British Red Cross

PREVENTION IN ACTION

How prevention and integration are being understood and prioritised locally in England

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Refusing to ignore people in crisis


#PreventReduceDelay

Contents

Important Note to Reader:
This document is large. It is not intended to be read from cover to cover but as a reference document. All readers should consult the 'Reflections and recommendations' section.

INTRODUCTION

The British Red Cross has been working in the space between home and hospital since before the NHS was established. Our UK health and social care services today include: lower-level support enabling people to continue living independently at home; A&E discharge support; helping people home from hospital; transport to and from hospital; short term mobility aids, like a wheelchair; first aid education; new services to tackle loneliness and social isolation; and more.

All of these services help prevent a situation escalate and enable people to regain their confidence and independence. It is this unique position, working within both the community and in hospitals that enables us to understand where people are falling through the gaps. Through this work we see first-hand what works and what does not, and use this insight and evidence to shape our advocacy and policy development.

We see too many people having to reach the point of health and social care crisis before they receive support. As such, we have long been calling for a shift towards prevention. Seemingly small interventions, such as the provision of a short-term wheelchair, a simple home adaptation or even help with the shopping, can be the difference between living independently at home, and being admitted to a care home or hospital.

We are delighted, therefore, that the ambition to shift towards a truly preventative system has been enshrined in both social care and in health: in law via the Care Act (2014) and emphasised in the NHS Five Year Forward View and its Next Steps document, respectively. Since April 2015, the Care Act has placed a duty on local authorities to ensure a range of services that prevent, reduce and delay the need for care and support are available in their area. Local authorities also have to consider whether people could benefit from preventative services, before they determine if they are eligible for statutory support. In practice, this means people with lower level needs should be able to access services that would help prevent them falling into crisis. A system that ensures people with lower-level needs can access services that prevent, reduce and delay the need for further care is good for the individual and the public purse.

Yet our system still largely focuses on reacting to, rather than preventing, crises. Research carried out by the Red Cross in 2015, a year after the Care Act's prevention duty came into force, found that Parliament's vision for prevention was not being fully realised. While the majority of local authorities reported making changes to the structures and processes that framed their provision of preventative services, such as the creation of new boards, roles, strategies and guidance, this had rarely translated into enhanced provision. We also found that some

local authorities were conflating their duty to provide information and advice with their duty to prevent needs for care and support. There also seemed to be no consistent understanding of exactly what 'prevention' is and how to put it into action. This is despite the Care Act's statutory guidance defining the term, using the triple definition of prevention.

To us, a truly preventative system would prioritise prevention at every stage of a condition (before, during and after). So, over two years since both the NHS Five Year Forward View and the Care Act came into force, we wanted to see whether the prioritisation and understanding of prevention has improved at a local level.

Since our last report, there have also been some significant changes to the way health and social care services are planned. Every locality in England now has a sustainability and transformation partnership (STP) and plan,[1] which are critical to transforming health and social care at a local level. For this year's report, we have taken the new opportunity to assess prevention in STPs as well as repeating a review of joint health and wellbeing strategies and local authority Freedom of Information (FOI) responses.

We have also looked beyond prevention to health and social care integration, which we believe to be critical to ensuring the funding and provision of preventative interventions in local health and social care systems. Single budgets, for example, mean savings would return to the same pot and benefit both the NHS and local authorities from cost-efficiencies. Integration also has the potential to eradicate the often false distinction between people's 'health' and 'social care' needs. This distinction all too often results in people falling through the gaps. As with prevention, we wanted to gain a better understanding of how integration is being prioritised and actioned locally.

1 Sustainability and transformation plans (STPs) are local plans setting out how the NHS Five Year Forward View will be implemented in 44 areas of England. For more information, please see page 16.

What is prevention?

The Care Act's triple definition of prevention:

- **Primary prevention** is about minimising the risk of people developing needs.
- **Secondary prevention** is about targeting people at high risk of developing needs and intervening early.
- **Tertiary prevention** is about minimising deterioration and the loss of independence for people with established needs or preventing the reoccurrence of a health and social care crisis.

(See full definition and example in appendix one).

What is integration?

'For care to be integrated, organisations and care professionals need to bring together all of the different elements of care that a person needs.'

– Monitor, now NHS Improvement, 2014

The Department of Health has adopted National Voices' definition of integrated care as 'person-centred, coordinated care' and developed what it feels like from the service-user's perspective:

'My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes.'

Likewise the Care Act's statutory guidance notes:

'The vision is for integrated care and support that is person-centred, tailored to the needs and preferences of those needing care and support, carers and families.'

As this research will demonstrate, however, there are different interpretations of what exactly needs to happen to achieve health and social care integration. Equally, the scale and pace of integration looks different from place to place.

REFLECTIONS AND RECOMMENDATIONS

Overall reflections

It is widely accepted that prevention and integration should sit at the heart of the sector's plans to innovate and adapt to new challenges, including financial. This research shows that, for the most part, both are being strived for at a local level. However, as previous British Red Cross studies have shown, there is no consistent understanding of exactly what 'prevention' is and how to put it into action. This also seems to be the case with regard to 'integration'.

Freedom of Information (FOI) responses indicate that local authorities are engaging with the Care Act's triple definition of prevention, but this terminology has yet to be fully embraced by health and wellbeing boards (HWBs) or sustainability and transformation partnerships (STPs).

We believe the triple definition of prevention is just as useful for the NHS, public health, and voluntary and community sector, as it is for adult social care. It's vital to ensuring preventative services are made available across the life course and pathology of a condition or illness. Sharing the same language will become increasingly important as we move towards increased integration and cross-working.

The FOI responses, joint health and wellbeing strategies, and sustainability and transformation plans review, indicate that prevention is a key consideration in local decision making, including commissioning.

However, interventions aimed at minimising the effect of disability or deterioration for people with established or complex health conditions (tertiary prevention), are still not being emphasised as much as primary and secondary prevention. In some cases, they are forgotten altogether. Many HWBs in particular are yet to place importance on preventative measures that could stop the deterioration or reoccurrence of a health or social care-related crisis by providing lower-level support.

Local authorities are generally working to meet their new responsibilities under the Care Act. **However, responses demonstrate a mixed level of understanding about both the prevention and integration duties, as well as ambition.**

Innovative solutions to preventing, reducing and delaying the need for care and support do not seem to be as ground breaking as the legislation intended. And examples of health and social care integration still seem to be small at scale. Given the huge financial pressures on local authorities, this is perhaps not so surprising.

We are concerned that some local authorities are still sometimes conflating their duty to provide information and advice with their duty to prevent needs for care and support. We will not achieve a truly preventative system by providing information and advice alone. We will not sufficiently improve outcomes for people and their carers, nor will we release the associated cost efficiencies and savings. **The proposed green paper on social care could provide a good opportunity to look again at what is needed to make the Care Act's vision for prevention a reality.**

Some local authorities seem to be 'cooperating' rather than 'integrating' with health services. Yet, the duty to co-operate (under Sections 6 and 7 of the Care Act) and the duty to integrate (under Section 3 of the Care Act) are distinct. Different interpretations of health and social care integration as well as scale and pace are also evident in STPs. **The proposed green paper also provides a good opportunity to explore what is meant by integration and what we want it to achieve. Is the aim to simply work better together? Is it to pool budgets? Or is it to go much further and combine our systems in a way that no longer distinguishes between 'clinical' and 'social' needs?**

The sustainability and transformation planning process no doubt provides another opportunity to see a real shift towards prevention as well as integration. Our review found, after all, that the

understanding and prioritisation of prevention in sustainability and transformation plans is generally very strong. We must make sure, however, that these plans for transformation can be put into practice on the ground. The same financial pressures that have encouraged this theoretical shift towards prevention might also be one of the key barriers to achieving these latest plans for prevention. We know, for example, that a large proportion of the sustainability and transformation budget has so far been spent on plugging deficits.

Indeed, FOI responses, joint health and wellbeing strategies, and sustainability and transformation plans emphasise the practical difficulties of shifting resources away from crisis intervention to prevention as well as integrating care in the current economic climate. **We hope this report supports this transition. We also encourage local decision makers to continue to explore ways of overcoming these challenges and to share useful learning.**

KEY FINDINGS

Prevention

- **Prevention is an evident consideration in local strategies and plans.** All joint health and wellbeing strategies and sustainability and transformation plans mention prevention.
- **Yet, the term 'prevention' is still understood differently across the country.** This is despite the Care Act's triple definition of prevention.
- **Thirty-seven per cent of joint health and wellbeing strategies still do not incorporate a full understanding of prevention.** Prevention should be seen as an ongoing consideration and not a single activity or intervention.
- **All too often, local authorities and health and wellbeing boards fail to recognise the importance of interventions aimed at minimising deterioration and the loss of independence for people with established needs, or preventing the reoccurrence of a health and social care crisis (i.e. 'tertiary' types of prevention).** Many understand prevention only as minimising the risk of people developing care and support needs (primary prevention), or as targeting people at high risk of developing needs (secondary prevention).
- **Sustainability and transformation plans generally prioritise prevention very strongly.** Nevertheless, they too place more emphasis on primary and secondary prevention. With over 15 million people in England living with a long term condition (such as diabetes and dementia) accounting for 70 per cent of the money we spend on health and social care,[2] as well as an ageing population, tertiary types of preventative interventions are becoming increasingly important. Stretched funds may also be putting these promising plans for prevention at risk.
- **Local authorities have responded to Section 2 of the Care Act ('preventing needs for care and support') in a range of ways.**
- **There has been clear progression since the last series of FOI responses we received towards the end of 2015 enquiring after Section 2 of the Act, with, in many cases, a clear shift from planning to implementation.** Around a half of local authorities now report 'developing or investing in new services that prevent, reduce or delay'.
- **However, the overall impression was that local authorities' responses still demonstrate a mixed level of understanding about the prevention duties, as well as ambition.** While some local authorities have identified and met unmet need by investing in new, innovative developments that prevent, reduce or delay, others are yet to develop a local approach to prevention.
- **In some cases, local authorities are still conflating their duty to provide information and advice with their duty to prevent needs for care and support.** These are two distinct duties, which should be distinguished in local strategies and plans.

Integration

- **Local authorities and sustainability and transformation partnerships also demonstrate an inconsistent level of understanding of 'integration' as well as ambition.** This is despite government plans for full integration by 2020.
- **Local authorities have also responded to Section 3 of the Care Act ('promoting integration of care and support with health services etc.') in a range of ways,** from pooling budgets to integrating services to integrating management structures.
- **Yet, few actions have been done at scale.**
- **And, in some cases it seems local authorities are 'cooperating' rather than 'integrating' with health services.** The duties to co-operate (under Sections 6 and 7 of the Care Act) and the duty to integrate (under Section 3 of the Care Act) are distinct.
- **Local decision makers across the board emphasise both the need to invest in prevention and integration as well as the practical difficulties of doing this, especially in the current economic climate.** This Red Cross report is intended to help decision makers make this transition. It provides a national picture of local developments, and highlights areas of good practice.

2 Department of Health (May 2015), 2010 to 2015 government policy: long term health conditions: gov.uk/government/publications/2010-to-2015-government-policy-long-term-health-conditions/2010-to-2015-government-policy-long-term-health-conditions

KEY RECOMMENDATIONS

Prevention

We want preventative services to be made available to everyone, regardless of level of need or ability to pay:

- **Local authorities should implement the full ambition of the Care Act's prevention duties.**
- **Every health and wellbeing board and sustainability and transformation partnership** should *fully* incorporate and prioritise prevention in their strategies and plans. Prevention is about more than just stopping a condition or illness arising. It is about preventing, reducing and delaying needs and associated costs.
- **The Government should look again at what resources are required to enable local authorities to implement their prevention duties in a meaningful way.**
- **The Government should also ensure that sustainability and transformation plans are equipped with the necessary funds to truly invest in transformation.**
- **The proposed upcoming green paper on social care should explore whether the Care Act's prevention duty in its current form goes far enough in realising the prevention vision.** For example, there is no individual entitlement to access preventative services, suggesting a preventative system is a nice-to-have rather than a must-have.

Integration

We want to see an integrated health and care system where nobody falls through the gaps:

- **The Government should better define what is meant by health and social care integration at a local level, so that local decision makers understand the scale and pace to which they should aspire.**
- **As part of its proposed green paper on social care, the Government should explore what is needed to make integration work in practice, at both a local and national level.** This should involve an exploration of the resources needed to achieve the full ambition of integration as well as whether a legislative framework, as implemented in Scotland, is needed to aid the process.
- **In the meantime, local authorities should seek to move beyond 'cooperation' to 'integration' with health, using the sustainability and transformation partnership process as a vehicle to drive this transformation forward.**

CONTEXT

Pressures on health and social care

While it has long been recognised that 'prevention is better than cure', England's health and social care system has largely focussed on reacting to crises rather than preventing them.

