

## 2. Preventing, reducing or delaying needs

*This chapter provides guidance on section 2 of the Care Act 2014.*

### **This chapter covers:**

- Defining “prevention”;
  - Primary prevention/promoting wellbeing;
  - Secondary prevention/early intervention;
  - Tertiary prevention/intermediate care and reablement;
- The focus of prevention;
- Developing local approaches to prevention;
  - Working with others to focus on prevention;
- Identifying those who may benefit from prevention;
- Enabling access to preventative support;
- Charging for preventative services.

**2.1.** It is critical to the vision in the Care Act that the care and support system works to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point. To meet the challenges of the future, it will be vital that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence, and prevents need or delays deterioration wherever possible.

**2.2.** There are many ways in which a local authority can achieve these aims whilst promoting wellbeing and independence and reducing dependency. This guidance sets out how local authorities should go about fulfilling their responsibilities, both individually and in

partnership with other local organisations, communities, and people themselves.

**2.3.** The local authority’s responsibilities for prevention apply to all adults, including:

- people who do not have any current needs for care and support;
- adults with needs for care and support, whether their needs are eligible and/or met by the local authority or not (see chapter 6);
- 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.

2.4. The term “prevention” or “preventative” measures can cover many different types of support, services, facilities or other resources. There is no one definition for what constitutes preventative activity and this can range from wide-scale whole-population measures aimed at promoting health, to more targeted, individual interventions aimed at improving skills or functioning for one person or a particular group or lessening the impact of caring on a carer’s health and wellbeing. In considering how to give effect to their responsibilities, local authorities **should** consider the range of options available, and how those different approaches could support the needs of their local communities.

2.5. “Prevention” is often broken down into three general approaches – primary, secondary and tertiary prevention – which are described in more detail below.

### Prevent: primary prevention/ promoting wellbeing

2.6. These are aimed at individuals who have no current particular health or care and support needs. These are services, facilities or resources provided or arranged that may help an individual avoid developing needs for care and support, or help a carer avoid developing support needs by maintaining independence and good health and promoting wellbeing. They are generally universal (i.e. available to all) services, which may include, but are not limited to interventions and advice that:

- provide universal access to good quality information;
- support safer neighbourhoods;
- promote healthy and active lifestyles (e.g. exercise classes);
- reduce isolation (e.g. befriending schemes); or,
- encourage early discussions in families or groups about potential changes in the future, e.g. conversations about potential care arrangements or suitable accommodation should a family member become ill or disabled.

### Reduce: secondary prevention/ early intervention

2.7. These are more targeted interventions aimed at individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration or prevent other needs from developing. In order to identify those individuals most likely to benefit from such targeted services, local authorities may undertake screening or case-finding, for instance to identify individuals at risk of developing specific health conditions or experiencing certain events (such as strokes, or falls), or those that have needs for care and support which are not currently met by the local authority. Targeted interventions **should** also include approaches to identifying carers, including those who are taking on new caring responsibilities. Early intervention could include a fall prevention clinic, minor adaptations to housing which improve accessibility or provide greater assistance for those at risk of a fall, or telecare services. Carers can also benefit from support to help them develop the knowledge and skills to care effectively and look after their own health and wellbeing.

### Delay: tertiary prevention

2.8. These are interventions aimed at minimising the effect of disability or deterioration for people with established health conditions, complex care and support needs or caring responsibilities, including

supporting people to regain skills and reduce need where possible. Local authorities **must** provide or arrange services, resources or facilities that maximise independence for those already with such needs, for example, interventions such as rehabilitation/reablement services (discussed below) and joint case-management of people with complex needs, e.g. community equipment service, handyman services. This could also include helping carers to continue to care, enabling them to have a life of their own alongside caring, to have breaks from their caring responsibilities, develop mechanisms to cope with stress associated with caring and awareness of their own physical and mental health needs, e.g. emotional support or stress management classes. Social Workers and Occupational Therapists are well placed to be the lead professional to undertake assessment or review of an individual or their carer with complex care and support needs.

