CARE & SUPPORT ALLIANCE

Response to the regulations and guidance of the Care Act 2014

Section 2: Preventing, reducing or delaying needs

Contact: Chloë Carter, Care & Support Alliance lead – prevention
CCarter@redcross.org.uk / 020 7877 7946

The Care & Support Alliance (CSA) was set up in July 2009. It is a consortium of over 70 organisations that represent and support older and disabled people, including disabled children, those with long-term conditions and their families, and campaigns to keep adult care funding and reform on the political agenda.

Overview and headlines

The CSA is pleased to have been working with the Department of Health on the development of the prevention regulations and guidance (and other aspects of the Care Act).

Overall we are very pleased with this drafting of both the regulations and guidance. This drafting is both useful and readable.

We are especially pleased with the tone of the guidance, which locates prevention in the context of personalisation and community resilience, but does not imply receiving a state-arranged/funded service to be a negative thing. The tone helps to promote prevention across the life course and throughout an adult's interactions with adult social care. It is important that preventative services, facilities and resources are promoted and available to both adults in receipt of state-arranged/funded services, and to adults not in receipt, of state-arranged/funded services.

Some areas can nonetheless be strengthened further and there is scope to improve the read across to other chapters. These areas are the focus of the response below.

Consultation questions

Question 3: Is the description of prevention as primary, secondary or tertiary, a helpful illustration of who may benefit from preventative interventions, when and what those interventions may be?

Yes, the description is helpful. It is helpful to have recognition of the different types of prevention, and to have a description of these. We are pleased that each type of prevention is given equal weighting and merit. The description of primary, secondary and tertiary helps to convey prevention as a continuum, rather than as a single, particular type of intervention.

Question 4: Is the list of examples of preventative 'services, facilities or resources' helpful? What else should be included?

In the main, yes, though some alterations and additions would make the guidance stronger and clearer:

2.6

One of the examples of primary prevention in this section is to 'provide universal access to good quality information'. There needs to be clarity that the information and advice clause is separate from the prevention clause. While we recognise that providing information and advice can be a successful preventative measure, using it as an example here may imply that fulfilling the information and advice duty of clause 4 is sufficient for a Council to fulfil the prevention duty of clause 2.

A line should be added along the lines of 'providing information and advice is not enough…'

2.7

An example of secondary prevention in this section includes 'minor adaptions to housing…' Councils are already obliged to provide minor aids and adaptations. We welcome examples that illuminate the duty of cooperation, but this particular example implies that maintaining the status quo is sufficient to meet the duty of clause 2. We ask that an alternative be used. The short-term provision of wheelchairs (i.e. wheelchair loans) might be a good alterative, as this provision is not currently legally obligated, and it calls for cooperation between local authorities and CCGs.

GP-practice-based social prescribing would be a useful addition, which would also highlight the need for cooperation with GPs. Social prescribing enables primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector. This can reduce needs and prevent crisis.

Case study between 2.7 and 2.8

2.39 refers to 'improving skills'. It would be good to have more of a focus on this and its potential role in reducing needs.

Access to education, learning and training can increase independence and wellbeing. For example, ensuring people with a learning disability have access to opportunities to improve their independent living skills can increase their confidence and wellbeing. In some cases this can reduce needs. For example, some people with a learning disability who receive support to use public transport, may not need this support once they have had travel training. It is important there are ongoing opportunities to improve skills.[1]

2.8

We are really happy to see the focus on people regaining their skills included in this section.

[1] There are examples of travel training available online, including within this 2011 Department of Transport guidance: http://assets.dft.gov.uk/publications/travel-training-good-practice-guidance/guidance.pdf

No examples have been provided on rehabilitation for blind people, particularly around if/when their circumstances change. Prevention should be a focus for adults with changing needs, and not something only put in place at the beginning of an adult's journey.

People with sight problems do not always realise that they are entitled to support, or what support is available to them. They may not read the later section in the guidance on registers, so perhaps 2.8 could signpost to that?

We welcome the inclusion of befriending schemes, but feel this section can be strengthened through an example of what such a scheme might involve.

2.9

There is no mention of what rehabilitation is and this should be included to complete the set of definitions.

There is an issue with the last sentence in this section: 'to reduce their needs, in particular through the use of therapy or minor adaptions'. We feel that 'in particular…' should be changed to 'including', as there is no evidence-based reason we are aware of for therapy and minor adaptations to be prioritised over other types of intervention.

2.11

This might not be the right section for its inclusion, but there is no mention about care at the end of life and how preventative services can support this.

It is important to recognise that people at the end of their life can benefit from reablement. There is a perversity within the ASCOF that makes it especially important that this be recognised: because the success measure for reablement is that the recipient is still at home 91 days after discharge, people who are at the end of life can be excluded from accessing reablement (because if the local authority included them it would negatively impact upon reported performance).