Britain's population is ageing fast and more people are living with multiple long-term conditions. More than one in 12 of the population is projected to be aged 80 or over by mid-2039.[3] In 2012, the Department of Health projected a rise of those with multiple long-term conditions to 2.9 million in 2018 from 1.9 million in 2008.[4]

Despite this, between 2010 and 2015 **adult social care budgets were reduced** by £4.6 billion, representing 31 per cent of real terms net budgets.[5] And **the number of older people receiving local authority-funded social care has fallen**, dropping by 26 per cent between 2009 and 2013/14 (the last year for which comparable data is available).[6]

These cuts adversely affect the NHS. Delayed transfers of care from hospitals due to social care have also risen by 65 per cent since 2011.[7] In 2015, 88 per cent of NHS Trust finance directors and 80 per cent of clinical commissioning group (CCG) finance leads felt funding pressures on local authorities were adversely affecting the performance of health services in their local health economy.[8]

Health and social care are under real pressure. The 2014 NHS Five Year Forward View warned of a £30 billion funding gap in the health budget by the end of the decade.[9] Adult social care was estimated to be facing a funding gap of £4.3 billion (29 per cent of the budget)[10] over the same period.

The Government has responded to these warnings in numerous ways over the last few years. Most recently, the Conservative 2017 election manifesto recommitted to increasing 'NHS spending by a minimum of £8 billion in real terms over the next five years, delivering an increase in real funding per head of the population for every year of the parliament'.[11] They have also given local authorities the power to increase social care funding by raising council tax. A two per cent council tax precept was announced in 2015[12] and powers to increase this again to three per cent in 2017-18 and 2018-19, provided increases do not exceed six per cent in total before 2019-20, were announced again in 2016. Two hundred and forty million pounds of new homes bonus money was also made available to adult social care as part of the 2017 to 2018 local government finance settlement.[13] The government then announced an additional £2 billion will be given to councils in England over the next three years for adult social care in the Spring Budget 2017.

Despite this additional funding, the Association of Directors of Adult Social Services (ADASS) estimates adult social care in England will face a £2.3 billion funding gap by 2020. The ADASS budget survey 2017 found that 'only nine of the 138 Directors who responded feel at all optimistic about the future financial state of the local health and care economy in their own areas.'[14]

In response to this year's ADASS budget survey, the Chairman of the Local Government Association's Community Wellbeing Board, Councillor Izzi Seccombe said:

3 ONS (October 2015), National population projections, 2014-based Statistical Bulletin: ons.gov.uk/ons/dcp171778_420462.pdf
4 Department of Health (2012), Long Term Conditions Compendium of Information, Third Edition: gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf
5 ADASS (June 2015), ADASS Budget Survey 2015: adass.org.uk/uploadedFiles/adass_content/policy_networks/resources/Key_documents/ADASS%20Budget%20Survey%202015%20Report%20FINAL.pdf
6 The Care Quality Commission (October 2016), The state of health care and adult social care in England 2015/16: cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf
7 House of Commons Library briefing paper (February 2017) NHS Indicators; England
8 The King's Fund (October 2015), Quarterly Monitoring Report: qmr.kingsfund.org.uk/2015/17/
9 NHS (October 2014), Five Year Forward View: england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
10 LGA & ADASS (October 2014), Adult social care funding: 2014 state of the nation report: local.gov.uk/documents/10180/5854661/Adult+social+care+funding+2014+state+of+the+nation+report/e32866fa-d512-4e77-9961-8861d2d93238
11 The Conservative and Unionist party (2017), THE CONSERVATIVE AND UNIONIST PARTY MANIFESTO 2017: eu-west-2.amazonaws.com/manifesto2017/Manifesto2017.pdf
12 Chancellor George Osborne's Spending Review and Autumn Statement 2015 speech (25 November)
13 Department for Communities and Local Government (February 2017), Final local government finance settlement 2017 to 2018
14 ADASS (2017), ADASS BUDGET SURVEY 2017: adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf

"...the £2 billion of extra funding announced in the Spring Budget, while helpful to councils in meeting some short term pressures, is not a long-term solution and still leaves councils facing a £2.3 billion funding gap by 2020…

…Adult social care is at a tipping point, and unless urgent action is taken we will continue to see more and more of the consequences of underfunding that we have seen in recent years, particularly care providers either handing back contracts to councils or ceasing trading altogether."[15]

Something needs to change

One way to ease the pressure is to invest in preventative services and integrate care…

"It is only with this greater focus on prevention and integration that both the NHS and care and support can respond to the financial pressures of an ageing population."[16]

– Earl Howe

It pays to spend on prevention. Investing in preventing minor situations escalating into crises is more cost-effective than picking up the pieces. This principle applies across health and social care and should span our lifetimes. It should also be enshrined in universal public health campaigns, right up to the management of chronic illnesses and long-term conditions.

Directors of adult social care recognise this. The Association of Directors of Adult Social Services (ADASS) has identified 'moving towards prevention and early intervention', as the most important priority area for making savings in 2017/18.[17]

There is good evidence of these cost savings. An independent economic analysis of British Red Cross lower-level preventative services by the London School of Economics and Political Science, identified cost savings related to a reduced need for care and support equivalent to £880 per person.[18]

The Local Government Association's prevention spending model concluded that handyperson services have a return of £1.13 for every £1 invested and telehealth care has a return of £2.68 for every £1 invested.[19]

Similarly, the Department of Health's Mental Health Strategy 2011 estimated that its plans to expand the provision of talking therapies services would 'be strongly cost saving to the overall public purse, with a net saving of an estimated £302m,' representing a public sector saving of £1.75 for every £1 spent.[20]

Public Health England recently found that tackling loneliness through volunteering and social activities among older people also saves money: every £1 invested results in an estimated saving to society of £1.26 (over five years).[21]

Yet, while local authorities see prevention as a key source of savings for the future, spend on prevention is decreasing. It only forms 6.3 per cent of local authorities' budgets in 2017/2018 (a reduction of 6.7 per cent from the previous year).[22] As ADASS explains:

'As budgets reduce it becomes harder for councils to manage the tension between prioritising statutory duties towards those with the greatest needs and investing in services that will prevent and reduce future needs.'[23]

In 2016, ADASS identified 'integration' as the second most important priority area for making savings over three years, after 'moving towards prevention and early intervention'. **This year, however, only 40 per cent identified 'integration of health and social care' as 'very important' in making savings compared to 82 per cent in 2016.** Prevention, better procurement and shifting

15 Chairman of the Local Government Association's Community Wellbeing Board, Cllr Izzi Seccombe (28 June 2017)
16 Earl Howe (29 July 2013), publications.parliament.uk/pa/ld201314/ldhansrd/text/130729-0001.htm#1307296000176
17 ADASS (2017), ADASS BUDGET SURVEY 2017: adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf
18 Personal Social Services Research Unit, LSE & Research, Evaluation and Impact team, British Red Cross (January 2014), An Analysis of the Economic Impacts of the British Red Cross Support at Home Service: pssru.ac.uk/archive/pdf/dp2869.pdf
19 Personal Social Services Research Unit, LSE & Research, Evaluation and Impact team, British Red Cross (January 2014), An Analysis of the Economic Impacts of the British Red Cross Support at Home Service: pssru.ac.uk/archive/pdf/dp2869.pdf
20 The Department of Health (February 2011), Talking therapy services – impact assessment: gov.uk/government/publications/talking-therapies-impact-assessment
21 Public Health England (August 2017), PHE highlights 8 ways for local areas to prevent mental ill health: gov.uk/government/news/phe-highlights-8-ways-for-local-areas-to-prevent-mental-ill-health
22 https://www.adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf
23 ADASS (2017), ADASS BUDGET SURVEY 2017

activity to cheaper settings all assumed more importance than integration.[24]

NHS England also identified prevention as a priority in its Five Year Forward View:

'…the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.'[25]

Several preventative programmes have been implemented as a result of this plan including, but not limited to, falls prevention initiatives being undertaken by fire services and a large-scale diabetes prevention programme.

In 2017, further preventative programmes were announced in the Next Steps on the NHS Five Year Forward View,[26] ranging from NHS health checks for people at high risk of cardiovascular disease to working with employers to keep employees with a health condition in work, to designing a common approach to self-care and social prescribing.

Legislative background

The importance of both prevention and integration is recognised in national policy and practice.

Prevention

In 2014 the ambition to shift towards a truly preventative system was enshrined in law. **Section 2 of the Care Act, that came into force in April 2015, places a duty on local authorities to ensure the provision of services that prevent, reduce or delay the need for care and support.**[27] Prevention is also a key component of the NHS Five Year Forward View, a shared vision for the NHS that notably calls for 'a radical upgrade in prevention and public health',[28] as well as its follow up plan, Next Steps on the NHS Five Year Forward View.[29]

Historically, preventative services were only available to people with needs that met council eligibility thresholds. This meant that in the large majority of areas, people were required to have 'substantial' or 'critical' needs before they could access preventative services like reablement.

During the passage of the Care Bill, the British Red Cross argued that this wasn't sufficiently preventative. We wanted preventative services to be available to everyone who may benefit from them, so that fewer people reach the point of crisis. **Under Section 9(6)(b) of the Care Act, local authorities now have to consider whether people could benefit from preventative services when carrying out a needs assessment, before a determination is made as to their eligibility.**[30] And, as noted in the statutory guidance:

'Where the local authority judges that the person may benefit from such types of support [services that prevent, reduce or delay the need for support], it should take steps to support the person to access those services.'[31]

The Red Cross also advocated strongly for prevention to be clearly defined. We were concerned that because the term is understood differently across the country, there was a need to be explicit about what 'prevention' entails, in order to support local authorities to fulfil their new duty effectively. We were pleased that three equally important forms of prevention were written into the statutory guidance (see appendix one).

Integration

Under Section 3 of the Care Act (2014), local authorities also have a duty to promote the integration of care and support with health and health-related services where it considers this would:

- promote the wellbeing of adults with care and support needs or of carers in its area
- contribute to the prevention or delay of the development of needs of people
- improve the quality of care and support in the local authority's area, including the outcomes that are achieved for local people.[32]

24 ADASS (2017), ADASS BUDGET SURVEY 2017: adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf
25 NHS (October 2014), NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
26 NHS (March 2017) Next steps on the NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
27 Care Act 2014, Section 2: legislation.gov.uk/ukpga/2014/23/section/2/enacted
28 NHS (October 2014), NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
29 NHS (March 2017) Next steps on the NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
30 Care Act 2014, Section 9(6)(b): http://www.legislation.gov.uk/ukpga/2014/23/section/9/enacted
31 Department of Health (October 2014), Care and Support Statutory Guidance, Chapter 6 (6.62)
32 Care Act 2014, Section 3: legislation.gov.uk/ukpga/2014/23/section/3/enacted

This is in addition to a general duty to cooperate with relevant partners under Section 6 of the Care Act and a duty to cooperate with relevant partners in specific cases under Section 7 of the Act.

The Care Act was not the first time integrated working between health and social care has been encouraged under English law. The Health and Social Care Act (2012), for example, placed a duty on clinical commissioning groups (CCGs) to promote integration between both health services and health-related and social care services where it considers doing so would improve the quality of services or reduce inequalities.[33] It also established health and wellbeing boards that have a duty to encourage integrated working.[34] The National Health Service Act (2006) and the Health Act (1999) also provided an enabling framework for the pooling of NHS and local authority budgets.[35]

In addition to legislation, various initiatives set out to further encourage integration have been implemented.

