CEQUA
LTC network

Quality and cost-effectiveness in long-term care and dependency prevention

COUNTRY REPORT

The English policy landscape

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Introduction

England is undergoing a series of social, demographic and economic changes that are affecting the nature and intensity of support received by people with long-term care needs. According to the Department of Health (2012), the number of people in England with multiple long-term conditions will increase from 1.9 to 2.9 million between 2008 and 2018. Whereas expectations regarding the quality of care continue to grow (Knapp, 2013), public resources have fallen sharply following the economic recession, and social care public spending is under significant pressure (Fernandez et al., 2013). Unless this trend is reversed, current levels of social care provision are unlikely to be sustainable in the future (Curry, 2006, Humphries, 2010). Given this context, not surprisingly, significant policy attention is focused on maximising the cost-effectiveness of the social care system, so that service users' and carers' quality of life is maximised within available resources. Thus, the key underlying goal of the reforms in the long-term care sector has been managing demand and reducing costs.

This report summarises emerging policy developments in England[1] in relation to quality and cost-effectiveness and dependency prevention in the long-term care area [2]. The report begins with a brief overview of the long-term care system in England. It then reviews key recent policy developments in the following four areas:

- Reducing dependency cost-effectively
- Supporting unpaid carers
- Use of innovative care models/technologies
- Strategies for maximising care coordination.

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[1] The UK consists of England, Scotland, Wales and Northern Ireland, and each constituent country has a separate long-term care system. This report focuses on England only, however the population of England accounts for 84% of UK population.

[2] It does not aim to provide a comprehensive description of the English social care system. Excellent summaries of the English social care system can be found in Comas-Herrera et al. (2010); Glasby (2012), NAO (2014).

Brief overview of the formal LTC system in England

The support received by people with long-term care (LTC) needs in England is provided by a complex system involving a number of organisations in charge of health, social care, housing and other services. The majority of LTC in England, however, is provided by unpaid carers; according to the Census, 5.4 million people in England provided unpaid care [3] in 2011, with a third providing over 20 hours per week of care (Office for National Statistics, 2013, HM Government, 2014b).

In England, an important distinction is made between social care, non-medical services aimed at supporting people with LTC needs with their daily living needs, and other, healthcare dominated care services. Formal social care services include residential/institutional care, day care, home-based care services, professional support services such as social work, occupational therapy, and aids and adaptations (Comas-Herrera et al., 2010, Wittenberg et al., 2015). Clinical Commissioning Groups (CCGs) commission most health care services for local populations, and the National Health Service (NHS England) is responsible for commissioning primary care and some specialist services. Local authorities are responsible for assessing needs and arranging social care services based on national minimum eligibility criteria. They are also responsible for public health and housing services (Wittenberg, 2017 forthcoming).

LTC services provided by the health care system are funded from general taxation and are free at the point of delivery. Social care services are funded through a mixture of local taxation, grants from central government and user charges for services, which are means-tested. Public social care support has become increasingly rationed and concentrated on those with the highest needs. Whereas capital and savings below £14,250 are disregarded in the means-test, people with capital and savings above £23,250 are excluded from public financial support.

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[3] The same proportion of population as in 2001 Census.

It is planned that from 2020, the capital threshold for the social care means-test will be increased to £118,000 (Hancock *et al*., 2013, HM Government, 2014a, Age UK, 2015). In the Care Act 2014, the government adopted proposals for a lifetime cap on private contributions to care costs set at £72,000, which is due to come into effect in April 2020. The cap will only apply to direct care costs, and accommodation costs in residential care will still be the responsibility of private individuals. In 2015, the government announced that local authorities will be allowed to increase the local council tax on property by up to 2% to fund adult social care (ASC). Further similar increases in council tax to invest more money into care services are being considered. This social care council tax precept has exacerbated significant concerns about the local variability of social care provision, as more affluent local authorities would be able to collect more funds through the tax than others (Fernandez & Forder, 2015). The government has promised to devote an additional £1.5 billion to compensate councils for differences in their capacity to raise revenue through the council tax precept (HM Government, 2015).

Rising demand for LTC, combined with public austerity measures, have led to significant decreases in state-funded social care support. These reductions have affected particularly community care users. Due to inadequate community services, there are concerns over bed blocking in acute care settings, and the number of older people with delayed transfers of care from hospital is increasing. Recent policy developments have aimed to support integration between social and health care systems, in the hope that better coordination will reduce demand for acute health care (National Collaboration for Integrated Care and Support, 2013, Miller, 2014, NHS, 2014, Erens *et al*., 2016). Home and residential social care in England are provided almost exclusively by private for-profit and not-for-profit organisations; around 90% of residential and homecare is outsourced. The Care Act 2014 encouraged local commissioners to increase provider and care options for service users, and imposed a duty on Councils to develop and manage sustainable, high-quality care markets (HM Government, 2014a). Public sector commissioners have significant purchasing power and often act as monopsonist purchasers, and concerns have been raised over pushing profit margins below the level needed to invest in existing or new facilities. The nature of the care market, however, is highly variable. Affluent areas are dominated by privately-funded demand, less wealthy parts of the country by publicly-funded demand. It has been reported that self-funders cross-subsidise publicly funded users which could jeopardize market sustainability particularly in less affluent areas with fewer cross subsidies from private payers (Laing, 2014). The formal care market in England is highly regulated; the Care Quality Commission (CQC), the independent regulator and inspector for health and social care services, is responsible for ensuring that people receive safe, effective and high-quality care. Since April 2015, CQC has also responsibility for evaluating the financial sustainability of care providers to safeguard against care market failures (HM Government 2014; www.cqc.org.uk, accessed on 15/11/2016). NHS Improvement, which came to existence in April 2016, brings together several organisations responsible for monitoring NHS trusts and independent providers of NHS-funded care (www.improvement.nhs.uk; accessed on 15/11/2016).

Policies aiming to reduce dependency cost-effectively

Recent policy documents

Prevention and early intervention have been a prominent policy focus over the last decade in England. The aim is to shift activity away from long hospital stays and residential care by reducing, preventing and/or delaying the need for intensive and expensive LTC services (HM Government, 2006, 2007, Departament of Health, 2010, Think Local Act Personal, 2011b, Knapp, 2013, Lombard, 2013). The appeal of preventing people's needs from deterioration, and the accompanying promise of saving scarce public money, has greatly

underpinned recent reforms in England. The core assumption is that preventative services will promote individuals' well-being, quality of life, health and independence which, in the long term, will result in a decrease in demand for high-cost services.

There have been numerous policy references to the strategic importance of investing in prevention. The 2006 white paper Our Health, Our Care, Our Say placed preventative approaches at the core of the reform agenda in social care with an aim to reduce cost pressures on acute care and promote efficiency (HM Government, 2006). Putting People First, published by the Department of Health (DoH) in 2007, further reinforced the importance of prevention and early intervention. This led to the signing of a concordat between Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and the NHS, which defined a shared vision and commitment to system-wide social care reforms focussed on prevention, early intervention, reablement, personalisation and information and advice (HM Government, 2007). Think Local Act Personal, a national partnership of central and local government, the NHS, providers, service users and carers was established in 2011. It states that achieving a shift towards prevention and early intervention is a central objective of social care transformation (Think Local Act Personal, 2011b see also www.thinklocalactpersonal.org.uk).