2.12

The examples of services, facilities or resources that could contribute to preventing, delaying or reducing the needs of carers are good. The case study which is carer-focused is also good.

The provision of information and advice is used as an example of a preventative service, facility or resource, and – just as in 2.6 – we do not want Councils to be misled into thinking that the provision of information and advice is sufficient to fulfil the duty of prevention in clause 2.

A slight improvement to this section (or to the case study) would be to insert a line stating that a review should be scheduled, since carers' needs are likely to increase over time.

We feel that reducing social isolation needs to be made clearer in the case study.

This section would benefit from an explicit recognition of grandparents, as many of the issues are related to their experiences.

Preventing mental health crisis

Hospital aftercare should be specifically referred to or identified in the discussion about prevention – probably at secondary and tertiary prevention. Any patient who has been a psychiatric inpatient may be at risk of future relapse and vital services put in at this stage will promote recovery and can also prevent relapse, which is costly to the person and to the state. Likewise, assessment and provision of adequate mental-health-crisis services prevent people in the community going into hospital.[2]

Likewise, we consider there to be a particular need for preventative crisis care and it would be helpful if this was included in the guidance. It would be helpful to a case study that provides an example of a person who has a mental health problem resulting in needs that could precipitate a crisis in their life if they were not met. People have in the past contacted CSA members' advice services to complain that reablement services fail to take account of their mental health needs.

The existing case study of Mr. A (with a physical need, p.23) could include an aspect of mental health support and prevention, or an additional case study could be included to illuminate this.

The regulations

Charging regulations:

p.17 definition of 'intermediate care'

It is very helpful that the definition now clearly includes reablement. This is something that has previously caused confusion and had to be clarified through Local Authority Circulars. We welcome this clarity.

We are pleased that the definition is focused on regaining and maintaining skills. We are also pleased that 'limited period of time' has become 'specified period of time'; as stated above, we welcome the location of prevention in the context of personalisation.

Prevention regulations:

p.34 definition of 'intermediate care'

2(a)

This is not consistent with the definition in the charging regulations and we believe this to be a legal oversight. We welcome indications from the Department of Health that the definition of 'intermediate care' given in the charging regulations is the intended definition: 'programme of care and support' is much clearer and easier to understand than 'programme of services, facilities or resources'.

[2] There is considerable evidence, including of economic pay-offs per £ of expenditure for a variety of service models, in this PSSRU resource: http://www.centreformentalhealth.org.uk/pdfs/Economic_case_for_promotion_and_prevention.pdf

p.35 services to be provided free of charge

4(2)

We would query why section 117 services are not listed as one of the , preventive services. In their effect, s 117 services are promoting recovery but also preventing relapse.

Prevention guidance: full submission

2.1 and 2.2

It seems as though there are different aims in these two sections, which we suspect are intending the same thing. We'd like to see greater clarity of aim/s.

It is important to remember that authorities can decide to meet needs that are not deemed to be eligible, if they choose to do so (chapter 6). Local authorities should understand the benefits of meeting lower level social care needs. A bit of social care support early on can prevent a person's life tipping into crisis. (For example: a few hours support to help someone with a learning disability with moderate needs to manage their money; supporting people who are alcohol dependent to manage their housing tenancies; ensuring older people who live alone receive a couple of hours of practical and emotional support upon discharge from hospital). If people do not get the support they need, their needs are likely to escalate. As well as having a significant, detrimental impact on those who need support, the escalation of need has a significant financial impact on local authorities, the NHS and criminal justice systems.

Research commissioned by charities found that tightening eligibility for social care is a false economy: for every £1 spent on support for people with moderate needs, £1.30 will be returned to the NHS, local and central government, and individuals.[3]

2.7

The paragraph that starts with 'Targeted interventions should also include approaches to identifying carers…' does not relate to the examples that follow. If this paragraph was swapped with the paragraph that starts with 'Early intervention could include a fall prevention clinic…' then it would flow nicely to the last paragraph, where carers are also mentioned.

2.9

The 2003 definition of 'intermediate care' has been inadvertently included here and needs to be updated.

2.13

We are very pleased with this section.

[3] http://www.mencap.org.uk/ending-the-other-care-crisis

We do though need to recognise that many people live alone. Promoting wellbeing therefore needs to go beyond holistic consideration of the role a person's family and friends can play in helping them to meet their goals. This would probably sit best in an additional paragraph.

The given case study could more-strongly emphasise preventing social isolation.

2.14 to 2.16

The person-centred approach is welcome, including the focus on achieving goals.

We also welcome to the focus on asking people "what does a good life look like for you…?"

A link to a case study has been included in this section, but we feel the case study will be overlooked unless the information is summarised, or an alternative, shorter case study replaces it. At the moment the link does not go anywhere, which is a persistent risk with including hyperlinks in documents of this nature.