## Intermediate care and reablement

2.9. “Intermediate care” is a structured programme of care provided for a limited period of time, to assist a person to maintain or regain the ability to live independently at home. “Reablement” is a particular type of intermediate care, which has a stronger focus on helping the person to regain skills and capabilities to reduce their needs, in particular through the use of therapy or minor adaptations.

2.10. There is a tendency for the terms “reablement”, “rehabilitation” and “intermediate care” to be used interchangeably. The National Audit of Intermediate Care<sup>2</sup> categorises four types of

intermediate care: **crisis response** – services providing short-term care (up to 48 hours); **home-based intermediate care** – services provided to people in their own homes by a team with different specialities but mainly health professionals such as nurses and therapists; **bed-based intermediate care** – services delivered away from home, for example, in a community hospital; and **reablement** – services to help people live independently which are provided in the person’s own home by a team of mainly care and support professionals.

2.11. Three of the four types of intermediate care have historically been clinician-led and provided by health staff, with reablement being provided by local authorities. However, these are not concrete, mutually-exclusive categories – and, furthermore, with greater integration and co-operation between health and local authorities, there should be greater use of qualified staff from health and social care working together to provide intermediate care.

## Carers and prevention

2.12. There may be specific interventions for carers that prevent, reduce or delay the needs for support. These interventions may differ from those for people without caring responsibilities. Examples of services, facilities or resources that could contribute to preventing, delaying or reducing the needs of carers may include interventions, information or advice that help carers to:

- care effectively and safely – both for themselves and the person they are supporting, e.g. timely interventions or advice on moving and handling safely or avoiding falls in the home, or training for carers to feel confident performing basic health care tasks;

<sup>2</sup> <http://www.nhsbenchmarking.nhs.uk/projects/partnership-projects/National-Audit-of-Intermediate-Care/year-two.php>

- look after their own physical and mental health and wellbeing, including developing coping mechanisms;
- make use of IT and assistive technology;
- make choices about their own lives, for example managing care and paid employment;
- find support and services available in their area;
- access the advice, information and support they need including information and advice on welfare benefits and other financial information and about entitlement to carers' assessments (see chapter 6).

## The focus of prevention

### Promoting wellbeing

2.13. Local authorities must have regard to promoting wellbeing and the principles set out in chapter 1. Local authorities should look at an individual's life holistically. This will mean considering any care and support needs in the context of the person's skills, ambitions, and priorities. This **should** include consideration of the role a person's family or friends can play in helping the person to meet their goals, not creating or adding to their caring role but including them in an approach supporting the person to live as independently as possible for as long as possible. In regard to carers, the local authority should consider how they can be supported to look after their own health and wellbeing and to have a life of their own alongside caring.

An older man lives alone with some support from his daughter who works full time. He needs occasional personal care to remain living independently with dignity, and it is likely that these needs will increase. He has lost contact with family and friends following his wife's death and rarely goes out without support from his daughter who is restricted to taking him out at weekends because of work commitments.

An assessment would consider all of his needs, including those currently being met by his daughter, along with the outcomes he wishes to achieve. A separate carer's assessment offered to his daughter (or a combined assessment if both father and daughter agreed) would establish the daughter's willingness and ability to care and continue to care and the outcomes she wishes to achieve. This joint assessment would look at issues such as the possible impact on the daughter of supporting her father while in full-time employment as well as the man's isolation, ability to connect with others or be an active citizen.

Community groups, voluntary organisations, and buddying services could support the man to maximise opportunities to look after his own health and wellbeing and participate in local community activities. This, in turn, could lessen the impact of caring on his daughter and enable her to continue to support her father effectively alongside paid employment. Such support can be identified/suggested alongside other, perhaps more formal services to meet personal care needs.