These include, but are not limited to, the Better Care Fund, a single-pooled NHS and local authority budget; 25 integrated care 'pioneers' that were chosen to be supported by national bodies to implement particularly ambitious and innovative approaches to integrate care; new integrated models of care introduced by the NHS Five Year Forward View; the devolution of an integrated health and social care budget of over £6 billion in Greater Manchester and opportunities for other areas to work towards a similar agreement; sustainability and transformation partnerships (STPs); and more recently the creation of accountable care systems (ACSs). ACSs are evolved versions of STPs that may evolve into accountable care organisations (ACOs) 'where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area.'[36]

While these steps are promising, legislative change might be necessary to take the integration agenda forward at scale. The Department of Health confirmed earlier this year that it is working with NHS England to consider 'what further changes could be made to secondary legislation to support more integrated, place-based approaches to health and social care,' as well as 'whether further amendments to the section 75 partnership regulations would support local areas to extend the benefits of partnership working as they take forward their integration vision.'[37]

A recent Institute for Public Policy Research (IPPR) report, 'Sustainability and Transformation Plans: what, why and where next?', concluded that amending Section 75 of the NHS Act 2006 would indeed be necessary 'to better enable the pooling of budgets and commissioning functions locally.'[38] They also called on government to 'consider the creation of new national legislation to give the regional (STP) level a formal role in the system, codify place-based health and care, soften emphasis on organisational silos, and move from competition to collaboration.'[39]

33 Health and social care act 2012, Section 26 (14Z1) ("Duty as to promoting integration"): legislation.gov.uk/ukpga/2012/7/section/26/enacted
34 Health and social care act 2012, Section 194 ("Establishment of Health and Wellbeing Boards"): legislation.gov.uk/ukpga/2012/7/section/194/enacted
35 National Health Service Act (2006), Section 75 ("Arrangements between NHS bodies and local authorities"): legislation.gov.uk/ukpga/2006/41/section/75
36 NHS (March 2017) Next steps on the NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
37 Department of Health & Department of Communities and Local Government (March 2017), 2017-19 Integration andBetter Care Fund: Policy Framework: gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf
38 Smith J (2016) Sustainability and Transformation Plans (STPs): What, why and where next?, IPPR. ippr.org/publications/stps
39 Smith J (2016) Sustainability and Transformation Plans (STPs): What, why and where next?, IPPR. ippr.org/publications/stps

A shared language

The Care Act clearly recognises that prevention is about more than just stopping something arising. It is about preventing, reducing and delaying needs and associated costs.

While public health interventions and reablement services are generally recognised as preventative, there is much more to prevention than these alone. And while public health initiatives – such as diabetes and obesity prevention – are gathering pace, not enough attention is being paid to other preventative measures.

It is not possible to prevent everything entirely, so it's important that preventative approaches and interventions are adopted across the life course and pathology of a condition or illness. The triple definition of prevention helps us do this.

Yet, while the triple definition of prevention has been adopted by adult social care through the Care Act, it was notably not mentioned in the NHS Five Year Forward View or its more recent Next Steps document.

The Red Cross is pleased that both sides of the coin recognise the need to shift from reaction to prevention. However, unless we share a common language, we cannot be confident that we are all talking about the same thing. **With plans to integrate health and social care by 2020,[40] sharing the same definition will prove ever more important in effectively working together to make prevention a reality.**

40 HM Treasury (25 November 2015), Spending review and autumn statement 2015: gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents/spending-review-and-autumn-statement-2015#a-sustainable-health-and-social-care-system-1

Legislation to enable health and social care integration in Scotland

The Public Bodies (Joint Working) (Scotland) Act 2014, provides a legislative framework for health and social care integration in Scotland. The legislation came into effect in April 2016 and new Integration Authorities now have responsibility for over £8 billion of funding for local services, previously separately run by NHS Boards and local authorities. Under the Act, health boards and local authorities have a choice between two integration models. They can either:

- delegate between each other, often referred to as a 'lead agency' arrangement, or
- can delegate to a third body called the 'Integration Joint Board'.

A little over a year since the Act came into force, a recent Nuffield Trust report found there to be a few teething problems and concerns for the future, primarily around there being 'a risk that the financial situation will undermine the best aspects of the Scottish NHS before they can be brought to bear in addressing it.' Nevertheless, all in all it concluded that these models have appeared 'to shift local and national attention away from structure towards relationships, specific changes and performance' – exactly what most believe integration is supposed to achieve.

The same report noted that having legislation behind integration gives Scottish Integration Authorities 'a much firmer legal standing and a clearer role for local government than English STPs.' It also acted as a sort of '"catalyst", important primarily for its initial effect and for areas lagging behind.'[41]

Health and wellbeing boards

Under the Health and Social Care Act (2012) each top tier and unitary authority in England had to establish a health and wellbeing board in order to improve health and wellbeing and reduce inequalities. As a minimum, they are made up of one local elected representative, a local healthwatch representative, a representative of each local clinical commissioning group, the local authority director for adult social services, the local authority director for children's services, and the director of public health.

One of their core responsibilities is to carry out a joint strategic needs assessment and develop a joint health and wellbeing strategy that meets the needs identified in that assessment. Both should 'sit at the heart of local commissioning decisions, underpinning improved health, social care and public health outcomes for the whole community.'[42] The Care Act's statutory guidance reiterates the importance of these strategies, noting that they 'should be informed and emphasise preventative services that encourage independence and wellbeing, delaying or preventing the need for acute interventions.'[43]

Health and wellbeing boards have also played a key role in the development of Better Care Fund plans. The £5.3 billion Better Care Fund (previously called the Integration Transformation Fund) created a local, single-pooled NHS and local authority budget to encourage health and social care integration. The previous Chancellor committed an extra £1.5 billion to the Better Care Fund by 2019-20 as part of its 'radical, local-led plan to create an integrated health and social care system by 2020,'[44] during his 2015 Spending Review.

Leaders of the social care sector were concerned about the time frame of this funding, noting that it does not reach 'levels of any significance until towards the end of this parliament.' They also warned this puts 'the delivery of the NHS Five Year Forward View and the Care Act at risk.'[45] More recently, the Better Care Fund has also been criticised for not achieving its principal financial or service targets over 2015-16.[46]

41 Nuffield Trust (July 2017) Learning from Scotland's NHS: nuffieldtrust.org.uk/files/2017-07/learning-from-scotland-s-nhs-final.pdf

42 Department of Health (2011), Joint strategic needs assessment and joint health and wellbeing strategies explained: gov.uk/government/uploads/system/uploads/attachment_data/file/215261/dh_131733.pdf

43 Department of Health (October 2014), Care and Support Statutory Guidance, Chapter 4 (4.53)

44 HM Treasury (25 November 2015), Spending review and autumn statement 2015: gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents/spending-review-and-autumn-statement-2015#a-sustainable-health-and-social-care-system-1

45 Joint letter for the Chancellor and Secretaries of State, from Care and Support Alliance, Association of Directors of Adult Social Services, Care Provider Alliance, NHS Confederation (December 2015): careandsupportalliance.com/social-care-sector-response-to-the-spending-review/#sthash.eS0VEpiv.dpuf

46 National Audit Office (February 2017) Health and social care integration: nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

Sustainability and transformation plans

Sustainability and transformation plans (STPs) are local plans setting out how the NHS Five Year Forward View will be implemented in 44 areas of England. As such they set out ways to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap. As place-based plans, they 'must cover all of areas of CCG and NHS England commissioned activity', as well as 'better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.'[47]

They should also have been developed collaboratively with local leaders from across the board including: 'clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing board.'[48] There have been concerns, however, that such collaboration has not actually happened. A Local Government Association poll found, for example, that the majority of councillors felt they had 'not been involved with shaping, commenting on or approving the NHS's 44 sustainability and transformation partnerships (STPs).'[49] STPs have also been criticised for proposing controversial changes to hospital services as well as for initially producing unviable plans, resulting in the deadline for submission repeatedly being pushed back.[50]

Despite these criticisms, they are now considered by some health and social care thought leaders as 'the best opportunity for the NHS and its partners to plan together for the future.'[51] At the same time, as recognised by IPPR, challenges persist. These include a deficiency in leadership, funding pressures resulting in money for transformation being used to plug deficits and STPs having no statutory powers to drive through reform.[52]

47 NHS (December 2015), Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21: england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
48 NHS (December 2015), Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21: england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
49 LGA (5 July 2016), Lack of confidence in STPs, councils warn: local.gov.uk/about/news/lack-confidence-stps-councils-warn
50 Smith J (2016) Sustainability and Transformation Plans (STPs): What, why and where next?, IPPR. ippr.org/publications/stps
51 King's Fund (May 2016), What are STPs and why do they matter? big election questions: kingsfund.org.uk/publications/articles/big-election-questions-stps
52 Smith J (2016) Sustainability and Transformation Plans (STPs): What, why and where next?, IPPR. ippr.org/publications/stps

RESEARCH OBJECTIVES

Research objectives

The aim of this research study was to explore the extent to which local authorities, sustainability and transformation partnerships, and health and wellbeing boards across England recognise and prioritise the Care Act's understanding of prevention, as well as to better understand how and to what extent local decision makers are integrating health and social care. For more detail on our research objectives, please see appendix two.

Methodology

To achieve the research objectives we:

- reviewed joint health and wellbeing strategies for the fourth year in a row
- reviewed sustainability and transformation plans for the first time
- made a Freedom of Information (FOI) request of all English local authorities for the second year running (although this year we added some additional questions around identifying preventative services and unmet need as well as integration).

Please see appendix two for the detailed methodology.

How is integration being understood and prioritised locally?

The following sections on integration will demonstrate there are different interpretations of what exactly needs to happen to achieve health and social care integration at a local level. Equally, the scale and pace of integration looks different from place to place.

What do local authorities say they are doing to integrate with health?

The following section reflects on the 138 responses we received to question six of our Freedom of Information (FOI) request:

Question 6. What actions has your council taken to comply with Clause 3 of the Care Act 2014 ('Promoting integration of care and support with health services etc.') Please give details.

While several local authorities responded that they had either not yet taken any steps or are still in the early stages of developing a plan, the majority have taken action to comply with Section 3 of the Care Act.

From integrating management structures to setting up multidisciplinary teams to pooling budgets, **local authorities reported taking a wide range of actions to promote health and social care integration.**

This is in keeping with the Care Act's guidance that notes:

'There are many ways in which local authorities can integrate care and support provision with that of health and related provision locally. Different areas are likely to find success in different models. Whilst some areas may pursue for integrated organisational structures, or shared funding arrangements, others may join up teams of frontline professionals to promote multi-disciplinary working.'[53]

Usually, however, these actions seem to be small in scale, often only affecting a small number of people or services, or only targeted at one group of people with a specific condition or illness. For example, solely integrating community equipment or developing a joint strategy only for people with dementia. This suggests that government plans for full integration by 2020 might be 'over-optimistic',[54] as was also reported in a February 2017 National Audit Office report on health and social care integration.

In some cases, local authorities have only reported 'working closely' or 'building relationships' with health-related staff. This is undoubtedly important and clearly sits underneath the local authority's duties under Sections 6 and 7 of the Care Act to 'co-operate generally' and to 'co-operate in specific cases'. **However, ambitions to integrate should go further than mere cooperation.[55]**

More information on how local authorities are integrating with health:

At the strategic level, local authorities have reported integrated planning (with many referring to their local sustainability and transformation plans and joint health and wellbeing strategies), integrated commissioning frameworks and teams, integrated management structures, integrated services and pooled budgets.

At the level of the individual service, local authorities have reported recruiting and training individual care coordinators, multi-disciplinary teams, better information sharing and the co-location of different teams and care professionals in places such as hospitals and general practice surgeries. As noted within the Care and Support Statutory Guidance these, 'would not necessarily require structural integration – for example, organisations merging –

53 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 15 (15.11)

54 National Audit Office (February 2017) Health and social care integration: nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

55 "'Co-operation', like integration, can be achieved through a number of means, and is intended to require the adoption of a common principle, rather than to prescribe any specific tasks." Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 15 (15.19)

but a seamless service, from the point of view of the person, could be delivered by staff working together more effectively.'[56]

Local authorities also report to have **combined and aligned processes**, such as single assessments.

The most prevalent examples mentioned by local authorities in responses to question six include pooling budgets (with many reflecting on their work via the Better Care Fund), joint commissioning, integrated services and integrated or multidisciplinary teams.

Pooled budgets are typically being used for prevention services, including dementia support and reablement and reducing delayed transfers of care and residential, care home and emergency admissions. With many drawing on the Better Care Fund, these focuses are not surprising. As guidance on integration and the Better Care Fund prepared by the Department of Health and the Department for Communities and Local Government in March 2017 explains:

'…areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four metrics: Delayed transfers of care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and Effectiveness of reablement.'[57]

While the Better Care Fund has so far not achieved its main financial or service targets, by, for example, reducing emergency admissions or delayed transfers of care, there has been an improvement in reduced permanent admissions of older people to residential and nursing care homes as well as an increased proportion of older people still at home 91 days after being discharge from hospital receiving reablement or rehabilitation services.[58] **Importantly, the National Audit Office found that the Better Care Fund has improved joint working 'with more than 90 per cent of local areas agreeing or strongly agreeing that delivery of their plan had improved joint working.'[59] This is further reflected by the fact that so many responses to question six (over 50) drew on their Better Care Fund plans.**

Typical examples of jointly commissioned and integrated services include: community equipment, services for carers, dementia and mental health services, learning disability services, intermediate care, and reablement and rehabilitation.