The legal obligations around prevention: Care Act 2014

The Care Act 2014 is the first legislation to make prevention a statutory responsibility of ASC in England. It identifies "promoting individual well-being" and "preventing needs for care and support" as the first two of seven general local authority responsibilities. The statute imposes a duty on councils to invest in new preventative services and to fully utilise any existing services, facilities and community assets to prevent people's care needs from escalating (HM Government, 2014a). The Care Act implementation guidance document notes that "at every interaction with a person, a local authority should consider whether or how the person's needs could be reduced or other needs could be delayed

from arising". The statute also imposed a legal duty on local authorities to establish and maintain information and advice services and provide this in accessible ways tailored to the needs of all local people, not just those who are entitled to funding or support from the council but also to self-funders. English local authorities have reported increasing levels of readiness to implement their new statutory duties related to prevention; in 2015, 64% of local authorities had a cross-organisation prevention strategy and 81% had arrangements in place to identify people who would benefit from prevention.

Prevention and the need for care coordination

Collaboration across sectors is particularly important in the prevention area. In part, its relevance stems from the fact that the benefits of preventative services often accrue to a different part of the system from the one which funded the intervention. Integrated working with other agencies was framed as an "essential, not optional" part of the ASC's vision to enable a more preventative model of care. The Care Act 2014 recognised that achieving prevention goals requires the involvement of a wide range of services alongside ASC, including public health, NHS, transport, leisure and housing services. Wider community resources are also expected to be part of the overall preventative model of care, including local support networks and facilities provided through the voluntary and community sectors (Department of Health, 2014). The transfer of public health from the NHS to local government in 2013 has created unique opportunities for councils to make a stronger impact on improving the health of local communities and to change the focus from treating illness to actively promoting health and wellbeing, reducing health inequalities and focusing on prevention (LGA, 2014). The move of public health to local authorities seems to have facilitated important opportunities to work towards an integrated approach to prevention and public health has been reported to often lead on the development of system-wide prevention strategies and commissioned integrated prevention services (LGA, 2016b).

The emphasis on health and social care collaboration to promote preventative approaches has been reinforced by expectations that it will reduce demand for more intensive social and acute health care. Prevention is a core aim of recent health policies such as NHS Five Year Forward View and Sustainability and Transformation Plans (STP)[4], although their prevention priorities vary from that of social care, with more focus on disease prevention and public-health related schemes such as smoking cessation, reducing obesity and alcohol consumption. However, health and social care prevention policies and initiatives increasingly focus on developing more integrated services. The potential for integrated prevention schemes to deliver benefits across health and social care systems was, at least initially, an incentive for developing the Integration Pioneer and Better Care Fund Programmes (National Collaboration for Integrated Care and Support, 2013, Erens *et al*., 2016, LGA, 2016a). It was also seen as a principle underpinning the development of new care models within the NHS and between it, local government, the third sector and individuals (NHS, 2014).

Housing, which is a statutory responsibility of councils in England, has been recognised to play an important role in the promotion of physical and mental wellbeing of individuals and in the prevention agenda (LGA, 2014, 2016b). The Care Act 2014 identified the preventative role that housing plays in wellbeing and the implementation guidance state that councils must integrate prevention provision with health-related services, which includes housing (Department of Health, 2014, LGA, 2015). The Supporting People (SP) programme was introduced in 2003 and the funding, guaranteed until 2009, was used to deliver supported housing[5] and other

housing-related support to vulnerable people to help them to gain the skills to live more independently. There is some evidence that the programme generated net benefits by delaying or avoiding long-term residential care (Bligh *et al*., 2015). Following the end of the ring fence around SP funds, however, local authorities in England have decreased funding for supported housing, and concerns have been expressed about the closure and decommissioning of supported housing schemes (Department of Health, 2014, Blood *et al*., 2016).

Prevention and healthy ageing

The last ten years of government policy have included repeated commitments to achieving the goal of healthy ageing. Policies on healthy ageing are often aligned with prevention strategies and focus on improving quality of life, independence and wellbeing (HM Government, 2006, NHS, 2014). The NHS Five Year Forward View mentioned higher levels of physical activity alongside prevention objectives as a measure to improve wellbeing (NHS, 2014). Emphasis on physical activity for older people was included in the commissioning guidance for the NHS (Department of Health, 2012b) and annual reports of the Chief Medical Officer[6] on the state of public health in England (Age UK, 2010, Department of Health, 2012c, 2015). Healthy life expectancy is also cited as a part of prevention strategy (NHS, 2014); the National Service Framework for Older People aimed at extending the healthy life expectancy of older people through a coordinated initiatives led by the NHS with councils' collaboration. The measure of healthy life expectancy at age 65 remained in the performance management system for the NHS[7] until recently,

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[4] STP were announced in 2015 – health and care systems in England have to produce STPs showing how services will evolve and become sustainable over the next five years in their local area and how they will deliver the Five Year Forward View

[5] Supported housing often refers to housing schemes where housing, support and sometimes care services are provided to help people to live as independently as possible in the community. Supported housing users include older people and

people with disabilities-many of whom would otherwise be living in long-term care or hospital settings. In 2015, it was estimated that 71% of supported housing units in Great Britain housed older people (Blood *et al*. 2016).

[6] The Chief Medical Officer (CMO) acts as the UK government's principal medical adviser and the professional head of all directors of public health in local government.

[7] Albeit primary care trusts could choose whether to prioritise it locally (The Operating Framework for the NHS in England 2010/11).

although the latest NHS Outcomes Frameworks and the NHS allocation formula include mortality only. Healthy life expectancies have also been cited in government reviews on healthy ageing and have been recommended for routine monitoring of inequalities (Jagger, 2015).

Maximising coordination in care provision

Commissioning and provision of LTC services in England is often described as fragmented and poorly coordinated. This is associated with the administrative, funding and professional divides between the NHS and the local social care systems. The NHS is itself also fragmented between primary, secondary and community health services, as well as between mental and physical health services (Barker, 2014). Integration has been advocated as a mechanism for improving cost-efficiency through coordination of a diverse range of providers and services, and it has become a crucial part of policy rhetoric with numerous policies and initiatives introduced over the last decade. Although the focus of many integration initiatives in England is on the coordination of health and social care services, integration has been promoted also with housing and leisure services, and with other sectors (e.g. the third sector).

Recent policy initiatives

The DoH and NHS England have introduced a range of schemes to support local areas to develop plans for integration within healthcare settings and across health and social care. The goals of integrated care were articulated in the 2006 white paper Our Health, Our Care, Our Say, which highlighted the need for social and health care services to be joint up and built around individuals' needs rather than service providers (HM Government, 2006). The 2008 NHS Darzi Review also voiced a need to ensure that fragmented services were better joined up and care was more integrated to enable more cost-effective interventions. The establishment of Health and Wellbeing Boards (HWBs) under the Health and Social Care Act 2012, was a major step towards facilitating collaboration of key leaders from the NHS, public health and local government, including Healthwatch as patients' representative. The principal statutory duties of HWBs were to assess health and care needs of local populations through producing joint strategic needs assessments (JSNAs). HWBs were to address identified needs through joint health and wellbeing strategies (JHWSs). The financial climate was reported as one of the biggest impediments to progress JHWSs which would provide a strategic framework for commissioning decisions for local authorities, NHS England and CCGs. A report on the implementation of HWBs noted that local authorities took strong leadership in establishing the boards and nearly all HWBs produced JSNAs and JHWSs a year after their establishment. The report also highlighted that the main priorities of most HWBs concerned public health and health inequalities and that boards were not very effective in the implementation of integrated care (Humphries & Galea, 2013).

The central function of HWBs to promote integration has been reinforced by policy developments in this area. The Better Care Fund (BCF)[8] announced in June 2013 created pooled budgets between health and social care services (from April 2015) to support transformation towards integrated care and to improve outcomes for people with care and support needs. Local plans for the use of the pooled budgets were agreed between local authorities and CCGs through their HWBs. Originally, BCF did not involve new money. Instead, it meant that some of existing NHS resources were targeted on social care-related activities, with the aim to reduce what was perceived to be increasing pressures on the acute sector[9]. Guidance notes clarified that pooled

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[8] BCF was initially called Integration Transformation Fund.