## Developing resilience and promoting individual strength

2.14. In developing and delivering preventative approaches to care and support, local authorities should ensure that individuals are not seen as passive recipients of support services, but are able to design care and support based around achievement of their goals. Local authorities should, where possible, actively promote participation in providing interventions that are co-produced with individuals, families, friends, carers and the community. “Co-production” is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered. Such interventions can contribute to developing individual resilience and help promote self-reliance and independence, as well as ensuring that services reflect what the people who use them want.

### Case Study

[http://www.thinklocalactpersonal.org.uk/Browse/SDSandpersonalbudgets/Reducing\\_Process/CaseStudies/Resource/?cid=9598](http://www.thinklocalactpersonal.org.uk/Browse/SDSandpersonalbudgets/Reducing_Process/CaseStudies/Resource/?cid=9598)

2.15. Through the assessment process, an individual will have direct contact with a local authority. A good starting point for a discussion that helps develop resilience and promotes independence would be to ask “what does a good life look like for you and your family and how can we work together to achieve it?” Giving people choice and control over the support they may need and access to the right information enables people to stay as well as possible, maintain independence and caring roles for longer.

2.16. Social workers, Occupational Therapists, other professionals, service providers and commissioners who are effective at preventing, reducing, or delaying needs for care and support are likely to have an holistic picture of the individuals and families receiving support. This will include consideration of a person’s strengths and their informal support networks as well as their needs and the risks they face. This approach recognises the value in the resources of voluntary and community groups and the other resources of the local area.

## Developing a local approach to preventative support

2.17. A local authority **must** provide or arrange for services, facilities or resources which would prevent, delay or reduce individuals’ needs for care and support, or the needs for support of carers. Local authorities **should** develop a clear, local approach to prevention which sets out how they plan to fulfil this responsibility, taking into account the different types and focus of preventative support as described above.

2.18. Whilst local authorities may choose to provide some types of preventative support themselves, others may be more effectively provided in partnership with other local partners (e.g. rehabilitation or falls clinics provided jointly with the local NHS), and further types may be best provided by other organisations e.g. specialist housing providers or some carers’ services. A local authority’s commissioning strategy for prevention **should** consider the different routes available, and the benefits presented by each.

2.19. In developing a local approach to prevention, the local authority **must** take steps to identify and understand both the current and future *demand* for preventative

support, and the supply in terms of services, facilities and other resources available.

**2.20.** Local authorities **must** consider the importance of identifying the services, facilities and resources that are already available in their area, which could support people to prevent, reduce or delay needs, and which could form part of the overall local approach to preventative activity. Understanding the breadth of available local resources will help the local authority to consider what gaps may remain, and what further steps it should itself take to promote the market or to put in place its own services.

**2.21.** Where the local authority does not provide such types of preventative support itself, it **should** have mechanisms in place for identifying existing and new services, maintaining contact with providers over time, and helping people to access them. Local approaches to prevention should be built on the resources of the local community, including local support networks and facilities provided by other partners and voluntary organisations.

**2.22.** Local authorities **must** promote diversity and quality in provision of care and support services, and ensure that a person has a variety of providers to choose from (see chapter 4). Considering the services, facilities and resources which contribute towards preventing or delaying the development of needs for care and support is a core element of fulfilling this responsibility. A local authority **should** engage local providers of care and support in all aspects of delivery and encourage providers to innovate and respond flexibly to develop interventions that contribute to preventing needs for care and support.

**2.23.** Local authorities **should** consider the number of people in its area with existing needs for care and support, as well as those at risk of developing needs in the future,

and what can be done to prevent, delay or reduce those needs now and in the future. In doing so, a local authority should draw on existing analyses such as the Joint Strategic Needs Assessment, and work with other local partners such as the NHS to develop a broader, shared understanding of current and future needs, and support integrated approaches to prevention.