Multidisciplinary or integrated teams, made up of various health and care professionals as well as the voluntary and community sector, were mentioned over 150 times within responses to question six in over 40 per cent of replies. These teams were often based in hospitals to enable safe discharge, with many referring to their 'discharge to assess'/ or 'home first' models. 'Discharge to assess', or 'home first' applies to cases where:

'…people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.'[60]

Such teams also commonly consisted of 'crisis response' or 'emergency' teams working in the community to prevent hospital admissions, often for those with the most complex needs or the top two per cent of those continually admitted into acute settings. Sometimes the multi-disciplinary teams mentioned were for specific conditions or illnesses. Other times, they were responsible for patients with a certain level of need in a defined geographical place.

Some of these responses captured the importance of co-locating (at least for some of the week), relationship building, shared care records and regular meetings to enable efficient and collaborative multi-disciplinary working.

56 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 15 (15.13)

57 Department of Health & Department of Communities and Local Government (March 2017), 2017-19 Integration and Better Care Fund: Policy Framework: gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

58 National Audit Office (February 2017) Health and social care integration: nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

59 National Audit Office (February 2017) Health and social care integration: nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

60 Department of Health & NHS England et al. QUICK GUIDE: DISCHARGE TO ASSESS: nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

Recommendations:

- **Those local authorities yet to do so** 'must ensure the integration of care and support provision, including prevention with health and health-related services' as per Section 3 of the Care Act 2014.
- **Health and social care local decision makers** should look to be more ambitious in their plans for integration and go beyond 'joint working' and 'cooperation'.
- Given the range of different actions local decision makers have taken to integrate health and social care as well as the different levels of progression, **the Department of Health and Department for Communities and Local Government** should continue to promote good practice and facilitate shared learning with regard to integration.

How are sustainability and transformation plans planning to integrate health and social care?

The NHS Planning Guidance (2015) instructed sustainability and transformation plans (STPs) 'to cover better integration with local authority services, including, but not limited to, prevention and social care.'[61] It is therefore not surprising that **the ambition to integrate health and social care is explicitly drawn on, albeit to different extents, in every plan.**

Notably, only six plans mention the Care Act despite it being 'the most significant reform of care and support in more than 60 years.'[62] This is compared to 41 mentioning the NHS Five Year Forward View, 34 mentioning vanguards and 19 mentioning the Better Care Fund. This might reflect a reported lack of local authority involvement in some areas.[63]

Nevertheless, the interdependency of health and social care was consistently drawn on, with several noting the importance of protecting and increasing social care budgets in order to sustain the NHS. North West London's STP notes, for example, 'To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan are fully funded.'[64]

As such, the importance of integration was highlighted in numerous plans. As reflected in the FOI responses, STPs typically hope health and social care integration will enable a shift towards a preventative and person-centred system. They also hope it will reduce delayed transfers or care and emergency admissions as well as improve efficiencies by, for example, avoiding duplication.

However, as we concluded via our FOI analysis, STPs also seem to place a varied emphasis on both the importance and understanding of integration, with some primarily talking about better collaboration rather than integration.

How STPs propose to integrate care:

STPs set out ways they wish to achieve the ambitions set out above. For example, several plans noted how integration could better enable prevention by, for example, realigning commissioning incentives:

'We recognise that increased investment can only do so much to increase prevention capacity. Therefore, using the STP as a vehicle, we will realign commissioning incentives for the NHS and local government, ensuring that resources flow to the area of the health economy where it will have the biggest impact, irrespective of commissioner. At minimum, this means sharing the risk and reward of commissioning prevention schemes between health and local authorities.'

– South East London STP[65]

61 NHS England (December 2015) Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21: england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdfCare and Support Minister, The Rt Hon Norman Lamb (15 May 2014).

62 Care and Support Minister, The Rt Hon Norman Lamb (15 May 2014).

63 The King's Fund (November 2016) Sustainability and transformation plans in the NHS: How are they being developed in practice? kingsfund.org.uk/sites/default/files/field/field_publication_file/STPs_in_NHS_Kings_Fund_Nov_2016_final.pdf

64 North West London (October 2016) Sustainability and Transformation Plan: Our plan for North West Londoners to be well and live well: healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/nwl_stp_october_submission_v01pub.pdf

65 South East London (October 2016) Sustainability and Transformation Plan: ourhealthiersel.nhs.uk/Downloads/Strategy%20documents/South%20East%20London%20STP%20October%202016.pdf

As well as how integration could better enable person-centred care by, for example, improved information sharing and shared care records:

'Proactive and person-centred care relies on there being one single care plan owned by the patient and their family, one electronic care record accessible by all, one set of best practice protocols all can adopt, and one route through which expert opinion can be accessed day or night. This means we need to share knowledge systematically. We will do this by providing appropriately secure access to patient records to all frontline staff providing direct care, be they the person's usual team or an out-of-hours or urgent response team, and by building stronger relationships between GPs, hospitals, domiciliary care workers, and care homes to speed up discharges.'

– Cambridgeshire & Peterborough STP

'Person-centred' care was explicitly mentioned in 28 of the 44 plans, with a further ten at least mentioning 'personalising' care. Other ways listed to achieve such care include: building services around the person by tailoring their care to their individual goals, personal care budgets, integrated teams, care navigators and so on.

As in the FOI responses, integrated and multi-disciplinary teams, often for people with complex conditions, were consistently mentioned in the plans. STPs often hope to reduce delayed transfers or care and emergency admissions via these teams.

Other listed ways areas plans to integrate health and social care include but are not limited to: joint commissioning, pooling budgets, integrating services, changing governance structures, joint care planning, single assessments, single points of access, and integrated personal health and care budgets.

In order to enable integration, STPs highlighted the importance of strong leadership to drive through cultural change with some appointing a health and social care integration director, ensuring social care and prevention are adequately funded, aligning incentives, objectives and outcomes, enabling better information sharing with several highlighting the importance of integrated care records and making better use of the voluntary sector.

Recommendations:

- **Sustainability and transformation** partnerships should clearly set out what they mean by integration, what they want integration to achieve, and what is needed to make it work in practice.
- **Sustainability and transformation partnerships** should draw on key social care policy and practice developments, such as the Care Act (2014) as much as those typically associated with 'health'.
- **The Government** should better define what is meant by health and social care integration as well as what is needed to make it work in practice to help facilitate plans for full integration. This should include learning from good and bad practice elsewhere, such as the UK's devolved nations.

Place-based health

Local and national decision makers see STPs as the vehicle for driving forward the place-based health agenda. Place-based health is about planning for care driven by whole systems rather than individual organisations.

To really achieve place-based health, some STPs as well as FOI responses, noted the importance of greater collaboration not just between health and social care but between community services, housing providers, business, the voluntary sector and so on. As illustrated by the Place-Based Health Commission's report, 'Get well soon: reimagining place-based health', place-based health starts at the point of view of people and place rather than services. It notes:

'If we ask a person "what health services do you want?" the answer might well be clinical and focussed on a more efficient experience. But if we ask that same person "what would help you to enjoy life more?" the answer would be different: perhaps about their lived experience at home, in the community and at work, and their hopes for the future.'

Starting with the latter question 'requires the NHS to broaden its focus and build stronger bridges to people', which 'would involve bringing expertise from local government, community pharmacy, the voluntary, community and social enterprise sector, housing providers and other local services together to effectively confront the broader drivers of poor health.'[66]

66 The Place-Based Health Commission (March 2016) Get well soon: reimagining place-based health: nlgn.org.uk/public/wp-content/uploads/Get-Well-Soon_FINAL.pdf

How is prevention being understood and prioritised locally?

How are sustainability and transformation plans planning to prevent, reduce and delay the need for care?

Sustainability and transformation plan labels

All 44 STPs were read and labelled accordingly:

- Very strong: 35 (80 per cent)
- Strong: 5 (11 per cent)
- Neither strong or weak: 4 (9 per cent)

- Prevention is mentioned in all STPs.
- 32 mention prevention within their 'priorities', and only four did not mention prevention in their priorities, principles or vision.
- Of the 42 that had some sort of summary (an executive summary/ foreword/ plan on a page etc.), 39 mention prevention.
- Eight plans have adopted the triple definition of prevention fully, with eighteen adopting it in part (usually only using the terminology 'primary' and 'secondary').
- Only six plans refer to the Care Act (2014).

An overview

Although STPs seem to place greater importance on primary and secondary types of prevention, the understanding and, especially prioritisation of prevention is mainly very strong. It seems the financial pressure on our health and social care system is encouraging a stronger emphasis on prevention. As noted by **North West London's plan**: 'To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care.'[67]

At the same time, the same financial pressures might be one of the key barriers to achieving their plans for prevention. As noted by the Kings Fund, '…developing new models of health and social care takes time and resources – both of which are in short supply.'[68] Notably, £1.8 billion (86 per cent) of the £2.1 billion of the Sustainability and Transformation Fund for 2016-17 was spent on meeting provider deficits.[69] With such stretched funds, local authorities spend on prevention[70] and public health has also been reducing.[71]

There is also generally a very strong emphasis on enabling people to live more independently at or closer to home. However, as the Kings Fund warns:

'Services outside of hospitals are also under strain – with growing pressures in general practice, district nursing, mental health, and adult social care. In this context, proposals in STPs to reduce capacity in acute hospitals will only be credible if there are coherent plans to provide alternatives in the community. This will require additional investment in these services.'[72]

Prevention

Prevention is consistently prioritised throughout the plans. All plans mention prevention and all but four include prevention in their vision, goals, priorities, approaches, principles or values. Prevention is drawn upon as a way to reduce each of the three gaps highlighted in the NHS Five Year Forward View: the health and wellbeing gap, care and quality gap, and funding and efficiency gap.

For the most part, plans emphasise the importance of examples of all three types of preventative interventions (primary, secondary and tertiary). Thirty-five out of 44 plans were

67 North West London (October 2016) Sustainability and Transformation Plan: Our plan for North West Londoners to be well and live well: healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/nwl_stp_october_submission_v01pub.pdf 67

68 The King's Fund (21 February 2017) Sustainability and transformation plans (STPs) explained: kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained

69 National Audit Office (February 2017) Health and social care integration, Department of Health, Department for Communities and Local Government and NHS England nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

70 ADASS (2017), ADASS BUDGET SURVEY 2017: adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf

71 https://www.kingsfund.org.uk/press/press-releases/big-cuts-planned-public-health-budgets

72 https://www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained

labelled 'very strong', meaning prevention is not only a key component of the plan, but the importance of lower-level/tertiary types of prevention are emphasised in addition to primary and secondary examples. Examples of all three types of prevention are also intended to be available before, during and after crisis point for a range of people, conditions and illnesses. The remaining were either labelled 'strong' or 'neither weak nor strong'.

The tertiary types of prevention mentioned range from short-term intensive support to help people get back on their feet after a stay in hospital, to support to self-care or self-manage long-term conditions in order to avoid further complications.

Primary and secondary examples typically include lifestyle interventions and health education, such as smoking cessation, initiatives to tackle obesity and alcoholism, and programmes to increase physical activity as well as ambitions to increase immunisation rates, screenings and, in particular, the early detection of cancer.

STPs often set out plans to better target people at-risk of developing needs or complications, such as older people. For example, **Coventry and Warwickshire's STP,** highlights a couple of targeted programmes in South Warwickshire, including an over 75s programme that seeks to develop holistic care plans and increase engagement in the at-risk over 75s population to 'identify needs earlier and avoid emergency admission'. They have also set up a hydration project that targets patients with catheters and promotes good hydration to prevent community visits and avoid further complications.[73]

However, overall, plans place more importance on primary and secondary types of prevention than tertiary types (those aimed at minimising deterioration and the loss of independence for people with established needs or preventing the reoccurrence of a health and social care crisis). This is partly reflected by the fact that 14 of the 18 plans that have adopted the triple definition in part are only using the language 'primary' and 'secondary'. **Some of these, however, seem to have conflated 'secondary' and 'tertiary' prevention into 'secondary prevention'.**

In other cases, examples of tertiary preventative interventions are mentioned but not under the umbrella of 'prevention'. Yet, with such a focus on prevention under both the NHS Five Year Forward View and the Care Act, recognising their preventative value is an important step to ensuring their provision.