[9] Initially £3.9 billion was allocated to BCF: £1.1 billion from existing transfer from health to social care; £130 million from Carers' Breaks funding; £300 million from CCG reablement funding; £350 million from capital grant funding (including £220 million Disabled Facilities Grant) and £1.9 billion from NHS allocations. Later, the BCF allocation increased to 5.3 billion (based on www.local.gov.uk/health-wellbeing-and-adult-social-care, accessed on 06/12/2016).

budgets should be used to support ASC services with a health benefit, and that BCF would involve a shift of resources from hospitals to the community, while hospital emergency activities would need to be reduced (Bennett & Humphries, 2014). The original intention was to make part of the BCF budget conditional on a number of performance indicators such as delayed transfers of care, avoidable emergency admissions, effectiveness of reablement, admissions of older people to residential and nursing care, and patient and service user experience. These requirements were later withdrawn due to concerns that they would penalise populations which already experienced poorly performing services. Payment for performance has been replaced by an agreement to invest in non-acute services which may include social care services. An element of performance payment still remains as part of the BCF money allocation, which depend on the extent of reductions in avoidable emergency admissions. Failure to achieve these targets would result in the resources being allocated to hospitals to cover costs of continuing admissions (Departament of Health & Departament for Communities and Local Government, 2016, Department of Health *et al*., 2016, Erens *et al*., 2016). The BCF has been reported to have helped initiate joint working. However, it has been seen to generate unnecessary bureaucracy where integration was already taking place (Erens *et al*., 2016). National Audit Office report noted that BCF did not help to reduce the demand for healthcare or save money as planned and has not achieved the expected value for money (NAO, 2017). A comprehensive BCF evaluation is to be completed in 2017.

The 2015 Treasury Spending Review made a further commitment to integrating health and social care by specifying that local plans for full integration would be developed by 2017, to be implemented by 2020. Local areas are expected to use different models for integration which matched their local needs. The Spending Review also supported devolution to local government, which is likely to stimulate new approaches to care coordination. For example, in

2016 Greater Manchester Combined Authority (GMCA) was granted full control of integrated health and social care budget, and it has committed to drawing together a wider range of services to provide fully integrated care.

Integration programmes, including BCF schemes, have increasingly focused on better patient data and information sharing between health and social care for effective integration. Data sharing in England is regulated by the Data Protection Act 1998, The Health and Social Care Act 2012, The Care Act 2014 and various other legislation, which require providers to ensure that data are used appropriately and legally (Houses of Parliament, 2014). Integration schemes have, however, reported problems with inconsistent guidance around information sharing from different bodies, which creates doubts around lawful practice (RAND Europe & Ernst & Young LLP, 2012, Erens *et al*., 2016). There have been initiatives to improve data sharing and a National Data Guardian was appointed in 2014 to build trust in the use of data across health and social care (Departament of Health, 2016). The 2015 Health and Social Care (Safety and Quality) Act further strengthened the efforts towards more robust data sharing and it imposed a legal duty on health and ASC bodies to share information when such practices can facilitate individuals' care (Departament of Health, 2015).

Experimentation

Various novel ways to integrate services have been trialled over the last decade in England. In 2009, DoH launched a two-year pilot programme in 16 sites to explore different ways of providing integrated care. Experimentation was encouraged and the initiatives varied greatly. The evaluation of the pilots showed mixed results. For example, although the evaluation illustrated improved team working and collaboration among staff, patients' views on the quality of care did not necessarily improve.

In 2013, 14 local "Pioneer" areas were selected to develop new integration models, and a further 11

new areas were added in 2015. The 25 integrated care Pioneer sites are developing and testing innovative and novel ways of joining health and social care services, using the expertise of the voluntary and community sectors. The (highly heterogeneous) schemes include efforts to integrate social care with primary care through collocating social, voluntary and primary care staff [10]. Pioneers have been developing and experimenting with information sharing systems, new contracting models to develop incentives to shift activity from acute to community based care, joint performance framework, and joint workforce development. An early evaluation of 14 Pioneers reported that numerous local and national barriers to integration hampered progress among Pioneer sites and found few improvements to services or impacts that could be quantified. The report also highlighted that the sites were increasingly focusing on short-term, financially driven goals through interventions at the interface between hospital and community care. Such goals were reported to narrow some of the wider original ambitions envisaged for the initiatives. An evaluation of all 25 pioneer sites will run until 2020 (Erens et al., 2016).

In 2014, the NHS England's Five Year Forward View launched "New Models of Care" for different types of integrated care. The document emphasized the importance of care integration between primary and acute health, mental health, social care, whilst engaging with communities, voluntary and third sector organizations. In 2015, the £2.1 billion[11]

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[10] For example, jointly funded (CCG/local authority) posts were in place and integrated care 'navigators'/case managers across health and social care were working in some areas. Some took a person-centred approach where people with high service use were assigned a care navigator to help them to express their needs in specific 'I statements'. The care navigator would e.g. organise a multidisciplinary team meeting (including e.g. social and housing services, GPs) to develop an action plan to meet the 'I' statements. Other pioneers worked with voluntary organisations to improve care provision for older people (for more details see Erens and Wistow et al. 2016).

[11] £300 million of the STF includes funding for the new models of care (available from www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/; accessed on 05/12/2016).

Sustainability and Transformation Fund (STF) was announced to drive sustained transformation in health and care systems and to deliver the NHS Five Year Forward View. As a result, each health and care system in England has been asked to produce Sustainability and Transformation Plan (STPs) to show how areas will achieve the 3 aims of NHS Five Year Forward View: improved health and wellbeing, transformed quality of care delivery, and sustainable finances. Local plans are developed by senior leaders (mostly from the NHS) (www.england.nhs.uk/2016/03/footprint-areas, accessed on 21/12/2016).

One of the first steps towards delivering the Five Year Forward View was the creation of 50 Vanguard sites. Each site is developing new care models which will act as blueprints for the rest of the health and social care system. Five vanguard models have been trialled, three of which include integration between health and social care: "Enhanced Health in Care Homes" is focusing on integrating services for older people in residential care. "Integrated Primary and Acute Care Systems" are trialling ways to join up GPs, hospitals, community and mental health services while "Multispecialty Community Providers (MCPs)" are testing ways to move specialist care out of hospitals into communities by providing primary care as well as community-based health and care services. The approaches taken by vanguards differ within each of these three models (accessed from www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/, on 02/12/2016). The 50 vanguards were allocated a total of £114 million in 2015/16 and £112 million in 2016/17 and a national support package, developed by the 5 Five Year Forward View partners, is in place to enable vanguards to implement changes effectively and at pace. The package also supports shared learning across the vanguards and spreading good practice across entire health and care system.

One of the latest vehicles for delivering the Five Year Forward View involves the Integrated Personal Commissioning (IPC) pilots launched in 2015. The IPC sites will facilitate the pooling of health and

social care funding at the individual level, and it will allow patients and carers to control resources available to them across the system to commission their own care. Nine demonstrator sites in England are developing different approaches to IPC that will expand to cover everyone with complex needs in their area by 2018, and it is planned that by 2020 the model will be in place in every locality in England (NHS England & Local Government Association, 2016). New models of care are expected to cover 50% of the population by 2020; it is anticipated that by the end of 2017/18, when new models of care cease in their current form, they will achieve 25% coverage. No evaluation of the 5-year programme has been commissioned as yet, and there is little evidence of the outcomes of new models of care.

Policy measures to support unpaid carers

Unpaid carers in England provide the lion's share of the support for older people with LTC needs. Overall, it is estimated that 5 million carers provide ongoing support to 2.1 million older people (Brimblecombe et al., 2016, Wittenberg, 2017 forthcoming). Long-term, there is significant concern about the extent to which the availability of unpaid carers might be reduced. Assuming no changes in the prevalence of disability among older people and constant prevalence of unpaid support across the population, a shortfall of 2.3 million unpaid carers by 2035 has been projected (Brimblecombe et al., 2016).