**2.24.** In particular, local authorities **must** consider how to identify “unmet need” – i.e. those people with needs which are not currently being met, whether by the local authority or anyone else. Understanding unmet need will be crucial to developing a longer-term approach to prevention that reflects the true needs of the local population. This assessment should also be shared with local partners, including through the health and wellbeing board, to contribute to wider intelligence for local strategies. Preventative services, facilities or resources are often most effective when brought about through partnerships between different parts of the local authority and between other agencies and the community. Local authorities **should** consider how they can work with different partners to identify unmet needs for different groups, for example working with the NHS to identify carers, and how to coordinate shared approaches to preventing or reducing such needs.

## Working with other partners to focus on prevention

**2.25.** In developing and delivering local approaches to prevention, the local authority **should** consider how to align or integrate its approach with that of other local partners. Preventing needs will often be most effective when action is undertaken at a locality level, with different organisations working together to understand how the actions of each may

impact on the other. Within the local authority, prevention of care and support needs is closely aligned to other local authority responsibilities in relation to public health, children's services, and housing, for example. Across the local landscape, the role of other bodies including the local NHS, welfare and benefits, Jobcentre Plus, the police, service providers and others will also be important in developing a comprehensive approach.

**2.26.** Local authorities **must** ensure the integration of care and support provision, including prevention with health and health-related services, which includes housing (see chapter 15). This responsibility includes in particular a focus on integrating with partners to prevent, reduce or delay needs for care and support.

**2.27.** A local authority **must** cooperate with each of its relevant partners and the partners must cooperate with the local authority (see chapter 15 on cooperation and details of specific relevant partners), for example, in relation to the provision of preventative services and the identification of carers a local authority must cooperate with NHS bodies.

**2.28.** A local authority **must** also set up arrangements between its relevant partners and individual departments in relation to its care and support functions, which includes prevention. Relevant partners and individual departments include, but are not limited to, housing departments where, for example, housing services or officers can provide support through early identification of people with dementia and their carers, provide housing related support and or in partnership with others, home from hospital services or "step up step down" provision.

## Identifying those who may benefit from preventative support

**2.29.** Local authorities **should** put in place arrangements to identify and target those individuals who may benefit from particular types of preventative support. Helping people to access such types of support when they need it is likely to have a significant impact on their longer-term health and wellbeing, as well as potentially reducing or delaying the need for ongoing care and support from the local authority.

**2.30.** In developing such approaches, local authorities **should** consider the different opportunities for coming into contact with those people who may benefit, including where the first contact may be with another professional outside the local authority. There are a number of interactions and access points that could bring a person into contact with the local authority or a partner organisation and act as a trigger point for the local authority to consider whether the provision of a preventative service, or some other step is appropriate. These might include, for instance:

- initial contact through a customer services centre, whether by the person concerned or someone acting on their behalf;
- contact with a GP, community nurses, housing officers or other professionals which leads to a referral to the local authority;
- an assessment of needs or a carer's assessment (see chapter 6 on assessment), which identifies that the person would benefit from a preventative service or other type of support available locally.

**2.31.** Prevention **should** be a consistent focus for local authorities in undertaking their care and support functions. However, there may be key points in a person's life or in the care and support process where a preventative intervention may be particularly appropriate or of benefit to the person. Approaches to identifying those people who may benefit from preventative support **should** consider how to locate people in such circumstances, for example:

- bereavement;
- hospital admission and or discharge;
- application for benefits such as Attendance Allowance, or Carer's Allowance;
- contact with/use of local support groups;
- contact with/use of private care and support;
- changes in housing.

**2.32.** A local authority **must** establish and maintain a service for providing people with information and advice relating to care and support (see chapter 3). In addition to any more targeted approaches to communicating with individuals who may benefit from preventative support, this service should include information and advice about preventative services, facilities or resources, so that anyone can find out about the types of support available locally that may meet their individual needs and circumstances, and how to access them.

## Helping people access preventative support

**2.33.** Many different kinds of service, facility or resource can be preventative and can help individuals live well and maintain their independence or caring roles for longer.

Local authorities should be innovative and develop an approach to prevention that meets the needs of their local population. A preventative approach requires a broad range of interventions, as one size will not fit all.