Sharing a common language is also an important step to effectively working together to make prevention a reality. As noted by **Dorset**:

'Our two Health and Well-being Boards will be central to this work ['prevention at scale'] and are currently refreshing their Joint Health and Well-being Strategies to align with this plan... **They will provide a common framework and language so that all our partners from across health and social care, the voluntary sector and the independent sector, can understand how they can contribute to this work.'**[74]

The lesser importance placed on tertiary preventative interventions, echoes the NHS Five Year Forward View and more recent next steps document,[75] which, mainly focus on primary types of prevention (such as public health education) as well as secondary (such as health checks and flu vaccinations). In fact, tertiary types of prevention have received little explicit recognition at a national NHS level. The triple definition has also been largely overlooked by health, with neither the NHS Five Year Forward View nor its Next Steps document adopting this language in full. But it should be just as useful to the NHS as adult social care and public health, as it helps ensure people's needs don't escalate at any stage of their condition (before, during or after).

It is therefore pleasing that eight local plans have adopted the Care Act's triple definition of prevention fully. Take for example, **Lincolnshire's STP**, which commits to 'primary, secondary and tertiary prevention being integral to **all** of [their] clinical redesign programmes'.[76] The majority of the other plans give appropriate recognition to the importance of interventions aimed at minimising the effect of disability or deterioration for people with established or complex health conditions, as well as those that prevent the reoccurrence of a crisis. However they do not use the same triple definition.

73 Coventry & Warwickshire (December 2017) Sustainability & Transformation Plan: uhcw.nhs.uk/clientfiles/File/STP.PDF

74 Dorset, Our Dorset Sustainability and Transformation Plan for local health and care: dorsetccg.nhs.uk/Downloads/aboutus/Our%20Dorset%20STP/Our%20Dorset%20Substainability%20and%20Transformation%20Plan%2020%2004%2017.pdf

75 HS (March 2017) Next steps on the NHS Five Year Forward View: england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

76 Lincolnshire, Lincolnshire Sustainability and Transformation Plan: lincolnshirehealthandcaredotorg.files.wordpress.com/2017/07/stp-full-plan-20161212-web.pdf pg.9

With so many people already living with a long term condition,[77] as well as an ageing population, these types of preventative interventions are essential in ensuring as many people as possible can live as independently as possible.

Ensuring local plans prioritise prevention in its entirety is a first step towards shifting to a truly preventative health and care system. However, whether or not the vision for prevention set out in these plans will be achieved is yet to be seen. Plans do, however, commit to certain activities to help guide this process. These include but are not limited to: properly investing in prevention; working with the voluntary and community sector more; making better use of and investing in technology; looking beyond just health and care to the wider determinants of health, such as employment, housing and poverty; working with other parts of the system; aligning health and social care payment mechanisms and incentives; developing shared outcomes frameworks for prevention; pooling budgets; hiring prevention leads; and systematically writing prevention into contracts, service level agreements and business plans.

Recommendations:

- **Sustainability and transformation partnerships** should fully adopt the Care Act's triple definition of prevention into their plans in order to help ensure preventative interventions are prioritised across the life course and pathology of a condition or illness.
- **NHS England** should lead the way and incorporate the triple definition of prevention into the next iteration of the NHS Five Year Forward View. In the meantime, it should communicate the importance of tertiary as well as primary and secondary preventative interventions.
- **The Government** should review the resources needed to make the prevention vision set out in STPs a reality. New initiatives need new resources to avoid money being spent on plugging deficits rather than on transformation.

77 Department of Health (May 2015), 2010 to 2015 government policy: long term health conditions: gov.uk/government/publications/2010-to-2015-government-policy-long-term-health-conditions/2010-to-2015-government-policy-long-term-health-conditions

Voluntary and community sector

All STPs mention the voluntary sector, with almost all plans explicitly referring to the value the voluntary and community sector brings in improving the system, particularly with regard to prevention. For example, **Herefordshire and Worcestershire's STP**, recognises 'the depth of understanding that the [voluntary and community] sector can bring and the significant benefits of prevention' as well as its 'vital role in reducing demand on formal services such as unplanned hospital admissions for example through care navigation/bridging roles, peer support and group activities'. As such it commits 'to find[ing] ways to tap into the energy, enthusiasm and innovation of the VCS in a coordinated manner, including a simplification of the commissioning process to enhance the contribution that the VCS can make…'[78]

Some STPs, such as Northamptonshire's, noted the importance of investing in the [voluntary, community and social enterprise] sector in order to 'build VCSE capacity & capability to shift non-clinical & wider determinant activity out of primary & secondary care…'[79] As noted by **Shropshire and Telford and Wrekin**, the voluntary, along with the private and independent sector, are also 'feeling under pressure.'[80]

Likewise, the importance of non-clinical (or non-medical) interventions has been highlighted in several plans. Shropshire and Telford and Wrekin note: 'There is an increasing recognition that non-clinical approaches have a crucial part to play in supporting people in the community and that voluntary and community organisations have an important role.'[81]

Indeed, social prescribing was consistently cited as a way to improve a population's health and wellbeing. **South Yorkshire and Bassetlaw** want to build on a successful social prescribing service for people with long-term conditions in Rotherham that 'targets the top 5% of patients at risk of hospitalisation using a process that helps to identify those most at risk of a hospital admission and the judgement of their

78 Herefordshire and Worcestershire (November 2016), Draft Sustainability and Transformation Plan: hacw.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=120702

79 Northamptonshire (October 2016) Northamptonshire's Sustainability and Transformation Plan (STP) for the Health and Social Care system through to March 2021: neneccg.nhs.uk/resources/uploads/STP_Submission_Final_Draft_071216.pdf

80 Shropshire and Telford & Wrekin (October 2016) Sustainability and Transformation Plan: sath.nhs.uk/wp-content/uploads/2016/11/Shropshire-and-Telford-Wrekin-STP-Full.pdf

81 Shropshire and Telford & Wrekin (October 2016) Sustainability and Transformation Plan: sath.nhs.uk/wp-content/uploads/2016/11/Shropshire-and-Telford-Wrekin-STP-Full.pdf

GP.' As part of this, 'non-medical interventions have been identified for over 5000 patients with significant success, saving money and improving outcomes.'[82]

Recommendation:

> **Sustainability and transformation partnerships** yet to do so, should explore the potential added value of non-clinical interventions and personnel.

How are health and wellbeing boards planning to prevent, reduce and delay the need for care?

Joint health and wellbeing strategy labels:

All 151[83] health and wellbeing boards' joint health and wellbeing strategies were read and labelled accordingly:

> Very strong: 61 (40 per cent)
> Strong: 34 (23 per cent)
> Neither strong or weak: 50 (33 per cent)
> Weak: 5 (3 per cent)
> Very weak: 1

> Prevention is mentioned in all joint health and wellbeing strategies.

> In total, 125 strategies include prevention in their vision, goals, priorities, approaches, principles or values.

> It's the 'primary approach/principle/value' of 11 strategies and listed as an 'approach/principle/value' in another 45 (a decrease of 21 since last year).

> Fifty-six strategies mention prevention within their 'priorities', five in their 'goals' and eight in their 'visions'. This has slightly increased.

> Of the 121 that had some sort of summary (an executive summary/foreword/ plan on a page or separate summary strategy), 84 (69 per cent) mention prevention. This is similar to last year.

> Only 17 joint health and wellbeing strategies use the full triple definition of prevention.

> Some strategies have not been updated since 2014 or 2013 and only around a quarter (41) mention the Care Act (or Care Bill) and just 10 mentioned the NHS Five Year Forward View.

An overview

Our 2016 review of joint health and wellbeing strategies saw an improvement in the understanding and prioritisation of prevention from the previous two years. Yet, prevention is understood and prioritised similarly to last year. Each of our measures has seen slight increases and decreases since last year's review. The number of strategies labelled 'very strong' has increased slightly by two per cent. Likewise, the number of strategies labelled 'weak' or 'very weak' has decreased from eight to six. And, while the number of those that include prevention in their vision, goals, priorities or summary has increased slightly, the number of those that include prevention in their approaches, principles or values has decreased by 15 per cent.

This stagnation could be due to the previous several years' particularly strong national push for prevention, which has quietened down a little over the last year. These included, the Care Act (2014) coming into force, the transfer of public health responsibilities to local government and Public Health England, the NHS Five Year Forward View, and the Better Care Fund.

There's still a way to go. Around a third (56) of the 151 strategies have been labelled 'neither strong nor weak', 'weak' or 'very weak', meaning 37 per cent still do not incorporate a full understanding of prevention or emphasise the importance of taking a preventative approach. Many of these strategies understand prevention only as minimising the risk of people developing care and support needs (primary prevention), or as targeting people at high risk of developing needs (secondary prevention).

82 South Yorkshire and Bassetlaw , Health and care in South Yorkshire and Bassetlaw: Sustainability and Transformation Plan: smybndccgs.nhs.uk/application/files/1514/8037/0832/South_Yorkshire_and_Bassetlaw_Sustainability_and_Transformation_Plan.pdf

83 While there are 152 local authorities with responsibility for adult social care, Bournemouth and Poole share a Health and Wellbeing Board.

Recommendation:

> **Health and wellbeing boards** should *fully* incorporate and prioritise prevention in their joint health and wellbeing strategies. A well-rounded understanding of prevention should be clearly emphasised throughout the strategy and across the life course and pathology of a range of conditions or illnesses mentioned.

The Care Act, NHS Five Year Forward View and Better Care Fund

Some strategies have not been updated since 2014 and only around a quarter (41) mention the Care Act (or Care Bill) despite it being 'the most significant reform of care and support in more than 60 years.'[84]

Only nine of the 41 that mention the Care Act (or Care Bill) explicitly refer to the prevention duty (Section 2 of the Care Act). However, others mention the Care Act putting greater responsibilities on local authorities, including 'an increased focus on prevention'.

Of the 41 strategies that mention the Care Act (or Care Bill), 35 (88 per cent) were labelled 'very strong' or 'strong'. This indicates that the Care Act (when engaged with properly) has likely had a positive influence on the prioritisation and understanding of prevention.

Thirty-nine, in comparison to just ten last year, mention the NHS Five Year Forward View. The increase in the number of strategies that explicitly recognise the relevance of this national plan may be due to the fact that sustainability and transformation plans, developed over the course of the last year, set out plans to take this national strategy forward at a local level. This is, of course, in addition to an ever-increasing push for health and social care integration.

Sixty-seven per cent (26) of the strategies that mention the NHS Five Year Forward View were labelled 'very strong' or 'strong'. This is similar to the overall stat of 63 per cent. As such, there is no obvious correlation between engaging with it and a high-rating label. Perhaps this is because the Forward View fails to emphasise the importance of tertiary preventative interventions in the same way it emphasises primary and secondary.

Fifty-four strategies mention the Better Care Fund in comparison to just 37 the year before and six the year before last. This could be because Better Care Fund plans have also further developed over the course of the year.

Recommendation:

> **Health and wellbeing boards** should update their joint health and wellbeing strategies regularly so that they include key policy and practice developments.

The triple definition of prevention

While two-thirds of the strategies have been labelled 'very strong' or 'strong', **only 17 joint health and wellbeing strategies use the full triple definition of prevention (either primary, secondary, tertiary/prevent, reduce, delay/both terminologies). This is a slight increase from only 12 the year before but there is still a long way to go.**

A further 68, up from 46 last year, use this terminology in part. For example, only talking about 'delaying and reducing the need for care and support'. In other cases, only the terms 'primary' or 'secondary prevention' are mentioned.

Confusion as to what constitutes primary, secondary or tertiary prevention was evident in some of the strategies. Some strategies appear to conflate 'secondary' and 'tertiary' prevention into 'secondary prevention'.

The British Red Cross does not want the sector to be diverted by discussions about which interventions sit where, so long as preventative interventions are being adopted before, during and after a health and social care crisis. Indeed, there is no hard and fast rule as to where each preventative intervention sits. As the statutory guidance explains, 'services can cut across any or all of these three general approaches'.[85] **However, using the triple definition of prevention is a useful way**

84 Care and Support Minister, The Rt Hon Norman Lamb (15 May 2014).
85 Department of Health (August 2017) Care and Support Statutory Guidance, Chapter 2 (2.5

to ensure preventative interventions are being adopted across the life course and the pathology of a condition or illness.

