on the Care Act was not 'in line with expectations'.[28] We found that local authorities are concerned that they will not get enough Care Act allocations through the Better Care Fund.

3.25 The Department relies on the Better Care Fund plans, approved locally by each local health and well-being board, to:

- confirm that their local proportion of the Care Act funding has been identified to meet new Care Act duties;[29] and
- explain how they will meet their new Care Act duties.

NHS England has approved Better Care Fund plans for all local areas and in doing so required local areas to amend their plans where the confirmation of funding or explanation of how Care Act duties would be met was not adequate. Ongoing monitoring by NHS England requires local authorities to confirm that adult social care is protected but does not require anything specific on the Care Act or funding.

25 Excludes £11 million of funding for care and support in prisons, originally included within the Better Care Fund but following consultation to be allocated as a separate grant based on bespoke formulae.
26 National Audit Office estimate using Local Government Association data.
27 Comptroller and Auditor General, *Planning for the Better Care Fund*, Session 2014-15, HC 781, National Audit Office, November 2014.
28 Department of Health, Association of Directors of Adult Social Services and the Local Government Association, *Care Act Implementation, Results of Local Authority Stocktake 2*, September 2014.
29 Notional share based on Better Care Fund Allocation as a proportion of the overall fund.

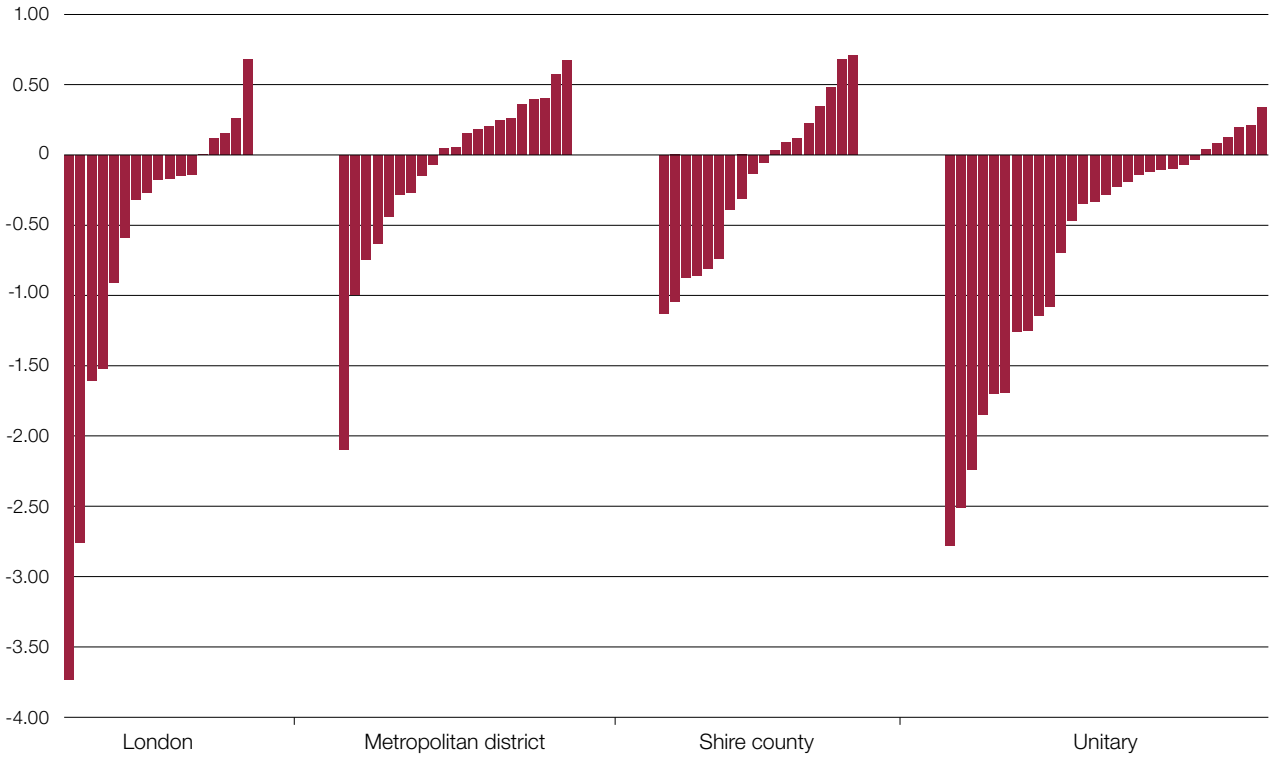
Funding allocations

3.26 To test the reasonableness of the Department's funding allocations we estimated the net funding position of local authorities for new carer's rights and early assessment of self-funders (**Figure 16**). Net funding is the difference (shortfall) between funding that the Department distributes and the local authorities' estimate of the cost of the activity, expressed relative to total current spending on adult social care including all extra Care Act funding.