**2.34.** Where a local authority has put in place mechanisms for identifying people who may benefit from a type of preventative support, it **should** take steps to ensure that the person concerned understands the need for the particular measure, and is provided with further information and advice as necessary.

**2.35.** Contact with a person who is identified as being able to benefit from preventative support may lead to the local authority becoming aware that the person appears to have needs for care and support, including support as a carer. This appearance of need is likely to trigger the requirement to carry out a needs assessment (in the case of an adult with needs for care and support), or a carer's assessment (see paragraphs 2.38-2.42 below). However, where a local authority is not required to carry out such an assessment under the Care Act, it **should** nonetheless take steps to establish whether the person identified will benefit from the type of preventative support proposed.

**2.36.** Where a person is provided with any type of service, or supported to access any facility or resource as a preventative measure, the local authority **should** also provide the person with information in relation to the measure undertaken. The local authority is not required to provide a care and support plan or a carer's support plan where it only take steps under section 2 of the Care Act; however, it **should** consider which aspects of a plan should be provided in these circumstances, and **should** provide such information as is necessary to enable the person to understand:

- what needs the person has or may develop, and why the intervention or other action is proposed in their regard;

- the expected outcomes for the action proposed, and any relevant timescale in which those outcomes are expected; and
- what is proposed to take place at the end of the measure (for instance, whether an assessment of need or a carer's assessment will be carried out at that point).

2.37. The person concerned must agree to the provision of any service or other step proposed by the local authority. Where the person refuses, but continues to appear to have needs for care and support (or for support, in the case of a carer), then the local authority **must** proceed to offer the individual an assessment.

## Assessment of adults' and carers' needs

2.38. In assessing the needs of either an adult with care and support needs or a carer, the local authority **must** consider whether the person concerned would benefit from the preventative services, facilities or resources provided by the local authority or which might be available in the community. This is to ensure that as part of the assessment process, the local authority considers the capacity of the person to manage their needs or achieve the outcomes which matter to them, and allows for access to preventative support before a decision is made on whether the person has eligible needs (see chapter 6 on assessment for more information).

2.39. As part of this process, the local authority **should** also take into account the person's own capabilities, and the potential for improving their skills, as well as the role of any support from family, friends or others that could help them to achieve what they wish for from day-to-day life. This should not assume

that others are willing or able to take up caring roles, and where necessary a carer's assessment **should** always be offered. Children should not undertake inappropriate or excessive caring roles that have an impact on their development. However, considering the support from family, friends or others is important in taking a holistic approach to see the person in the context of their support networks and understanding how needs may be prevented, reduced or delayed by others within the community, rather than by more formal services (also see chapter 6, paragraph 6.43 to 6.50 about the whole family approach to assessment).

2.40. If a person is provided with care and support or support as a carer by the local authority, the authority is also required to provide them with information about what can be done to prevent, delay, or reduce their needs as part of their care and support plan or carer's support plan. This **should** also include consideration of the person's strengths and the support from other members of the family, friends or the community (see chapter 10 on care and support planning).

2.41. If a person's needs are not to be met by the local authority, the authority must in any case provide in writing, information about what can be done to prevent, delay, or reduce their needs. This is to ensure that all people, whatever their level of need, are provided with targeted, personalised information that can support them to take steps to prevent or reduce their needs, connect more effectively with their local community, and delay the onset of greater needs to maximise their independence and quality of life. Where a person has some needs that are eligible, and also has some other needs that are not deemed to be eligible, the local authority must consider similarly what information and advice would contribute to preventing, reducing or delaying

the needs for care and support or support as a carer which are not eligible, and this **should** be aligned with the care and support plan or carer's support plan.

2.42. It is important that people receive information in a timely manner about the services or interventions that can help or contribute to preventing an escalation in needs for care and support. Supporting people's access to the right information at the right time is a key element of a local authority's responsibilities for prevention.