Bournemouth and Poole's strategy makes the case for implementing prevention at scale, noting that closing the health and wellbeing gap 'will require a sustained focus on prevention over many years, at sufficient scale and reach, to really make a difference.' It also clearly defines 'prevention at scale' as encompassing all three types of prevention:

'By "prevention at scale" we mean that we must take a comprehensive approach, including the wider determinants of health and wellbeing, and including activity at primary, secondary and tertiary levels of prevention and at every stage in life.'[86]

Some health and wellbeing boards have used their own terminology. In some cases the terms applied cover all three types of prevention, but in many cases do not. For example, sometimes tertiary prevention is captured solely as 'reablement', 'self-care', 'specialist' or 'long term care'. However, tertiary prevention is more than just reablement or 'self-care' and applies to more than those with long term or specialist needs. They should encompass all those interventions aimed at minimising deterioration and the loss of independence for people with established needs or those that seek to prevent the reoccurrence of a health and social care crisis.

Various strategies also include a definition or explanation as to what is meant by 'wellbeing'. These definitions vary despite 'wellbeing' being defined under Section 1(2) of the Care Act.

Recommendations:

> **Health and wellbeing boards** should incorporate the Care Act's triple definition of prevention into their joint health and wellbeing strategies.
> **Health and wellbeing boards** are encouraged to look to define 'wellbeing' using the Care Act's definition set out in Section 1 of the Care Act.[87]

Minimising the loss of independence for those with existing needs

The importance of primary and secondary preventative interventions is still emphasised much more than tertiary types of preventative interventions.

And in some cases it's not clear this third type of prevention is recognised at all.

In some cases, lower-level tertiary preventative interventions are mentioned (for example, reablement/care in the home/support to self-manage/home adaptations/ assistive technologies/ respite for carers etc.) but aren't recognised as preventative. **Recognising their preventative value is an important step to ensuring their provision.** Under Section 2 of the Care Act, local authorities must ensure the provision of preventative services. And under Section 9(6)(b) they must assess whether people who do not meet the national eligibility threshold would benefit from such services.

Tertiary types of preventative service are sometimes only referred to in the context of mental health, long term conditions or older people. While many strategies set out a life-course approach, prevention and early intervention are often only emphasised at the beginning or end of that course. They also tend to mention tertiary preventative services towards the latter stages of life. However, as **Warrington's** strategy notes a 'preventative approach needs to be focussed on enabling people to maintain their independence and enabling them to regain it at any age'.[88]

Recommendations:

> **Health and wellbeing boards** should prioritise and emphasise all three types of prevention across the life course.
> **Health and wellbeing boards** should pay special attention to explicitly recognising the value of tertiary prevention interventions.

86 Bournemouth and Poole (September 2016) Health & Wellbeing Strategy Refresh 2016 – 2019: bournemouth.gov.uk/councildemocratic/AboutYourCouncil/AboutYourCouncilDocs/BPHWB/BPJHWS.pdf
87 Care Act 2014, Section 1(2): legislation.gov.uk/ukpga/2014/23/section/1/enacted
88 Warrington Health and Wellbeing Board, Warrington Health and Wellbeing Strategy 2015 – 18: warringtontogether.co.uk/media/1017/health-and-wellbeing-2015-18-low-res.pdf

What do local authorities say they are doing to ensure preventative services?

We received responses to 148 out of 152 Freedom of Information (FOI) requests. The responses varied in detail as well as content.

An overview

Local authorities have responded to Section 2 of the Care Act in a range of ways, including developing or investing in new services that prevent, reduce or delay, enhancing or expanding existing preventative services and changing their approaches to commissioning.

Despite financial pressures, some have allocated new funds or looked for ways to increase the number of people accessing preventative services by, for example, not charging for them. **The importance of shifting towards prevention is undoubtedly recognised by most local authorities, with some noting it to be 'at the core of their transformation programmes'.**

However, the overall impression was that local authorities' responses demonstrate a mixed level of understanding about the new prevention duties, as well as ambition. There has been clear progression since the last series of FOI responses we received towards the end of 2015, with, in many cases, a clear shift from planning to implementation.

Almost a half of the FOI responses mentioned 'the development or investment in new services'. Nevertheless, innovative developments have been patchy and for the most part have not been as ground breaking as we had hoped. This is despite the Care Act 'embracing innovation and flexibility, unlike previous legislation that focussed primarily on traditional models of residential and domiciliary care'.[89]

Responses to question one

What actions your council has taken to comply with Clause [Section] 2 of the Care Act 2014 ('Preventing needs for Care and Support').

Similar themes to our 2016 research were identified within the responses to question one. These included: working with the voluntary and community sector; working across departments; integrating with health; developing or investing in new services; the expansion or enhancement of existing services; reviewing services; revised guidance or training; the creation of new boards, roles, teams, programmes, strategies, plans, policies or priorities; revised procedures; implementing new approaches; identifying needs and services, funds, information and advice.

Various other themes mentioned in responses to question one that may enable local authorities to carry out their new prevention responsibilities, but are not necessarily results in themselves, are listed in appendix three.

New services and the expansion or enhancement of existing ones

Almost half of the FOI responses mentioned 'the development or investment in new services'. This was the most recurrent theme within responses to question one. Over 80 different services were mentioned, including but not limited to:

- telecare alarm systems;
- sensors for bed and chair occupancy
- temperature and falls detection
- care navigation for people with both non-eligible and eligible needs
- home adaptations
- integrated community equipment
- training in food hygiene and first aid
- domiciliary care
- home from hospital

89 LGA (August 2015) Guide to the Care Act 2014 and the implications for providers: local.gov.uk/documents/10180/6869714/L14-759+Guide+to+the+Care+Act.pdf/d6f0e84c-1a58-4eaf-ac34-a730f743818d

- advocacy
- debt management
- active walking
- cooking and singing
- proactive falls prevention
- community-based transport
- good neighbour schemes
- and befriending services.

Several local authorities wrote about being more proactive by investing in initiatives that seek people at-risk of falling into health and social care crisis. For example, **Lewisham's** Community Falls pathway has being redesigned to prevent the numbers of falls and fall-related injuries for people over 65 by establishing a community-based falls team. As explained within their FOI, 'The Community Falls Team will utilise a screening tool to better identify people at risk and will provide proactive outreach into the community, primary care and care homes. Physical activity programmes for people who have fallen or who are at risk of falls.'

A couple of FOI responses also drew on initiatives that seek to identify and then support people at imminent risk of being admitted to hospital in order to prevent this from happening. Others spoke about partnerships with fire brigades to support the prevention agenda by carrying out 'safe and well checks' as part of their own safety checks when visiting local people.

A fifth of all responses mentioned developing and investing in services specifically for carers. The Care Act's prevention duty applies to all adults, including carers. As per section 2.3 of the Care and Support Statutory Guidance, this should include '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.'

Most of these responses were vague with regard to what these services look like, stating 'support for carers'. However, more specific examples included: awareness raising among local employers and providing them with access to a range of initiatives to help them support carers; 'Carers' Cards' that provide access to discounts and offers on health and wellbeing activities; sitting services; a rapid response service that supports cared-for people in the event of unforeseen unavailability of carers in an emergency; support line services; befriending; and peer support. Seed funding being made available directly to carers to develop their own support groups was also mentioned.

Earl Howe made clear that Section 2 of the Care Act was intended to encourage innovation:

"We want local authorities to be truly innovative in the services offered in their area."[90]

Last year, we were disappointed that the 'new' services identified were not particularly innovative.[91] **This year, however, we were pleased to read about some innovative, lower-level preventative interventions (including some of those mentioned above).** Despite the cuts local authorities have faced over the last several years they clearly recognise the importance of continuing to invest in services that prevent, reduce or delay the need for care and support.

Nevertheless, these new, innovative services rarely seem to be available at-scale. Rather, they are often described as available solely for one particular group of people, for example, older people or people with a particular condition or illness. They are also sometimes only available in one part of the local authority's area. **Indeed, such examples are still far and few between.**

Local authorities also wrote about having 'expanded or enhanced existing services' in light of the prevention duty. This ranged from redesigning services so that they are more preventative to improving their accessibility. Similar to last year, reablement was included under this theme. For example, extending the reablement offer to support not only people discharged from hospital but also people in the community who would benefit from a period of reablement. Other examples of services that have typically been extended or expanded include handyperson schemes, occupational therapy, falls prevention, assistive technology, and information and advice.

90 Earl Howe, The Parliamentary Under-Secretary of State at the Department of Health (3 July 2013): publications.parliament.uk/pa/ld201314/ldhansrd/text/130703-0003.htm

91 For example, telecare and handyperson services were referred to in various responses. While they both have clear preventative value, they should not be new to local authorities. In April 2006, the government invested £80 million into the Preventative Technology Grant that focussed on increasing the numbers of people able to remain independent with telecare. Similarly, the Department for Communities and Local Government introduced a handypersons grant in 2009/10 allocating approximately £13 million in 2009/10 and £17 million in 2010/11 to English local authorities.

Several local authorities described opening up services to new cohorts of people and making them available prior to a full social care assessment. Others describe opening up services to anybody who makes a request. For example, **Doncaster** created a 'wellbeing' service open to 'anyone who would wish to receive informal, low level support on any grounds that would benefit them, covering from minor home adaptations to finance advice and engaging with communities.'

Recommendations:

- **The Department of Health, Department for Communities and Local Government, Local Government Association and the Association of Directors of Adult Social Services** should work together to review 'opportunities for shared learning' to help local authorities be 'truly innovative in the services offered in their area.'[92]
- **Despite budget constraints, local authorities should continue to look for ways to invest in 'a broad range of (preventative) interventions, as one size will not fit all.'[93]**

Information and advice

The second most commonly recurrent theme within responses to question one was 'information and advice'.

The prevalence of information and advice within the FOI responses is not so surprising. The sixth Care Act stocktake found that '81 per cent of councils report that their arrangement for the provision of information and advice are effective, with the remainder developing but not yet fully effective.' The provision of information and advice was also reported to have made the largest positive difference to practice and culture within the local authority.[94]

Despite this, however, a Think Local Act Personal (TLAP) survey completed by 1,181 people aged 18 and over in September 2016, found that less than a quarter of people who had looked for information in the last year said it was easy to find and just over half found it 'quite' or 'very' difficult to find. It also found that accessing information and advice was harder for those that don't receive any support. Sixty-seven per cent of respondents who didn't receive any support reported finding it hard to access as opposed to 32 per cent of those that were receiving support.[95]

The information and advice referred to was focussed on a range of issues, primarily available services but also new policies and new rights. Local authorities report providing information and advice in a variety of ways (including booklets, written fact sheets, newsletters and videos), but primarily via 'universal' websites, that have sometimes been complemented by a self-assessment tool, and improved directories for health and care professionals to offer information and advice both face-to-face, particularly for those making assessments, and via the telephone (often the local authority's first point of call centre).

Last year we concluded that, in some cases, Section 2 ('preventing needs for care and support') and Section 4 ('information and advice') of the Care Act were being conflated. With some responses to question one only touching on new or improved information and advice services this year, it seems this conflation still sometimes applies.

Information and advice is recognised within the Care and Support Statutory Guidance as a 'vital component of preventing or delaying people's need for care and support.'[96] **However, while good quality information and advice may be necessary for effective prevention, providing information and advice is not sufficient to fulfil the prevention duty.**

As chapter two of the Care and Support Statutory Guidance makes clear, Section 2 of the Care Act is about ensuring the provision of a range of services that prevent, reduce or delay the need for care and support.

The information and advice developments referred to within responses often centre upon use of the internet. **However, it is important to remember the discrepancy between younger and older generations' use of the internet.** For example, the ONS Quarterly Internet Access Update in 2014

92 Earl Howe, The Parliamentary Under-Secretary of State at the Department of Health (3 July 2013): publications.parliament.uk/pa/ld201314/ldhansrd/text/130703-0003.htm
93 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.42)
94 LGA (November 2016), Care Act Implementation: Results of Local Authority Stocktake 6: local.gov.uk/sites/default/files/documents/results-local-authority-s-ecd.pdf
95 TLAP (June 2017) Care Act 2014 survey results: Exploring the impact of the Care Act on the lives of people with care and support needs: thinklocalactpersonal.org.uk/_assets/Resources/TLAP/CareActSurveyResults-002.pdf
96 Department of Health (October 2014) Care and Support Statutory Guidance, Chapter 3 (3.1)

found that while only one per cent of 16 to 24 year olds had never used the internet, 63 per cent of the over 75s had never been online. Section 4 of the Care Act is clear that information and advice must be 'accessible to, and proportionate to the needs of, those to whom it is being provided.'[97]

Nevertheless, local authorities also highlighted other means of providing better information and advice. **Derby** told us, for example, about their community-led support approach, 'Talking Points'. This initiative provides the opportunity for local people to have a conversation with social care at an earlier stage by offering drop in sessions in their local area for people requiring information and advice on social care issues.