Recent policy developments

The past decade has witnessed manifold strategies and reforms aiming to help unpaid carers to continue their caring roles, simultaneously enabling carers to engage in other activities, including paid work. The policies relevant to carers focus a wide range of issues covering support for care recipient as well as support for carers. The latter include: recognition of carers (e.g. by NHS or ASC), prevention, provision of information, carers' assessment, employment laws and practices, cash for carers, and pension rules. The sections below provide an overview of selected policies in the aforementioned areas.

Four Carers Strategies published since 2008 are the key policy documents highlighting plans and approaches to supporting carers. The Labour document *Carers at the Heart of 21st-century Families and Communities* set out the strategic vision and outcomes for carers in 2008. The updated priorities for the strategy were subsequently published in 2010, 2012 and 2014 [12] by the Coalition Government[13] and the Conservative Government is expected to issue an updated strategy in 2017. The Care Act 2014 was a landmark statute for carers as it introduced a duty on local authorities to provide carers' assessment and support. Furthermore, voluntary organisations play a vital role in supporting carers in England, local and national charities provide services and support to carers which sometimes are unavailable elsewhere. Local authorities often act in partnership with voluntary sector and, after assessing carers' needs, may refer or signpost carers to a voluntary organisation for an on-going support (see, for example, Yeandle & Wigfield, 2011, HM Government, 2014b).

Identification and assessment of carers' needs

The identification and assessment of carers needs is an important policy issue in England. The latest Carers' Strategy has four priority areas, one of which is 'supporting people with caring responsibilities to identify themselves as carers so they can access the information, advice and support that is available' (HM Government, 2008, 2010, 2014b). The Care Act 2014 notes that Councils' duties to provide prevention should include approaches to identifying carers' and that authorities should consider working with different

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[12] *Recognised, Valued and Supported: Next Steps for the Carers Strategy*; *Caring for our future: Reforming Care and Support* and *Carers Strategy: Second National Action Plan 2014–2016* were published subsequently in 2010, 2012 and 2014 by the Coalition Government.

[13] The Conservative-Liberal Democrat coalition government was established in 2010 and was in power until 2015.

partners (e.g. NHS) to achieve this goal. Furthermore, the Care Act 2014 imposed a legal obligation on local authorities to undertake cares' assessments replacing earlier laws [14], and removing prior requirement that the carer had to provide a substantial amount of care on a regular basis to be eligible for assessment. The criteria for a carer's assessment have not only been broadened, but the statute introduced a new legal duty on local authorities to provide support to meet carers' needs. Prior to the Care Act 2014, carers did not have a legal right to receive support although local authorities were required to provide services to meet the needs of some carers e.g. when carer's employment was at risk. Councils could also provide support to carers at their discretion, however this meant that access to support for carers depended on the area where they lived.

Prevention

The legal obligations imposed on Councils by the Care Act 2014 include preventing, reducing or delaying carers' needs for support and promoting carers' wellbeing. This duty relates not only to people who are already carers but also people who may be about to take on a caring role or individuals who do not presently have any needs for support. The implementation guidance gives examples of interventions that may support carers such as assistive technology, access to information and advice, knowledge and skills to care effectively, avoiding falls and training in performing basic health care tasks. The document also mentions that prevention could include interventions helping carers to 'have a life of their own alongside caring', to have breaks from caring, develop mechanisms to cope with stress linked to caring and awareness of their own needs (Department of Health, 2014). Despite the new prevention duties towards carers,

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[14] The Carers (Recognition and Services) Act 1995 gave carers the right to request an assessment if the carer provided a substantial amount of care on a regular basis, and if the local authority was carrying out an assessment of the cared-for person. Overall, the Law Commission report recognised five pieces of legislation relating to carers' assessments (Law Commission 2011).

an early report on how local authorities implement their Care Act duties found that carers were most often provided with information and advice services, and that many Councils were focusing their preventative work on people with care needs, rather than carers (Carers Trust, 2015).

Supporting carers' employment

There is widespread policy interest in the employment outcomes linked to caregiving. Employment rates of working age unpaid carers in England are below the national average. According to 2011 Census, 55% and 45% of female and male adult carers respectively reported that they were economically active, moreover, only 12% of female and 9.3% of male unpaid carers were working full-time (Office for National Statistics, 2013). Carers have been reported to struggle financially because reducing working hours, and giving up employment to care often leads to a sharp decrease in income, and sometimes to double loss of income if they are caring for a partner who also left employment due to illness. Such a decrease in income is often coupled with an increase in costs of caring and disability (Carers UK, 2015, 2016).

It has also been estimated that supporting carers into paid work could result in substantial welfare savings, for example, the UK public finances could gain £1 billion per annum in additional tax revenues from carers returning to employment, and it would save at least £300 million if it did not need to pay benefits that carers who are not working are likely to claim (Pickard *et al*., 2012). Given the potential benefits of improving employment outcomes for carers, there has been a prominent policy emphasis on enabling carers to combine care with paid work (HM Government, 2008, 2014b). Historically, policies related to supporting unpaid carers' employment in England have primarily emphasised the role of employers in providing flexible working arrangements. Employees who cared for adults were given the right to request flexible working in 2006 by The Work and Families Act. The right to flexible work was extended to all employees by the Children and Families Act 2014.

The priorities for carers' employment have been reflected in a series of Carers Strategies. The 2008 Carers' Strategy, for instance, emphasised the importance of flexible working conditions to enable carers to juggle caring responsibilities with paid work and family life (HM Government, 2008, 2010, 2014b, Pickard *et al*., 2015). More recently, there has been increased policy interest on replacement care, which represents a distinct change from earlier policies, as former governments had rejected the idea of replacing unpaid care with paid services (Pickard *et al*., 2016). The 2008 Carers' Strategy first articulated a commitment to fund replacement care to help carers to re-enter the labour market, to participate in approved training, and to allow carers to attend hospital appointments and screenings (HM Government, 2008).

The 2010 Carers' Strategy asked Councils to develop and stimulate social care markets partly to provide good quality and affordable replacement care to support carers paid work (HM Government, 2010). The Carers Strategy 2014 noted how local authorities and other local partners should 'explore ways in which people can be supported to combine work and care, and the market for care and support services can be stimulated to grow to encompass their needs' (HM Government, 2014b).

The Care Act 2014 further noted that carer's assessment must have regard to whether the carer works or wants to work, and the implementation guidance point out that carers' needs may be met by providing replacement care to allow carers to look after their own wellbeing, to participate in recreational activities, or to combine care with employment or educational activities (Department of Health, 2014). The document also makes it clear that carers will not be charged for replacement care, and that any charges would need to be met by the adult needing care in line with existing means-testing arrangements. The replacement care rhetoric echoes a growing recognition of the necessity to overall provide better services for people with LTC needs as a means of supporting or replacing carers (Pickard *et al*., 2015). In practice, however, there is

strong evidence that formal care packages provided by local authorities are significantly reduced when unpaid carers are available, other things equal, and therefore that the extent to which "replacement care" has been funded is at best limited.

In 2013, the Government committed to a two-year project to develop five pilots investigating the use of assistive technology fund to support carers in employment, and to help the development of a care market for self-funders. The government also developed a wide-ranging 'back to work' support package including a Work Programme[15], which encouraged self-employment and piloted a number of new initiatives for unemployed individuals, including carers. The recent focus on employment opportunities for people over 50 has also the potential to support older carers. For example, an older workers champion scheme, trialled from 2015, offers intensive work support for older jobseekers with a career review, job training, and digital training/support and link-ups with small and medium sized businesses with vacancies to fill (Department for Work and Pensions, 2014).