## Charging for preventative support

2.43. Preventative services, like other forms of care and support, are not always provided free, and charging for some services is vital to ensure affordability. The Care and Support (Charging and Assessment of Resources) Regulations 2014 continue to allow local authorities to make a charge for the provision of certain preventative services, facilities or resources. The regulations also provide that some other specified services **must** be provided free of charge.

2.44. Where a local authority chooses to charge for a particular service, it **should** consider how to balance the affordability and viability of the measure with the likely impact of charging on uptake by individuals. Whilst some charging may act as an incentive for people to use a service or facility (for example, upfront charges for certain activities may make people more likely to attend), others may have the opposite effect. Charging may also make a preventative service viable or keep a service running.

2.45. When charging for any type of preventative support, local authorities **should** always take steps to ensure that any charge is affordable to the person concerned. This does not need to follow the method of the financial assessment used for mainstream

charging purposes; and the use of such a process is likely to be disproportionate. However, local authorities **should** consider adopting more proportionate or "light-touch" processes which ensure that charges are only paid by those who can afford to do so and would not in any case leave someone below the national minimum level of income (see chapter 8 on charging and financial assessment). In any event, a local authority **must not** charge more than it costs to provide or arrange for the particular type of support.

2.46. The regulations require that intermediate care and reablement provided up to six weeks, and minor aids and adaptations provided up to the value of £1,000 **must** always be provided free of charge.

2.47. Where local authorities provide intermediate care or reablement to those who require it, this **must** be provided free of charge for a period of up to six weeks. This is for all adults, irrespective of whether they have eligible needs for ongoing care and support. Although such types of support will usually be provided as a preventative measure under section 2 of the Act, they may also be provided as part of a package of care and support to meet eligible needs. In these cases, regulations also provide that intermediate care or reablement cannot be charged for in the first six weeks, to ensure consistency.

2.48. Whilst they are both time-limited interventions, neither intermediate care nor reablement should have a strict time limit, since the period of time for which the support is provided should depend on the needs and outcomes of the individual. In some cases, for instance a period of reablement for a person who has recently become sight-impaired, the support may be expected to last longer than six weeks. Whilst the local authority does have the power to charge for such types

of support where it is provided beyond six weeks, local authorities **should consider** continuing to provide it free of charge beyond six weeks in such circumstances, in view of the clear preventative benefits to the individual and, in many cases, the reduced risk of hospital admissions.

### Case study:

Mr A is a 91 year old man who lives alone with his dog in his house. He is usually independent, is a passionate cook and enjoys socialising. He drives a car. Whilst out walking his dog he suffered a stroke, he fell, causing a fractured neck of femur. He was admitted to hospital and underwent surgery for a hip replacement which meant he had to follow hip precautions for 6 weeks.

The stroke had left him with slight left sided weakness and problems with concentration, sequencing and attention. He was transferred to a Community Hospital for rehabilitation where the Physiotherapists (PTs) and Occupational Therapists (OTs) worked on mobility, transfers, personal care following hip precautions, stair climbing and kitchen tasks. Cognitive screens were completed and the OT's targeted their input on helping improve concentration, sequencing and attention.

Mr A was discharged, independently mobile using a frame, independent transferring using equipment and stair climbing with supervision. He was discharged home with 4 calls per day from BEST plus (Bradford Enablement Support Team). Joint sessions between the PT and OT and BEST plus were completed to work on the following:

- Practising walking safely indoors using 2 walking sticks.

- Increase hip strength through exercises.
- To be safe and independent washing and dressing.
- To be safe and independent preparing hot drinks and simple snacks and transport safely using trolley.
- The above goals were achieved and new goals were set in consultation with Mr A:
- To be safe and independent walking outdoors using 2 sticks.
- To be safe and independent bathing using bath lift.
- To be safe and independent preparing hot meals from scratch.
- To be safe and independent completing shopping using Access bus.
- To be safe and independent walking dog short distances using 4 wheeled walker.

After 6 weeks of continued BEST plus input in Mr A's home, he was able to achieve all of his goals and all Social Services input was withdrawn.