In some cases local authorities have acknowledged the value of ensuring the information and advice provided is meeting people's needs. For example, **Shropshire** informed us that up to 80 per cent of people who contact their first point of contact centre are provided with information and advice that enables them to obtain the informal support to meet their needs in their local community. They know this by providing a ring back service after two weeks to ensure that the information and support that has been provided met people's needs.

Importantly, Shropshire also made clear that they make individuals aware they are entitled to a full assessment of their needs under the Care Act. Under the Care Act, 'local authorities must undertake an assessment for any adult with an appearance of need for care and support, regardless of whether or not the local authority thinks the individual has eligible needs or of their financial situation.'[98]

Recommendations:

- **Local authorities** should clearly distinguish between their separate duties to provide information and advice and to provide preventative services within their local plans and strategies.
- **Local authorities** must be mindful that many adults and older people do not have the basic skills to use the internet.

Investing in prevention

Freedom of Information (FOI) responses, joint health and wellbeing strategies, and sustainability and transformation plans explicitly recognise resources need to be shifted from reactive to preventative spend. However, there is demonstrated uncertainty about how to go about doing this.

Several FOI responses mentioned utilising funding from the Better Care Fund to enable people to live independently. Others have created prevention-focussed funds, budgets or grants for individuals and community groups to develop community-led prevention and self-care support offers. Others intend to gradually shift resources from reactive to preventative spend.

The Southwark and Lambeth Early Action Commission (set up to find local ways of taking early action and preventing problems) noted in its final report:

'The only way to ensure a significant move towards early action is to commit to an incremental funding shift.'[99]

As a precursor to doing this, it recommends 'classifying spending' to distinguish reactive from preventative spend. Knowing whether money is being spent on preventing or coping with problems 'makes it possible to plan and scrutinise the transition to early action and to understand the trade-offs between prevention and downstream services.'[100] The triple definition of prevention can be a useful tool in doing this.

The Local Government Information Unit (LGiU) recognised that one of the biggest barriers to prevention is indeed 'a lack of clarity around what constitutes preventative activity, how this links to outcomes and how much money councils spend on it overall.'[101] In partnership with the British Red Cross and Mears, they therefore piloted an approach to mapping preventative spend against one of Camden council's key outcomes. At the end of the pilot, LGiU published a toolkit for other local authorities to do the same.[102]

97 Care Act 2014, Section 4: legislation.gov.uk/ukpga/2014/23/section/2/enacted
98 Department of Health (August 2017) Care and Support Statutory Guidance, Chapter 6 (6.13)
99 NEF, Southwark & Lambeth Early Action Commission (November 2015) Local early action: how to make it happen: b.3cdn.net/nefoundation/a5845188d1801a18bc_3nm6bkn3b.pdf
100 NEF, Southwark & Lambeth Early Action Commission (November 2015) Local early action: how to make it happen:b.3cdn.net/nefoundation/a5845188d1801a18bc_3nm6bkn3b.pdf
101 LGiU (October 2013), Tracking your preventative spend: a step-by-step guide: lgiu.org.uk/2013/10/16/tracking-your-preventative-spend-a-step-by-step-guide/
102 LGiU (October 2013), Tracking your preventative spend: a step-by-step guide: lgiu.org.uk/2013/10/16/tracking-your-preventative-spend-a-step-by-step-guide/

Recommendations:

- **Local authorities** should commit to shifting a percentage of their resources towards prevention. In doing so, they may find the recommendations set out in the Southwark and Lambeth's Early Action Commission's report, 'Local early action: how to make it happen', useful.[103]
- **Local authorities** can use LGiU's toolkit to track and better understand their preventative spend.[104]

An asset-based/strengths-based approach

Several FOI responses, as well as joint health and wellbeing strategies and sustainability and transformation plans, mention moving towards 'an asset-based approach'.

The terms 'strengths-based approach' and 'asset-based approach' are often used interchangeably. The Care and Support Statutory Guidance uses the terminology 'strengths-based approach' and instructs local authorities to 'consider what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve' when carrying out assessments. In doing so, 'authorities should consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help.'[105]

This approach should be centered on the individual, co-production[106] and maximising independence. **It must not be seen as a default alternative to statutory services.** Most importantly, family and friends should not be expected, and must not be pressured, to take on caring responsibilities. The guidance notes:

103 NEF, Southwark & Lambeth Early Action Commission (November 2015) Local early action: how to make it happen: b.3cdn.net/nefoundation/a5845188d1801a18bc_3nm6bkn3b.pdf

104 LGiU (October 2013), Tracking your preventative spend: a step-by-step guide: lgiu.org.uk/2013/10/16/tracking-your-preventative-spend-a-step-by-step-guide/

105 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 6 (6.63)

106 '"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.' (Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.20))

‘Any suggestion that support could be available from family and friends should be considered in light of their appropriateness, willingness and ability to provide any additional support and the impact on them of doing so. It must also be based on the agreement of the adult or carer in question.’[107]

A strengths-based approach should also recognise the value of the voluntary sector and community groups. **Local authorities recognise this: the importance of working with the voluntary and community sector was highlighted in numerous responses to question one.**

As reflected in the FOI responses, local authorities are increasingly looking to the voluntary sector and community groups to carry out a variety of functions, from promoting wellbeing to providing lower-level preventative support to those whose needs don’t meet the eligibility threshold.

Charging

The Care Act regulations prohibit local authorities from charging for intermediate care (including reablement) provided for up to six weeks, and minor aids and adaptations up to the value of £1,000.

While the Care and Support (Preventing Needs for Care and Support) Regulations 2014[108] allow local authorities to charge for certain preventative services, facilities or resources, the guidance warns of the risks this may have on uptake:

‘Where a local authority chooses to charge for a particular service, it should consider how to balance the affordability and viability of the activity with the likely impact that charging may have on uptake.’[109]

Several local authorities have carried our charging policy consultations and decided not to exercise these charging powers – at least in certain circumstances.

Technology could play a huge role in prevention.

For example, the UK’s national weather service, ‘Healthy Outlook’, is helping people with chronic obstructive pulmonary disease (COPD) to self-manage their illness by sending warning texts about local weather conditions and providing simple health advice. While the evidence base is still emerging, the alerts should prove useful ‘given that extreme temperatures, humidity and/or viruses in the air can aggravate the ill health of people who have COPD and increase hospital admissions.’[110] Similarly, a mobile phone-based malaria case reporting pilot in Botswana has ‘improved the accuracy, timeliness and geographic pinpointing of confirmed malaria cases.’[111] This has proved to be a ‘critical’ element of its elimination programme.

107 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 6 (6.4)
108 The Care and Support (Preventing Needs for Care and Support) Regulations 2014, Regulation 4(a): legislation.gov.uk/uksi/2014/2673/pdfs/uksi_20142673_en.pdf
109 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.56)
110 Phil Hope with Sally-Marie Bamford, Stephen Beales, Kieran Brett, Dr Dylan Kneale, Michael Macdonnell and Andy McKeon (Report of the Ageing Societies Working Group 2012), Creating Sustainable Health and Care Systems in Ageing Societies, Case Study 10
111 Malaria Journal (October 2012), Toward malaria elimination in Botswana: a pilot study to improve malaria diagnosis and surveillance using mobile technology: malariajournal.com/content/11/S1/P96

Working with partners to prevent, reduce and delay

The importance of working with the voluntary and community sector as well as with other bodies (such as the NHS, police and businesses) or departments (from housing to education) as a way to prevent, reduce and delay the need for care and support was highlighted in around a third of responses to question one.

This aligns with the Care and Support Guidance that notes:

"Preventing needs will often be most effective when action is undertaken at a local level, with different organisations working together to understand how the actions of each may impact on the other."[112]

Local authorities have also started to move beyond joint working to integration, as explored earlier on under the section on integration. Numerous responses to question one noted the particular importance of health and social care integration with regard to successful prevention, with some noting that 'a strategic shift to prevention requires a 'whole system' approach – this is not just about health and social care.'

Several local authorities within **Greater Manchester** touched on their devolution deal, which has given the region control over an integrated health and social care budget of over £6 billion. As noted by **Oldham**: 'We are developing relationships across this economy to deliver a single, integrated approach to prevention as part of a wider, more ambitious approach to co-ordinating agencies that together can most effectively help prevent, reduce or delay the development of care and support needs for individuals.'

The devolution of integrated health and social care budgets provides a real opportunity to properly invest in prevention. This is partly because both local authorities and the NHS would benefit financially from doing so. As noted by the Local Government Association:

'It is (also) difficult for local authorities to build a business case to invest their scarce resources in initiatives where the financial benefits accrue to other agencies such as the NHS or the benefits system...'[113]

At the same time, integration should eradicate the sometimes false distinction between people's 'health' and 'social care' needs. Distinguishing between such needs all too often results in no statutory agency taking responsibility for the person or service in question. As a result, we see too many people are falling through the gaps and too many people's needs escalating when they needn't be.

The provision of short-term wheelchair loans is just one example of this. There is currently no clearly defined duty for their statutory provision in England despite being included as an example of secondary prevention in the Care Act's statutory guidance.[114] Research demonstrates that they can prevent and delay people's need for health, social care and support, and reduce the level of need that already exists.[115] This is largely because of the false distinction between clinical and social needs for short-term wheelchairs resulting in a disagreement as to where the responsibility should sit.

Recommendation:

- **Devolved areas** should seize the opportunity to eradicate the false distinction between people's clinical and social needs, and to return prevention savings to a single integrated budget.
- **Local leaders** should ensure prevention (in all its forms) is a key aspect of all health and social care devolution deals going forward.

112 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.32)
113 LGA (September 2015), Prevention: A shared commitment: local.gov.uk/documents/10180/6869714/Prevention+-+A+Shared+Commitment+(1).pdf/06530655-1a4e-495b-b512-c3cbef5654a6
114 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.8)
115 McNulty, Carter and Beswick (July 2015), Putting the wheels in motion: Assessing the value of British Red Cross short-term wheelchair loan: British Red Cross redcross.org.uk/~/media/BritishRedCross/Documents/About%20us/BRC%20Wheels%20in%20Motion%20-%20July%202015.pdf

Have local authorities developed a local approach to prevention?

As per Section 2.23 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support'), local authorities should have developed a local approach to prevention.[116] A hundred and four local authorities (up from 88 last year) confirmed they have developed a local approach to prevention. Thirty-one marked they are in the process of doing so and one confirmed they have not developed such an approach.

Ninety-five (over 90 per cent) of the 104 local authorities that have developed an approach to prevention clearly specify and include a range of examples of all three types of prevention. Notably, this has doubled since last year. It seems progress is being made, albeit slowly.

Over two years since the Care Act came into force we would have expected all local authorities to have developed and implemented a local approach to prevention.

Have local authorities developed a commissioning strategy for prevention?

Disappointingly, only around 40 per cent (57) of local authorities confirmed they have developed a commissioning strategy for prevention as per Section 2.24[117] of the statutory guidance and a further 49 are in the process of doing so.

Almost a fifth (30) have not developed a commissioning strategy for prevention, some of whom explained they have instead refreshed existing commissioning strategies to capture prevention or developed new ones that are not specific to prevention.

Twenty-seven local authorities confirmed their commissioning strategies (either old, new, specific to prevention, or general) do not specify and include a range of examples for all three types of prevention.

Recommendations:

- **Those local authorities** yet to do so should develop a local approach to prevention. This approach should clearly specify and include a range of examples of all three types of prevention set out in chapter two of the current Care and Support Statutory Guidance ('Preventing, reducing or delaying needs').
- **Those local authorities yet to do so** should develop a commissioning strategy for prevention or at least update their existing commissioning strategies to reflect the changes made through the Care Act. These should clearly specify and include a range of examples of all three types of prevention.

Have local authorities identified services, facilities and resources that prevent, reduce or delay needs?

Findings

- Seventy-nine per cent (117) of the 148 of those that responded confirmed they have already identified services, facilities and resources available in their area, which could support to prevent, reduce or delay needs.
- Thirteen per cent (19) are in the process of doing so identifying such services.
- The remaining 12 either responded that they had not gone about identifying preventative services or didn't answer the question.

Section 2.26 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support') notes '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.' This exercise helps local authorities understand the breadth of available local resources as well as any gaps, which should in turn, 'form part of the overall local approach to preventative activity', including what 'further steps it should itself take to promote the market or to put in place its own services'.[118] **Despite this, not all English local authorities have identified such services.**

116 According to this Section, '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…'

117 According to this Section, 'a local authority's commissioning strategy for prevention should consider the different commissioning routes available, and the benefits presented by each.'