Despite numerous policy efforts to help individuals reconcile unpaid care with paid employment, many carers still feel these are incompatible. The Carers UK surveys reported that many carers of working age gave up employment to care because there were no suitable care services, the services needed were too expensive, the leave available from work was inadequate to combine care with employment, or they were unable to negotiate suitable working hours (Carers UK, 2014, 2015, 2016).

Cash benefits

In addition to support into employment, unpaid carers in England are eligible to claim cash benefits such as Carers Allowance. Although the allowance

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[15] The Work Programme was introduced in 2011 to create a single initiative to help the long-term unemployed, disabled or people with health conditions into work regardless of age (Department for Work and Pensions, 2012). In this fee-for-performance programme local providers are free to identify the most effective way of helping people into sustained work.

is not based on National Insurance records and it is not means-tested, eligibility depends on a number of criteria, including a demand that the carer provides at least 35 hours of care per week, and cannot earn more than threshold amount of £110 per week. Carer's Allowance can affect other benefits that the carer and the person cared for receive. Individuals receiving Carer's Allowance automatically get National Insurance credits which can help towards building state pension credit. Those who care for someone at least 20 hours a week are also eligible to Carer's Credit-a National Insurance credits to build towards their state pension (available at www.gov.uk/carers-allowance/overview, accessed on 06/12/2016).

The carer payment in the new Universal Credit[16], which is to be rolled out gradually, provides more flexibility for carers to combine paid work and caring than the present system. Currently, Carers Allowance ceases completely when the carer earns more than a threshold amount. In 2014, 10% of carers who left work or reduced working hours reported that the rules in the benefit system meant that there were no financial benefits from employment. Since the Universal Credit withdraws the benefit only gradually as people earn more, this could improve carers' financial benefits from paid employment.

Pension reforms and unpaid carers

Recent reforms to the state pension may impact negatively unpaid carers' financial situation. In 2016, the number of years of National Insurance contributions required to quality for full state pension increased from 30 to 35 years, with those with between 10 and 35 years of contribution receiving a pro-rata amount (HM Government 2015a). Although economically inactive carers may build up pension credits based on Carers Allowance

or Carers Credit (see above), they are typically missing out on occupational and private pension schemes[17]. Increases in state pension age may further change unpaid carers' position in the labour market [18].

The National Carers Demonstrator Sites

In 2008, DoH developed The National Carers' Strategy Demonstrator Sites (DS) which included 25 partnerships across England, each led by either local authority or Primary Care Trust. Each site was expected to develop and enhance their services and support for carers to improve their health and wellbeing and, if possible, to measure the quality and cost-effectiveness of the new schemes. The programme focused on three areas: carers' breaks; health checks; and better NHS support. The programme evaluation illustrated that carer identification required strong multi-agency collaboration, for example, many carers who had not previously received any support, were identified in primary and secondary care settings. Flexible and personalised breaks were shown to have potential to prevent carers' burn-out and health deterioration, while health and well-being checks led to sustained self-care and healthier behaviour. The evaluation report also noted multiple ways to make cost savings through carers' support (Yeandle & Wigfield, 2011).

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[16] Universal Credit is a new type of benefit rolled out in the UK from 2013 and implemented gradually, designed to support people who are on a low income or out of work. It will replace six existing benefits and is based on a single monthly payment (based on www.moneyadviceservice.org.uk/en/categories/universal-credit, accessed on 12/12/2016).

[17] The Pensions Act 2008 set up an automatic enrolment for occupational pensions for those in employment to be phased in between 2012 and 2018 (Department for Work and Pensions, 2013). Any contribution made under occupational/private pension scheme will be available to an individual upon retirement, however the precise retirement options will depend on the years of service and the size of pension pot an individual accrued.

[18] Until 2010, men over the age of 65 and women over the age of 60 were entitled to claim state pensions. Following The Pensions Act 2007, the retirement age for women is being harmonised to match that of men by 2020. Moreover, the increase in retirement ages for both women and men to 68 will be implemented between 2024 and 2046, and The Pensions Act 2014 provides for a regular review of the state pension age at least once every five years (HM Government, 2014c). The next review will take place in May 2017 and may bring further changes to pension system impacting unpaid carers.

Innovative care models to improve outcomes for people with LTC needs

Growing demand for LTC services, combined with financial pressures, are driving the development of new models of care to stimulate service innovation, reduce the costs of care provision and to improve quality of life service users and their carers. The sections below focus on two areas seen as key mechanisms to drive such innovation: technological solutions and personalisation.

Technological solutions

A number of technological solutions have emerged in health and care sectors to support people with care needs in their homes or in institutions, to help them live more independently and/or to self-manage their conditions. Technological solutions can also relieve pressure on unpaid and paid carers. The technologies available to support individuals differ with regards to their complexity, target populations and conditions[19], however some of the most widely used include: telecare, telehealth, telemedicine, self-care applications, sensors, home alarm systems, tracking systems (Knapp *et al*., 2015). Other technologies are designed to improve the efficiency of the management systems within and across LTC settings (e.g. ICT based training for care staff, eRostering[20], electronic health records, the use of e-commerce and e-business in care management systems). The focus of this section is mainly on the former, namely: technologies to support people with long-term conditions and their carers.

Despite significant hopes that technological

solutions will help improve the cost-effectiveness of the care system, legislation specifically related to such solutions in the LTC area is missing. Several policies have been important in influencing the development of telecare and telehealth services in England. In 2005, DoH published Building Telecare in England document which provided local authorities and their partners with guidance in developing telecare services, outlining two models to support Councils in the development of strategy and business cases for local telecare projects. The document aimed to support Councils in making decisions about how to spend the Preventative Technology Grant (PTG), which was allocated over two years from 2006[21]. PTG aimed to initiate a change in the design and delivery of health, social care and housing services to enhance the wellbeing and independence of individuals. Although the fund was allocated to local authorities, they were expected to work with housing, health, voluntary and independent sectors, service users and carers to develop telecare solutions and they could use pooled fund arrangements and joint commissioning.

In 2008, the DoH launched the Whole System Demonstrators (WSD)[22] to evaluate the impact of telehealth and telecare technology, and to provide evidence base to support further investment decisions in the information and communication technology (ICT) area (Department of Health, 2011, Steventon & Bardsley, 2012).

In 2012, the DoH also launched a 3millionlives campaign in partnership with industry, the NHS, social care and professional partners to use

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[19] There are differences in the terminology used to describe various technologies to support individuals and their carers, including (a) information and communication technology;(b) assistive technologies; (c) telecare and telehealth; (d) therapeutic technology. For more detailed discussions on typology of technological interventions see, for example, Carretero (2015), Knapp*et al*. (2015).

[20] E-Rostering is an electronic staff management tool-HealthRoster (e-rostering type) is used in NHS to plan staffing requirements, report on overtime, sickness, annual leave etc. The tool can be used to ensure that staff is employed where it is needed most, to enable efficiency improvements.

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[21] The Preventative Technology Grant was £80m which was allocated in the proportion of £30m in 2006/07 and £50m in 2007/08. The money was paid with no conditions attached, and it was allocated using the relative share of older people's Relative Needs Formulae (Department of Health, 2005).

[22] WSD consisted of three large pilots of telehealth evaluated using various methods including a randomised controlled trial where groups of service users either received telehealth services or were assigned to control groups and received their usual care. There were over 3,000 service users in the trial, which made the evaluation the largest and most complex of its kind in the world at the time (Steventon & Bardsley, 2012).

telehealth and telecare to improve the lives of 3 million people in the following five years, and to reduce burden on acute hospital use and improve cost-effectiveness of the system. The campaign aimed to support the uptake of telehealth and telecare as a mainstream service by providing health and social care commissioners with incentives to commission telehealth and telecare as an essential part of care pathways. Educating health and social care leaders, professionals, service users and carers was viewed as vital so they could fully understand the benefits of technology. To support the effective delivery of the 3millionlives campaign, the DoH signed a concordant with four trade associations[23] representing the telehealth and telecare industry to accelerate commitment to technological solutions. Industry was asked to lead market development, increasing awareness and supporting health and social care professionals in decision making, while the government committed to create a macro environment to help technological solutions succeed.