Figure 16

Net funding position of local authorities by local authority type

Funds the Department allocated to local authorities tend to be closer to the local authority estimates made by metropolitan councils and shire counties



Notes

1 Based on data from 86 councils with adult social care responsibility, for which data was available from the costing model exercise.

2 Includes funding for Care Act implementation from the Better Care Fund, based on assumption that Care Act funding follows the same distribution as Better Care Fund funding. The actual distribution of funding in the Better Care Fund is negotiated locally.

3 Includes £20.3 million of funding for 'general pressures' across Care Act implementation.

4 Local data collection subject to limitations of the model (paragraph 3.16).

5 Local authority gross expenditure on adult social care from Health and Social Care Information Centre, *Personal Social Services: Expenditure and Unit Costs, England – 2013-14, Final release*.

Source: National Audit Office analysis of Department of Health data

3.27 Our analysis shows the extent of potential variation in the risk that councils have been over or underfunded. Variations are due to the difference between local authority estimates and assumptions in the Department's funding distribution, specifically the number of new assessments of carers and unit costs. This will be affected by issues with the quality of the data provided by local authorities and their local spending decisions (paragraph 3.15) as well as by how well the formulae used match the need.

3.28 The analysis suggests that for two out of three local authorities (64%), there is a risk that funding allocation may be less than expected costs with the greatest shortfall for London boroughs and unitary authorities. The median net funding position for all local authorities equates to a shortfall of around 0.2% of total spend on adult social care or around £200,000 for an average-spending local authority. The net funding position of individual local authorities varies significantly by up to 4%.

3.29 The Department has assumed that if demand and costs rise, there should be scope for local authorities to make efficiency savings. We have identified in our report *Local government new burdens* that using central cost estimates and making efficiency assumptions lead to risks that local authorities will be under or overfunded.[30]

Monitoring

3.30 Given the risks in its central estimates, the Department has agreed with stakeholders a series of data to be collected from local authorities each financial quarter starting on 1 April 2015, using the stocktakes. The metrics cover the main areas of the Care Act including early assessment of self-funders and new rights for carers (**Figure 17**). However, with the exception of respite for carers, the metrics do not cover local authorities' costs for providing additional assessments or services. There is therefore a risk that the Department cannot monitor and respond to changes in local costs.

3.31 Should demand or cost exceed expectations, the Department does not have a contingency fund. Any problems meeting demand and cost will fall first to individual local authorities. In the short term, local authorities may have to make savings in other services, divert people to the third sector or delay or reduce services. The latter could create extra burdens for individuals, their families and carers.

30 Comptroller and Auditor General, *Local government new burdens*, Session 2015-16, HC 83, National Audit Office, June 2015.

Figure 17
Data to monitor the Care Act

Act section	Metric
Carers	Number coming for assessment.
	Number eligible for care and support.
	Cost of respite.
National eligibility framework	Number of people assessed for social care.
	Number of people eligible for services.
Self-funders	Number of people who request an early assessment as a self-funder.
Deferred payments	Number of people who request a deferred payment agreement.
	Number of people for whom a deferred payment agreement is agreed.
	Value of deferred payment agreement loans.
Prisons	Number of prisoners assessed.
	Number of prisoners eligible for services.
Advocacy	Number of people for whom an advocate is arranged.

Source: Department of Health

3.32 The Department plans to use monitoring data from the first financial quarter to support the next spending review. This will be the first opportunity for the Department to bid for extra funding if needed. However, there may not be a true picture of demand at this stage and therefore the Department may not have the best information to base its new estimates on. If demand increased further than expected, beyond the first financial quarter, then funding adjustments may be underestimated.

3.33 The Department has a strategy of increasing levels of guidance and support to help local authorities that run into difficulty (paragraph 2.10), including through peer-to-peer support and sector-led improvement activities. Other options for the government might include changes to the regulations. In the short term local authorities may have to cut or reduce services.

Appendix One

Our audit approach

1 Our study examined whether the Department is carrying out Phase 1 of the Care Act in a way that is likely to achieve the government's objectives and to be value for money. We examined:

- the challenges local authorities face and how they are responding;
- whether the Department planned and managed the reforms effectively; and
- whether the Department understands the resource implications of its reforms and is managing the associated risks.

2 There were three main elements to our work:

- **Sector context**

  We analysed data on local government demand and spending on social care to understand the impact of reforms on the sector.

- **Implementation management**

  We interviewed and gathered information from departmental staff and stakeholders to understand how the reforms are being made. We also visited nine local authorities with adult social care responsibilities to understand how local authorities are making the changes.

- **Funding**

  We analysed the information the Department used to understand the impact of the reforms, and which it used to support decisions on funding.

3 Our audit approach is summarised in **Figure 18**. Our evidence base is described in Appendix Two.

Figure 18
Our audit approach

The government's objective

To change the focus of the care and support system to prevent, postpone and minimise people's needs for formal care and support through the principals of promoting independence and well-being and that people should control their own care and support.

How this will be achieved

Through Care Act reforms beginning with Phase 1. These put significant new duties on local authorities from April 2015.