It would be useful to have an example of where state-funded/arranged community services work together with lower-level services, to illuminate that prevention is also about reducing and delaying need.

Prevention and Safeguarding

A key part of the Safeguarding Adults Board's role will be to develop preventative strategies with the aim of reducing instances of abuse and neglect in its area.

This might include: ensuring there is information and advice easily available and in an accessible format on keeping safe and reporting concerns; access to advocacy and social care support where appropriate; specific community initiatives; robust mechanisms in place for early sharing of risks, such as through multi-agency safeguarding hubs; and monitoring of commissioning decisions to ensure they are not putting people at unnecessary risk.

A link therefore needs to be made between chapter 2 and chapter 14. We note that the Department of Health senior policy manager leading on the safeguarding elements of the Care Act is speaking on this subject at a forthcoming event[4]. We therefore acknowledge that there may already be the intention to make this link in the final drafting.

A suggested case study for inclusion:

Stay Safe Project for people with Learning Difficulties

People with a learning difficulties said they felt scared at times and not safe in our community. They told us how it felt to live in the area. They told us of some of the crimes that had been committed against them. They told us they sometimes felt bullied and this frightened them and stopped them getting on with their lives

We worked with them and they had the idea of producing a booklet called 'Think Safe' which would help people think about their own safety

We also thought we should plan events that would be fun and interesting where people could learn about how to keep themselves safe. We called this the Stay Safe project. We have now had 12 Stay Safe events.

[4] http://www.communitycareconferences.co.uk/safeguardingprevention2014/agenda

Thurrock Safeguarding Adults Board[5]

2.17

The focus on future planning is welcome.

2.19

This section states that 'the local authority must take steps to identify and understand both the current and future demand for preventative support…' However, there is no example of how LAs can achieve this until 2.23. This could be better joined-up for clarity.

2.30

We would welcome recognition of the role of trusted professionals like pharmacists, ophthalmologists, optometrists, dentists etc.

2.31

This section would be stronger if it more-explicitly recognised that these points in a person's life are just as relevant to person already in receipt of state-funded/arrange care and support.

2.40

'also required to' should be a bolded 'must' in order to ensure consistency of language and formatting; we believe this is an inadvertent oversight in the drafting.

2.41

The 'must' in the beginning of this section should be bolded.

The beginning of this section states that 'the authority must in any case provide in writing, information about what can be done to prevent, delay or reduce their needs'. Information in writing may not always be accessible, so there should be a reminder about the importance of accessible information. This has been mentioned in some parts of the regulations, but it needs to be consistent throughout.

Towards the end of this section, it is cited that 'the local authority must consider similarly what information and advice would contribute…' This 'must consider' should read 'must provide'. If this is not changed then there will be a perversity within the guidance whereby:

- people with eligible needs must be provided with written information and advice about can be done to prevent, delay and reduce their needs;
- people with non-eligible needs must be provided with written information and advice about can be done to prevent, delay and reduce their needs;
- people with some eligible and some non-eligible needs may or may not be provided with written information and advice about can be done to prevent, delay and reduce

[5] Case study provided by a person from Thurrock SAB in the Safeguarding task and finish group. She is happy for it to be used in the statutory guidance either with Thurrock named, or with Thurrock removed in order to achieve consistency across the case studies.

their needs; they would be disadvantaged because no comparable duty applies to them.

2.44

We would like to see an evidenced example given as to when 'charging may also make a preventative service viable or keep a service running'. We have been unable to find one.

2.47

There needs to be clarity here that where local authorities provide *or arrange* intermediate care, or reablement to those who require it, this **must** be provided free of charge for a period of up to six weeks.

2.48

We are pleased that this section acknowledges that 'neither intermediate care nor reablement should have a strict time limit…' and especially the reference to supporting people who have recently become sight-impaired.

Insertion of 2.49

We would like to see an additional section at the end of the guidance that says local authorities should consider the impact and consequences of ending preventative services. Poorly considered and planned exit strategies can negate the positive outcomes and impacts of preventative services. For example, someone who has been supported to reduce their social isolation may find it very upsetting when their preventative service ends and their contact with the service's staff/volunteers will cease. It is important to clearly explain and set fair expectations about the nature of short-term services. It is also important that local authorities consider the risks and consequences of withdrawing support.

Case study: Considering a person's strengths and capabilities on p.75

We are very concerned with this case study, in which a neighbour is asked if they would be happy to assist their neighbour getting to work each day. No regard is shown as to:

- whether the neighbour is willing and able to do so;
- what their needs might be as a new carer;
- what contingencies should be put in place to support such an arrangement;
- nor whether it is ethical for the social worker to approach them in the first place.

This case study needs to be completely overhauled, or ideally removed entirely.