Following the negative results of the WSD trial, the government has been criticised for initiating the national rollout prematurely, and in the absence of robust evidence about the cost-effectiveness of telecare and telehealth (Godwin, 2012, Steventon & Bardsley, 2012, Henderson *et al*., 2014). A number of Councils in England which implemented major telecare programmes have, however, reported positive outcomes and costs savings from the initiatives. For example, North Yorkshire Council, praised in the past as an exemplar authority for the use of telecare, reported numerous benefits from the programme, including increased user satisfaction, delaying residential care or reducing the level of homecare required, and overall reduction in costs relative to traditional models of care (Valios, 2010). A number of Councils in East Midlands also reported some cost-savings and positive outcomes for users and carers after implementing telecare, although a number of challenges were mentioned by some

authorities, including resistance to the new model of care from staff and relatives (Think Local Act Personal, 2011a).

The 3millionlives approach has been accused of being excessively industry-led, lacking sufficient involvement from professionals and service users, and portraying an overoptimistic view of the potential of technological solutions. Despite the shortfalls of the initiative, it has been recognised that emerging technologies remain an important opportunity to transform the health systems, to empower service users and improve outcomes (http://3millionlives.co.uk; accessed on 13/01/2017). For example, the Care Act 2014 implementation guidance prompt local authorities to consider telecare as part of local prevention strategies for service users and carers (Department of Health, 2014). The 3millionlives initiative was replaced by the NHS England's Technology Enabled Care Services (TECS) programme which provides practical tools for health and social care professionals to commission, procure, implement and evaluate technology enabled care services. Moreover, the Assisted Living Innovation Platform, announced in 2012, provides a large-scale demonstration of a range of services, including telecare and telehealth, for people with long-term conditions. It promotes the use of online and mobile technologies to establish informal care networks and to manage health and social care needs (Border, 2014).

Technology-based services in the management systems are still underdeveloped in many regions in England. A report on efficiency in English hospitals, published in 2016, noted that trusts are underutilizing technological solutions and recommended, among other things, that hospitals improve their use of ICT-based solutions such as e-Rostering, e-Prescribing or electronic catalogues for procurement to improve productivity and reduce costs (Lord Carter of Coles, 2016). As the cost of new technologies falls, wide scale adoption of technology is becoming increasingly viable and may provide a significant tool for the future sustainability

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[23] The Association of British Healthcare Industries (ABHI), The Telecare Services Association (TSA), Intellect and Medilink UK (Department of Health, 2012a).

of the health and social care systems. Technologies such as mobile health applications, decision support to access other professionals' expertise, tools to prioritize and manage clinical workload, predictive analytics/risk stratification, patient-flow tracking systems, to mention few, can provide new resources and clinical management capabilities to improve cost-effectiveness of the health and care sectors (Deloitte, 2015, Knapp *et al*., 2015, Imison *et al*., 2016).

Personalisation as a bottom-up driver for change

Over a long time, a key policy objective in social care in England has been the desire to match care packages to the needs and preferences of service users and their carers. Achieving a better fit between services and individuals' needs, it is argued, leads to improvements in the quality of life of the people receiving the support, and to a more cost-effective use of the limited resources available.

In the 1990s, the desire for better matching of resources to needs led to wide-ranging reforms of community care services and to the implementation of care management processes for the assessment of needs and the commissioning of services (Davies *et al*., 2000). In spite of these reforms, the general perception at present is that the care that people receive is often driven by what supply is available rather than by their needs and by the imaginative use of the resources available.

Increased policy emphasis is therefore being placed on customer choice and on the "personalisation" of service delivery. Under the "personalised" model, service users and carers in England are given the opportunity to act as the budget holders and commissioners of their own care. The underlying logic is that they have a privileged understanding of their needs, and of the resources around them which they might be able to engage in designing their package of support. They are therefore best placed to judge what services will maximise their wellbeing, and have the strongest incentive to ensure that the resources available for their care are used as cost-effectively as possible (Needham &

Duffy, 2012, Watt, 2012). Direct Payments (DP) and Personal Budgets (PB) have been the main mechanisms to promote personalisation agenda in England.

DPs are the most extreme form of personalised care. They involve cash payments made to individuals, who can use them to meet some or all of their eligible care and support needs. DPs were introduced by the 1966 Direct Payments Act which enabled local authorities to make payments for working age disabled adults. The provision was extended in 2000 to include older people, and carers were included in 2001.

From 2003, local authorities have had a legal duty to provide DPs (Jarrett, 2015). In spite of their relatively low and variable uptake[24], DPs are still promoted heavily by central government policy. The Care Act 2014 implementation guidance note that DPs can be used flexibly and innovatively, provided that they are utilised to meet eligible needs, even if certain restrictions on their use remain. In particular, DPs cannot be used to pay for care provided by a relative living in the same household, unless local authority considers that to be necessary (Department of Health, 2014).

Until recently, DPs were available only to pay for community-based services. In 2012, the DoH decided to pilot DPs in council-funded residential care to enable residents to commission individually some or all of the components of their care, such as, for instance, hairdressing services. National roll-out of the scheme is planned for 2020. The early evaluation of the 14 pilot local authorities (trailblazers) providing DPs in residential care has showed mixed results. Service users and family members have reported problems with setting up DPs in institutions, and those receiving a full DP – to pay for all of the eligible care – noted the lack of flexibility in how the money could be used. Conversely, families who had accepted a DP on

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[24] In practice, the uptake of DPs has remained comparatively small among older people: in 2014, 15% of older people had a DP although there were regional differences (Fernández *et al*., 2007, ADASS, 2014).

behalf of a relative often felt empowered to challenge the care home standards, if these were not satisfactory (Wittenberg *et al*., 2015).

With the intention of increasing the take-up of personalised care in England, in 2008 the DoH rolled out personal budgets (PBs). Personal budgets provide service users a menu of options for the commissioning of their care, with different degrees of involvement of service users and carers. Since 2011, all new publicly funded users of home care in England have been provided with a PB, which they can take as a DP as a care package managed by a third party on behalf of the user (this option is usually called Individual Service Funds - ISFs), or as a care package managed by the local authority. The uptake of ISFs has been very limited, and in 2014 only 4% of individuals receiving community services used the option (ADASS, 2014). The ISFs option is however explicitly advocated in the implementation guidance of the Care Act 2014 on PBs (Department of Health, 2014, Duffy, 2015). The Care Act 2014 placed the concept of PB into the legislation for the first time, and guidance document notes that PBs are vital part of the aspiration to deliver personalised care. Several evaluations have suggested that PBs have the potential to generate care outcomes more cost-effectively, however not without challenges (Glendinning *et al*., 2008, Hatton & Waters, 2011, Waters & Hatton, 2014). For example, it was indicated that it was the size of the budget and spending more money, that was linked to better outcomes rather than PB per se (Slasberg *et al*., 2012).

As noted previously, the drive to empower individuals to make their care choices has extended to the health area, with the piloting and expected roll out of integrated personal commissioning (IPC) for people with long-term conditions. The IPC is a partnership between NHS England and the Local Government Association to facilitate personalisation and joint up care, selected IPC demonstrator sites are developing different approaches to IPC and the programme is expected to operate across England by 2020 (Bennett, 2016).