Our study

We examined whether the Department is carrying out Phase 1 of the Care Act in a way that is likely to achieve the government's objectives and achieve value for money.

Our evaluative criteria

Sector context

- The Department clearly understands the cost of wider pressures on local authorities.

Implementation management

- Accountability structures and governance arrangements are clear and working well.
- The Department understands all stakeholders' views.
- The Department can make operational changes well in the light of feedback.
- There is a clear evidence base and objectives.
- Plans for delivery through local authorities reflect risks and constraints.

Funding

- Required resources are in place to carry out plans.
- The Department clearly understands costs.
- The Department has clear monitoring arrangements in place.

Our evidence
(see Appendix Two for details)

- We reviewed the Department's business case and programme management documents.
- We analysed data from the Health and Social Care information Centre, Department of Health and Department for Communities and Local Government.
- We analysed quantitative health and social care data.
- We conducted case study visits to nine local authorities.
- We held interviews with central government representatives and sector experts.
- We drew on evidence gathered from our previous work.

Our conclusions

The Department has managed the introduction of Phase 1 of the Care Act well, with an innovative joint approach with the sector, and good ongoing consultation with involvement of stakeholders and open sharing of data and documents. Consequently, 99% of local authorities were confident that they would be able to carry out the Care Act reforms from April 2015. We judge therefore that the programme has been implemented well and the approach shows good practice from which other programmes could learn. However, with the level of demand so uncertain, the Department's cost estimates and chosen funding mechanisms put local authorities under increased financial risk. In a challenging financial environment, with pressures on all services, local authorities may not have sufficient resources to respond if demand exceeds expectation. In response, local authorities could delay or reduce services in the short term, risking legal challenge and potentially creating an extra burden for individuals, their families and carers, who in turn might seek help elsewhere that is not suited to their needs. This is a longer-term risk to value for money which needs to be managed and goes against the culture change envisioned by the Act. As the Department carries out phase 2 of the Act, it needs to monitor carefully the adequacy of funding each local authority has for Care Act new burdens.

Appendix Two

Our evidence base

1 We reached our independent conclusions on the value-for-money risks of introducing the Care Act Phase 1 reforms between July 2014 and May 2015. Our audit approach is outlined in Appendix One.

2 **We reviewed the Department's business case and programme management documents**. To analyse the Department's approach we examined the Care Act impact assessments and the Department's 'case for change'. We also reviewed:

- care and support reform programme governance documents, board minutes and risk registers;
- results of the 'stocktake' surveys that the Local Government Association and Association of Directors of Adult Social Services did for the care and support reform programme; and
- results of Major Project Authority reviews.

3 **We analysed quantitative health and social care data**. To understand the resource and demand context in which the Care Act is being introduced, we analysed data from:

- Department for Communities and Local Government on local authority revenue account budget and outturn;
- Health and Social Care Information Centre data on Projecting Older People Population Information and Projecting Adult Needs and Service Information surveys and on population numbers from the Office for National Statistics; and
- Health and Social Care Information Centre data on assessments and packages of care and data on population numbers from the Office for National Statistics.

To examine the Department's funding estimates, we analysed how it calculated the two largest areas – the cost and demand for self-funder assessments and assessments and services for carers using:

- Care Act impact assessments and supporting data; and
- the results of the Department's cost modelling exercise.

4 **We visited case study local authorities**. We spoke to directors of adult social services, cabinet members for social care and other senior officers responsible for Care Act implementation at nine local authorities: Bracknell Forest Council; Durham Country Council; London Borough of Lambeth; Lincolnshire County Council; Staffordshire County Council; Suffolk County Council; Redcar and Cleveland Borough Council; Devon County Council; and Wakefield Council. We selected these to cover a range of local authority types, in different regions, experiencing different pressures from Care Act implementation. We visited local authorities to understand the challenges they are facing and approaches they using to manage those challenges. In addition, we visited Coventry City Council and Kent County Council to inform our scope and methodology.

5 **We interviewed central government representatives and sector experts**. We designed the interviews to focus on how the Department has managed the main risks in introducing the Care Act including:

- the cost of the reforms and how funding is allocated;
- raising public awareness of the changes;
- local authority IT and workforce capacity;
- changes to information and advice services;
- monitoring of outcomes and evaluation of policy objectives; and
- support for social care providers.

As well as the Department, we interviewed representatives from the Department of Communities and Local Government responsible for social care reform. We also interviewed:

- programme management office partners; the Local Government Association and the Association of Directors of Adult Social Services; and
- sector experts from the care and support reform programme board including: Skills for Care; the Social Care institute for Excellence; and the Care Provider Alliance.

6 **We drew on evidence gathered from our previous work:**

- *Adult social Care in England: an overview.*
- *The impact of funding reductions on local authorities.*
- *Financial sustainability of local authorities 2014.*
- *Planning for the Better Care Fund.*
- *Central government's communication and engagement with local government.*

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