Care and Support Statutory Guidance

On 24 October 2014 the Government published the Care and Support Statutory Guidance (the regulations for the Care Act 2014). See copy here

The regulations come into force in April 2015. This briefing summarises the points of most relevance to the profession – largely concentrated in section one local authorities' general responsibilities to promote wellbeing and prevent, reduce or delay needs.

1. Duty to promote wellbeing

1.1 The Care Act introduces a duty on local authorities to promote wellbeing.

1.2 Wellbeing is defined in regulations as: personal dignity, health and emotional wellbeing, protection from abuse and neglect, control by the individual over day to day life, participation in work, education, training or recreation, social and economic wellbeing, domestic, family and personal wellbeing, suitability of living accommodation and an individuals contribution to society.

1.3 In promoting wellbeing authorities need to look at what interventions will impact on that individual's wellbeing in any of these areas, taking into account what will support improvement, and considering individual's needs, wishes and goals.

1.4 The regulations say that the wellbeing principle must be considered throughout the care and support system, including in the delivery of universal services (i.e. including people not eligible for care and support services) and including carers.

1.5 A strong theme running through the wellbeing principal is the importance of individuals participating, being in charge of their care and support and starting from an assumption that an individual knows their needs best.

2. Preventing, reducing or delaying needs

2.1 Local authorities have a duty to prevent, reduce or delay needs. The regulations promote early intervention to help people retain or retain their skills and confidence, prevent need or delaying deterioration wherever possible.

2.2 This prevention duty is universal, applying to people who do not meet eligibility criteria for care and support, and to carers.

2.3 The regulations describe prevention in three overlapping categories.

- Primary prevention and promotion of wellbeing – such as ways to promote health living e.g. exercise classes, and activities that reduce loneliness and social isolation.
- Secondary prevention - to slow down deterioration, such as falls prevention clinics and telecare services, and screening individuals at risk

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- Tertiary prevention - intermediate services to minimize disability or deterioration for people for people with complex or established health conditions and regaining skills e.g. rehabilitation and reablement services to help people retain independence.

2.4 The regulations say that intermediate care and reablement must be provided free of charge for up to six weeks and adaptations up to the value of £1000 and that local authorities should consider not charging for longer if needed.

2.5 Local authorities may provide prevention services themselves or they may identify where others provide prevention services, or provide services in partnership e.g. with NHS rehabilitation services.

2.6 The regulations uses a case study published in Physiotherapy Works for Social Care briefing as an example of an intermediate prevention service. The case study is from the Bradford Enablement Support Team.

3. Planning to prevent, reduce or delay needs

3.1 The regulations place a responsibility on local authorities to identify and understand the current and future demand for preventative support, and consider the numbers of people with existing needs for care and support and those at risk of developing needs in the future. It suggests this assessment of need is done through Health and Wellbeing Boards, and could form part of the Joint Strategic Needs Assessments (JSNAs)

3.2 Prevention objectives need to include arrangements to identify and target those who would benefit from preventative support, and be closely aligned to other local authority duties, including public health. It suggests these plans could form part of Health and Wellbeing Strategies.

3.3 Local authorities will have a responsibility to establish and maintain a service to advise and support people to prevent, reduce or delay care needs. They must also develop a plan for this, based in a detailed analysis of the needs of the local population, aligned to the Health and Wellbeing Strategy.

4. Outcomes to shape the market and inform commissioning

4.1 Local authorities must set local outcomes, based on consideration of the social care outcomes framework. It also directs local authorities to refer to the ‘Making it Real’ statements produced by Think Local Act Personal when framing outcomes for individuals, groups and their local population

4.2 Outcomes must be at the heart of commissioning and practice. The regulations suggest moving from purchasing units of provision (e.g. hours of care) to payment by outcomes where practical, purchasing specified, measurable outcomes for people, with a focus in this on prevention, enablement, reducing isolation and promotion of independence.

4.3 Commissioning should support the building of community capital – making the most of skills and resources in the area.

4.4 Local authorities should use commissioning to encourage services that respond to fluctuations and changes in peoples care and support needs.

4.5 Local authorities will be required to produce a market position statement and develop the JSNA based on this on provision, engaging with a wide range of people in this, including health and social care professionals.

5. Empowerment – of individuals, families, carers and communities

5.1 The language used throughout the regulations is in terms of empowerment: co-production of services and plans, and promotion of resilience and strength, among individuals and in communities.

5.2 This features in how services are delivered – developing interventions and services around an individual's needs, wishes and goals, involving the individual, their family and carers in making decisions.

5.3 It also features in planning services, with emphasis given to involving the community and a range of stakeholders (including health professionals) in planning what services are needed for their area.

5.4 In commissioning local authorities are also asked to consider how they are building community assets, and making the most of the skills and resources in any given community – including in the voluntary sector.

6. Integration, cooperation and partnerships

6.1 Local authorities are required to carry out their care and support responsibilities (in prevention, advice and support, market shaping and commissioning) through joining up with the services provided by the NHS and other health related agencies.

6.2 Within prevention it describes the importance of integration of different rehabilitation and other intermediate services, including going beyond traditional health and care specialists (e.g. to include voluntary sector activities in the community).

6.3 Local authorities must have an integration approach with health. This could be through Joint Strategic Needs Assessment and shared local data, pooled budgets, joint commissioning, integrated management and/or integrated provision.

6.4 There is a general duty for local authorities and partners to cooperate in the promotion of wellbeing, improving quality and outcomes, transition from child to adult services and protecting adults at risk of abuse or neglect.

6.5 Local authorities must cooperate with NHS bodies and the regulations include detail around supported discharge – both how NHS providers should notify local authorities and reimbursements by local authorities to NHS providers where delays in social care delay discharge from hospital.

7. Implications for the CSP

7.1 The Care Act regulations can inform how CSP staff and members engage with social care commissioners in England, as part of the Physiotherapy Works programme.

7.2 Their publication reinforces the relevance of the Cost of Falls Tool to social care commissioners, including as a means to measure and predict need for inclusion in Joint Strategic Needs Assessments.

7.3 It suggests that to make physiotherapy relevant to social care decision makers in England we need to frame what physiotherapy has to offer around how it helps local authorities meet their duties to prevent, delay and reduce need:

- Primary prevention e.g. exercise classes for people with long term conditions
- Secondary prevention – e.g. identifying those at risk of falling by timed get up and go tests, and referral of those at risk to physiotherapy
- Tertiary services – by showing the role of physiotherapy in intermediate care, and raising awareness of how rehabilitation and reablement interrelate.

7.4 It suggests further that we demonstrate to social care decision makers how physiotherapy prevents delays in discharge from hospital (and therefore the financial penalties that will be incurred by local authorities), and how access to physiotherapy can reduce the impact of caring on a carer's health and wellbeing.

7.5 It highlights the significance of Health and Wellbeing Boards, JSNAs and Health and Wellbeing Strategies and the need for CSP and members to be engaging with these decision makers and planning processes.

7.6 It shows the need for the CSP to understand the role of physiotherapy in existing examples of integration, be able to show what good integrated health and social care services look like, and to promote this both within the profession and externally.

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