The extent to which personalisation has been a success is contested. It does not appear to work well for older people, for which take up of PBs and DPs is low. Concerns were raised over additional bureaucracy and time spent on brokerage or support planning which limits resources to support people in the system (Glasby *et al*., 2015). Additional risk relate to safeguarding market stability and concerns were voiced that care markets could decrease in scale if user-led commissioning of services leads to less predictable and more fragmented patterns of demand that undermine financial stability of care providers. While some Councils have contingency funding for market failures, this adds pressure on resources that are already under growing pressure (Needham & Duffy, 2012).

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Care Act 2014 – Provision for Prevention

Policy theme	Reducing dependency
Design and implementation level	National design, locally implemented
Policy objective	To prevent and delay the development of needs for care and support
Start date – End date	April 2015 – No end date

Aims

Overall the Care Act 2014 has reformed the law relating to care and support for adults and carers; it made provisions about safeguarding adults from abuse or neglect; about care standards; about integrating care and support with health services.

The Care Act 2014 identifies preventing the needs for care and support as well as promoting individual well-being as the first two of seven general local authority responsibilities. The statute is the first legislation to make prevention a statutory responsibility of Adult Social Care in England. It also imposes a duty on Councils to identify already available services, facilities and resources with which to fulfil this new duty. Furthermore, the Care and Support Statutory Guidance point out that at every interaction with a person a local authority should consider whether or how the person's needs could be reduced or other needs could be delayed from arising (Department of Health, 2014). The Care Act mentions that there is no one definition for what constitutes preventative services and that prevention may cover many different types of support; however in its broad definition it mentions that prevention encompasses promoting social and economic wellbeing; developing resilience and promoting individual strength; promoting independence.

Implementation

Responsibilities for implementation lie with local authorities and although the Care Act implementation guidance note specific preventive services (such as reablement, rehabilitation etc.) the document highlights that local authorities should develop local approaches to prevention and should consider the range of options available, and how those different approaches could support the needs of their local communities.

The implementation guidance note that local authorities should consider working with other agencies to provide prevention schemes to local populations and the document recognises that achieving preventative goals requires the involvement of a wide range of services alongside adult social care-including public health, NHS, transport, leisure and housing services. Wider community resources are also expected to be engaged in providing prevention including local support networks and facilities provided through the voluntary and community sectors. The Care and Support Act Implementation Stocktake survey reported that in 2015 64% of local authorities had a cross-organisation prevention strategy and 81% had arrangements in place to identify people who would benefit from prevention (Local Government Association, 2015).

Target group

Overall the prevention duties imposed on local authorities by the Care Act 2014 apply to all individuals, including:

A   Those who do not have any current needs for care and support;

B   Those individuals with needs for care and support, whether their needs are eligible and/ or met by the local authority or not

C   Carers, including those who may be about to take on a caring role or who do not currently have any needs for support, and those with needs for support which may not be being met by the local authority or other organisation.

Eligibility criteria

There are no general eligibility criteria to prevention schemes: eligibility may however vary from project to project, and in line with locally set criteria.

Resources

There is no additional money allocated specifically to prevention. Observers have noted that the Care Act 2014 failed to recognise the increasingly limited budgets that local authorities are working within and the consequential constraints on the implementation of new statutory duties, including these related to prevention.

Performance assessment and monitoring

n/a

Evidence of success

The implementation of prevention duties is still at an early stage and there is little evidence of success.

Transferability/ Uniqueness

The wide range of local approaches to prevention and preventative schemes makes it difficult to draw conclusions about its transferability.

Is this an emergent practice?
(degree of innovation)

The advocacy of prevention is now new as prevention has been advocated in health and social care for decades (Wistow & Lewis, 1997, Godfrey, 2001, Wistow et al., 2003); however, the Care Act 2014 is the first to make prevention legal responsibility of local authorities.

Sustainability

The prevention duties are expected to lead to a decrease in demand for high-cost services which will overall lead to reduced use of resources and lower the costs therefore investment in prevention is expected to be sulf-sustainable.

Critical assessment

In the context of financial austerity and the lack of any substantial additional money to implement the Care Act, there have been doubts that prevention duty could be implemented at any substantial level, at least in the short-term. According to budget survey, councils' spending on prevention reduced in cash terms in recent years (ADASS, 2016).

However, there could be a longer-term value of the policy as the statute creates an expectation that preventative interventions will be developed and such expectations may provide a signification impetus to develop preventative services in the future (Clements, 2017).

Academic literature on this action

Some reports and academic papers are available either on prevention duties and the Care Act 2014 or mention the topic as a part of Care Act 2014 debate (Slasberg & Beresford, 2014, Local Government Association, 2015, Richards & Williamson, 2015, Clements, 2017).

Documents

www.legislation.gov.uk/ukpga/2014/23/contents/enacted

www.local.gov.uk/care-support-reform/-/journal_content/56/10180/6519369/ARTICLE

The Better Care Fund

Policy theme	Maximizing coordination in care provision
Design and implementation level	National design, locally implemented
Policy objective	Support acute health care sector performance by investing in joint health and social care schemes
Start date – End date	April 2015 (announced in 2013) – no end date planned at present

Aims

The Better Care Fund (BCF) creates a local single pooled budget between NHS and local authorities to incentivise the NHS and local government to work more closely together and to shift resources from health into social care and community services.

Guidance notes clarified that the pooled budget should be used to support adult social care services that have a health benefit and that BCF would involve a shift of resources from hospitals to the community and hospital emergency activities would need to be reduced. The money is deployed locally on health and social care through pooled budget arrangements between local Authorities and Clinical Commissioning Groups (CCGs).

Implementation

The BCF takes the form of a local, single pooled budget that aims to fund ways that the NHS and local government throughout England can work more closely together to shift resources from health into social care and community services. Local plans for the use of the pooled budget were agreed between local authorities and CCGs through their Health and Wellbeing Boards (HWBs were established in 2012 to facilitate collaboration of key leaders from the NHS England/CCGs, and public health and local government). Better Care Plans sit in the context of a broader vision for a transformed health and care system.

The BCF will provide funding to local services to give local populations a joint and improved health and social system. The guidance notes provide local areas with the details how they need to complete plans and how they will use their portion of the fund to join up health and care services around the needs of patients, so that people can stay at home more and be in hospital less.

BCF plans in 2014 had to detail how local areas will provide:

- protection for social care services
- seven-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- better data sharing between health and social care, based on the NHS number
- a joint approach to assessments and care planning and, where funding is used for integrated packages of care, an accountable professional
- agreement on the consequential impact of changes in the acute sector, with an analysis, provider-by-provider, of what the impact will be in their local area.

The planning requirements changed in 2016/17.

The Better Care Support Team (BCST) was created to provide relevant support to local areas. The Better Care support for 2016/17 is delivered through two streams; the centrally-led national and the regionally-led support programmes.

Target group

Although there is wide variability in the nature of the population they cover, overall the schemes funded by the BCF aim to support individuals at risk of unnecessary use of acute care.

Eligibility criteria

There are no general eligibility criteria to BCF schemes.

Eligibility varies from project to project, in line with its stated aims.

Resources

Initially, £3.8 billion was allocated to BCF: £1.1 billion from existing transfer from health to social care; £130 million from Carers' Breaks funding; £300 million from CCG reablement funding; £350 million from capital grant funding (including £220 million Disabled Facilities Grant) and £1.9 billion from NHS allocations.

The BCF's mandated minimum of funding can change from year to year and there is

local flexibility to pool more than the mandatory amount.

- In 2015–2016, a mandated minimum of £3.8 billion
- In 2016–17, the BCF was increased to a mandated minimum of £3.9 billion
- From 2017–18, the government will make funding available to local authorities, worth £1.5 billion by 2019–20, to be included in the BCF.

Performance assessment and monitoring

The original intention was to allocate part of the BCF budget on the basis of a set of local performance targets such as delayed transfers of care, avoidable emergency admissions, effectiveness of reablement, admissions of older people to residential and nursing care, and patient and service user experience. However, in 2016/17 the incentive payment schemes has been replaced by two new national conditions:

- Agreement to invest in NHS commissioned out-of-hospital services (which may include a wide range of

services including social care services)

- Agreement on local action plans and agreed targets to reduce delayed transfers of care (DTOCs). If local areas do not reduce admissions, the money will be allocated to hospitals to cover costs of continuing admissions.

NHS England continues to assess the scheme using the indicators noted above

A national academic evaluation of the BCF scheme has been commissioned by the English Department of Health

Evidence of success

The BCF national evaluation is to be completed in 2017

BCF has been reported to have helped initiate joint working between health and

social care however parties involved acknowledged that it has generated unnecessary bureaucracy where integration was taking place (Erens *et al*., 2016).

Transferability/ Uniqueness	The heterogeneity of the schemes funded through the BCF makes it difficult to draw conclusions about its transferability, at least at this stage.	
Is this an emergent practice? (degree of innovation)	Joint health and social care initiatives have a long history in England (see, for example, Henderson et al. 2003) however the integration of health and social care services in England has been very much fragmented and individually programme based.	BCF was announced as "one of the most ambitious programmes across the NHS and local government to date", which created pooled budgets beteen health and social care and creates opportunities to bring financial resources together to address pressures on services and create foundations for a much more integrated system care (Bennett et al. 2014).
Sustainability	The BCF policy is not meant to be self-sustaining. Whether or not it is continued in the future will depend on whether it is seen to contribute significantly to reducing pressure on the acute health care sector.	
Critical assessment	Since its beginning doubts have been expressed about the BCF strategic viability and about successful collaboration between social care and health agencies. Criticism has also been voiced about the quality of BCF planning and whether the programme	can achieve its objectives of reducing pressures on the accute sector (Humphries et al., 2016, NAO, 2017). Conversely, as a part of a of a longer-term focus on integrated care, the BCF has made a positive step towards achieving such a goal.
Academic literature on this action	Some reports are available either on BCF or partly related to BCF (Bennett & Humphries, 2014, Erens et al., 2016).	Limited academic literature found so far (Smith, 2014).
Documents	www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan www.local.gov.uk/health-wellbeing-and-adult-social-care/journal_content/56/10180/4096799/ARTICLE	

Care Act 2014 – Provision for Carers

Policy theme
Unpaid carers

Design and implementation level
National design, locally implemented

Policy objective
To define the principles and eligibility criteria for the support given to unpaid carers by local authority social care departments

Start date – End date
April 2015 – No end date

Aims

The Care Act 2014 represents the most important reform to social care regulations for the last sixty years. It has reformed the law relating to care and support for adults and carers; it made provisions about eligibility, assessment, care planning, personal budgets, financing, safeguarding adults from abuse or neglect, care standards, integrating care and support with health services. In the area of unpaid care, the Care Act 2014 gave carers in England new rights to assessment of their needs and clarified their entitlements to public support. It aimed to make support for carers more consistent and accessible. For carers, the Care Act 2014 brings enhanced recognition of their legal status of carers in England, giving them equal rights with service users to a needs assessment, and clarifying the factors that determine their eligibility for care and support. In contrast with the previous system, the Care Act 2014 places a duty on local authorities to carry out an assessment of the needs of carers on the appearance of need for support, regardless of the intensity of the care provided.

The Care Act 2014 also introduced a new legal duty on local authorities to provide support to meet carers' needs identified through carers' assessments (even if the person that they care for is not eligible themselves for statutory care and support from their local authority). The 2014 Act does not define 'care', although the Statutory Guidance notes that it includes both practical and emotional support.

The Care Act guidance also highlights that in assessing carers' needs local authority must consider whether the person would benefit from prevention either provided by the local authority or in the community. Overall, local authorities must promote carers' wellbeing when carrying out any of their care and support functions. Local authorities must also provide information and advice to carers, which may include topics such as: breaks from caring, health and wellbeing of carers themselves, carers' wider family relationships, carers' financial and legal issues, caring and employment, and carers' need for advocacy.

Implementation

Responsibilities for implementation lie with local authorities, and the Care Act implementation guidance notes that local authorities should develop local approaches to prevention and should consider the range of options available, and how those different approaches could support the needs of their local communities.

The Care Act guidance notes that in identifying carers a local authority must cooperate with NHS bodies and also must set up arrangements between relevant partners in relation to its care and support functions – including those which relate to supporting carers.

Target group

Overall, the duties imposed on local authorities by the Care Act 2014 apply to the following carers:

A those who may be about to take on a caring role or who do not currently have

any needs for support, and

B those with needs for support which may not be currently met by the local authority or other organisation.

Eligibility criteria

The new right to receive a carer's assessment is triggered by the appearance of need and is no longer dependent upon the carer providing (or intending to provide) regular/substantial care or on the carer making a request.

Where an assessment identifies that the carer has needs for care/support, then the authority must decide if these needs are sufficient to meet the eligibility criteria which are spelled out in Eligibility Regulations. The eligibility criteria for carers (broadly speaking) assess whether, as a consequence of providing care, the carer is unable to undertake certain key roles/tasks (ie household activities, other caring responsibilities, employment, education, recreation) or that their health is at significant risk.

Needs eligibility for carers should then be determined on the basis of three "conditions":

- The carer's needs for support arise because he/she provides necessary care to an adult

- As a result of their caring role, the carer's physical or mental health is affected or is at risk of deteriorating, or the carer is unable to achieve any of the outcomes specified in the regulations

- As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the carer's wellbeing.

Resources

Overall additional monies were allocated to meet the new statutory duties related to Care Act but they were not ring-fenced for support of carers. There was some concern

from commentators that costs related to carers, in terms of providing assessments and associated services,-posed a financial risk to the reforms (LGA & ADASS, 2014).

Performance assessment and monitoring

Support for carers is monitored as part of the overall monitoring of the outcomes of social care and more specifically through user experience surveys of carers in contact with their local authority.

Evidence of success

The implementation of duties related to carers is still at an early stage and there is as yet little evidence of success.

A national evaluation of the impact of Care Act 2014 on carers has been commissioned

Transferability/ Uniqueness	The wide range of local approaches to meet carers' needs makes it difficult to draw conclusions about its transferability.	
Is this an emergent practice? (degree of innovation)	Prior to the Care Act 2014 local authorities were required to provide services to meet the needs of some carers e.g. when carer's employment was at risk.	Councils could also provide support to carers at their discretion: this meant that access to support for carers depended on the area where they lived.
Sustainability	The support provided for carers is expected to lead to a decrease in (future) demand for formal care Care Act is a measure to increase carers' wellbeing and prevent their burnout, and to	help carers to combine caring and employment. Therefore it is hoped that the policy will assist the sustainability of the adult social care system.
Critical assessment	The statue has a simbolic value for carers as, for the first time, they were put on the same legal footing as the people they care for. Although there is some evidence that following Care Act obligations, councils focus on providing carers with information and advice,	rather than other services (Carers Trust, 2015). However, longer-term, the statute may create an expectation that councils will develop a wide range of services to support carers.
Academic literature on this action	Some reports and academic papers discuss the new duties related to carers overall, or as a part of Care Act 2014 debate (LGA & ADASS, 2014, Pickard et al., 2016, Clements, 2017).	
Documents	www.legislation.gov.uk/ukpga/2014/23/contents/enacted www.legislation.gov.uk/ukdsi/2014/9780111124185 BCF Planning Requirements: www.england.nhs.uk/wp-content/uploads/2017/07/ integration-better-care-fund-planning-requirements.pdf	