118 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.26)

Several local authorities further emphasised the importance of doing this, noting that having an up-to-date directory was essential in moving towards having a single point of access as well as for social prescribing.

Others have gone on to invest in specific preventative services they identified as missing. Most have compiled this information onto databases for internal use or for providers and social care assessors, with others having made, or intending to make, the information available publically, either via their websites, apps, noticeboards, flyers, factsheets or interactive resource maps. Some local authorities have used, or intend to use, these publically available directories for supported self-assessment tools.

While some local authorities reported identifying both commissioned and non-commissioned services, others only reported creating a directory of commissioned services. This is despite the Care and Support Statutory Guidance instructing local authorities to look further than council, or CCG-funded services:

'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.'**[119]

Others seem to have only focused on identifying preventative services for particular groups, usually older people. **It is important to remember, however, that local authority's responsibilities for prevention apply to *all* adults.**

Some local authorities reflected how time-intensive identifying services beyond those directly commissioned by the local authority as well as for all adults, including carers, adults with no needs at all as well as adults both with and without eligible needs, can be. **Importantly, the need to continually identify services and update their directories was highlighted in numerous responses.**

How have local authorities identified these services, facilities and resources?

Local authorities report identifying preventative services in a range of ways.

The following three steps have often been taken:

1. allocating responsibility, by, for example, hiring officers with a specific remit to look for new services and keep directories up-to-date
2. stakeholder engagement, with many noting the importance of on-going engagement with community and existing providers and groups
3. gathering information by, for example, consultations, workshops, mapping prevention exercises, online sharing forums and so on.

For more details on these three steps, please see appendix four.

Recommendations:

> **Those local authorities yet to do** so should identify services, facilities and resources in their area that prevent, reduce or delay needs. This should form part of their overall local approach to prevention.

> As part of this, **local authorities** should identify, as far as possible, both commissioned and non-commissioned services, facilities and resources that prevent, reduce and delay needs. This should cover services, facilities and resources for 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, as well as for carers.

Have local authorities identified unmet need?

Findings

> Forty-nine per cent (73) have identified unmet need.

> Forty-one per cent (60) are in the process of doing so.

119 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.27)

> Five confirmed they have not done so.

> The remaining did not answer the question.

As per section 2.30 of the Care and Support Statutory Guidance 'local authorities must consider how to identify 'unmet need' - for example, those people with needs which are not currently being met, whether by the local authority or anyone else.' This is again considered 'crucial to developing a longer-term approach to prevention that reflects the true needs of the local population.' **Despite this, only about half of all English local authorities confirmed they have done this.**

While several of the 60 local authorities that responded, 'the council is in the process of doing so' rightly noted this was because identifying such need is an ongoing process, it seems the others have not yet considered exactly how they will go about this, or have not yet implemented their relevant plans.

How have local authorities identified unmet need?

Ninety-two local authorities fed back how they have identified, or are in the process of identifying 'unmet need' as per section 2.30 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support'). This responsibility has been carried out in a range of ways. These include primary research, drawing on local and national data, and working in partnership. For more detail please see appendix five.

Recommendations:

> **Those local authorities yet to do s**o should identify unmet need in their areas. This identification should form part of their overall local approach to prevention.

> As part of this, **local authorities** should identify not only needs not being met by themselves but by anyone else.

Examples of unmet need

Some of the responses gave examples of the types as well as specific groups of people with unmet needs that they have identified in their area. The most commonly cited examples include people who are socially isolated, people being discharged from hospital, as well as people with non-eligible, low-level care and support needs. Other areas of unmet need mentioned are linked to money worries, housing, fuel poverty, falls, sensory impairment, end of life care, mental health, drugs and alcohol, lack of affordable transport services (particularly for wheelchair users), a lack of low-level support (specifically in rural locations), early intervention dementia services, and befriending services.

Addressing unmet need

The Freedom of Information (FOI) responses indicate local authorities are relying heavily on the voluntary and community sectors to meet unmet need. As one local authority observed:

'Although there is no new money to meet these needs, there are opportunities to work with a number of VCS organisations and with communities to try to find ways to address these needs.'

Despite stretched funds, some local authorities reported commissioning new services or programmes as a direct result of identifying unmet need. Services cited include social prescribing, frailty services, community navigation services and village agents, self-management and self-care services, supported signposting, peer support for carers including carers groups, mindfulness training and walking groups, information and advice, services helping people home from hospital, and low level support at home, including providing and installing equipment to support independence.

LONELINESS AND SOCIAL ISOLATION

The importance of tackling loneliness[120] and social isolation[121] has been emphasised across the board – in FOI responses, sustainability and transformation plans and joint health and wellbeing strategies.

- Just over half (26) sustainability and transformation plans mention loneliness and/or social isolation.
- Over 100 out of 151 joint health and wellbeing strategies mention loneliness and/or social isolation.[122]
- FOI responses have taken specific actions to reduce loneliness and social isolation as a way to comply with Section 2 of the Care Act.

Research[123] suggests that one in five people are always or often lonely in the UK. **Without the right support, loneliness can transition from a temporary situation to a chronic issue. This has a damaging effect on health as well as our hard-pressed statutory services.** As reflected in **County Durham's** joint health and wellbeing strategy (JHWS):

'People with stronger social networks are more likely to be healthier and happier. Those with weaker social networks can become isolated and, as a result, more likely to experience poor physical and mental health…Earlier interventions could help prevent some of the negative effects of social isolation.'

The Care Act's statutory guidance recognises this, and includes approaches to reduce loneliness or isolation, such as befriending schemes and linking people into community activities, as a preventative example.

Examples of approaches to reduce loneliness and social isolation

While many FOI responses, STPs and JHWSs include an ambition to reduce loneliness and social isolation without explaining how they intend to do this, some have given specific examples of approaches they will or are already taking. **These generally include: befriending, community navigators, social group schemes (such as getting people involved in their local parks and green spaces and libraries), marketing campaigns, social prescribing, mentoring and volunteering.**

Amongst the FOIs, STPs and JHWSs, there has been a general tendency to focus efforts on reducing loneliness and social isolation on older people. However, loneliness and social isolation do not only affect older people. In reality, they can affect people at all ages. There are particular groups of people particularly at-risk of becoming lonely. The Jo Cox Commission on Loneliness[124] has been highlighting some of these groups over the last year. In addition to older people, these have included: men, carers, disabled people, refugees, children, and parents.

Research sponsored by the British Red Cross and the Co-op, entitled 'Trapped in a Bubble',[125] also shows that life transitions can be key triggers for loneliness. Such triggers could include becoming a young new mum, developing mobility limitations or health issues, being recently divorced or separated, becoming an empty nester or retiree, or being recently bereaved.

A wide range of risk factors for loneliness has been captured in **Reading's JHWS**, which notes: 'Most research in this area [loneliness] has focused on

120 Loneliness is a feeling that occurs when there is something lacking in a person's social relationships, or when the quality or frequency of their relationships with other people is less satisfying than they would like.

121 Social isolation is when someone lacks social ties or social integration. While social isolation can cause loneliness, you can be isolated without feeling lonely or vice versa.

122 In 2013, the Campaign to End Loneliness found that over half of all health and wellbeing boards with published strategies (53 per cent) had not recognised that loneliness and/or isolation are issues that need addressing: campaigntoendloneliness.org/wp-content/uploads/downloads/2013/06/Ignoring-the-health-risks-a-review-of-health-and-wellbeing-boards1.pdf

123 Kantar Public supported by British Red Cross and Co-op (2016), Trapped in a bubble: an investigation into triggers for loneliness in the UK: redcross.org.uk/~/media/BritishRedCross/Documents/What%20we%20do/UK%20services/Co_Op_Trapped_in_a_bubble_report_AW.pdf

124 Jo Cox Commission on Loneliness: jocoxloneliness.org/

125 Kantar Public supported by British Red Cross and Co-op (2016), Trapped in a bubble: an investigation into triggers for loneliness in the UK: redcross.org.uk/~/media/BritishRedCross/Documents/What%20we%20do/UK%20services/Co_Op_Trapped_in_a_bubble_report_AW.pdf

the elderly population. However, loneliness can be a health risk at any age.' They then list some additional known risk factors for loneliness. These include: 'living alone; not being in work; poor health; loss of mobility; sensory impairment; language barriers; communication barriers; bereavement; lack of transport; living in an area without public toilets or benches; lower income; fear of crime; high population turnover; becoming a carer.'[126]

They plan to use this information to help them reach those most at risk of loneliness so that they can offer them 'direct support to improve the quality of people's community connections as well as the wider services which help these relationships to flourish – such as access to transport and digital inclusion.'

The other groups identified amongst the three document analyses were carers, with several drawing on their respite offer for carers as well as social care users, disabled people, and people with mental health conditions. A couple highlighted services set up to reduce loneliness amongst men. For example, **Brighton & Hove's FOI** response noted: 'In recognition of the isolation experienced by men, especially unemployed and newly retired men, a Men's Shed has recently been set up in East Brighton offering opportunities for men to come together to 'make and mend'.'

Several documents reflected how difficult it can be to identify people who are lonely or social isolated not least because, as **Bracknell Forest** wrote in their JHWS 'people find it hard to say they are lonely Barnet'. This means 'people could miss out on services and support which might help them feel less alone and more involved with the community in which they live.'[127]

Nevertheless, knowing that life triggers increases the chance of loneliness can help improve identification. Others, like **Barnet**, seek to improve identification through their healthy living pharmacies, hospital discharge teams and substance misuse treatment services.

Local decision makers also do not always know which interventions work best. With this in mind, **Bracknell Forest** intends to improve how they measure the effectiveness of interventions by, as recommended by the Campaign to End Loneliness, 'asking the same questions repeatedly over a number of years' and ensuring that 'any organisation offering services that might impact positively on loneliness will be asked to carry out an annual survey using the questions determined by the working group. If the service is one commissioned by the council or the CCG, this will be written into the contract.'[128]

Recommendations:

- **Local and national health and social care decision makers** should recognise that loneliness and social isolation can affect all ages.
- **Local health and social care decision makers** should focus on life transitions as one way to identify people at risk of loneliness and/or social isolation.
- **Local health and social decision makers yet to do so**, should ensure services that prevent, reduce and delay loneliness and social isolation are available in their areas.
- **The Government** should prioritise better understanding of what interventions that set out to reduce loneliness and social isolation are most effective for all age groups.

126 Reading Health and Wellbeing Board, Reading's Joint Health and Wellbeing Strategy: consult.reading.gov.uk/css/hwbstrategy/user_uploads/reading-health-and-wellbeing-strategy-2017-20-consultation-draft-v.10.pdf

127 Bracknell Forest Health and Wellbeing Board (December 2015) Bracknell Forest Health and Wellbeing Strategy 2016 – 2020: bracknell-forest.gov.uk/sites/bracknell/documents/seamless-health-2016-2020.pdf?VbHtb6FT0hPqbPRCL2RPD9jMojnYt52q

128 Bracknell Forest Health and Wellbeing Board (December 2015) Bracknell Forest Health and Wellbeing Strategy 2016 – 2020: bracknell-forest.gov.uk/sites/bracknell/documents/seamless-health-2016-2020.pdf?VbHtb6FT0hPqbPRCL2RPD9jMojnYt52q

WHAT THIS ALL MEANS FOR ADULTS IN ENGLAND

The new duties and responsibilities reiterated throughout this research report are important steps in ensuring fewer people fall into crisis. However, they will only truly mean something when more people are able to access services that prevent, reduce and delay their needs for care and support. The same applies to the strategies, policies and approaches labelled 'strong' or 'very strong'. This research therefore only tells part of the story.

While there is no individual entitlement to preventative services under the Care Act, there is a duty on local authorities to ensure the provision of preventative services and assess whether people could benefit from these services before a determination has been made as to their eligibility. When adults would benefit from a preventative intervention, they should expect support from their local authority to access those services.

This research study does not tell us whether more people are accessing preventative services, as the Care Act intended. However, the number of FOI responses still focusing solely upon the provision of 'information and advice' rather than of 'prevention' services suggests this ambition, at least in some areas, is yet to be realised. The fact that local authority spend of prevention has also reduced since the Act came into force, also suggests this.

Recommendations:

- **The Department of Health** should look into the legislation's impact on people. We hope this research serves as a useful foundation with regard to implementation of the prevention duties.
- **As part of the proposed upcoming green paper on social care, the Government** should look again at what else is needed to make the prevention vision a reality. This should include a further exploration of the resources local authorities need to implement the prevention duty in a meaningful way as well as whether the Care Act's prevention duty in its current form goes far enough in ensuring people's need for care and support is prevented wherever possible.

APPENDIX ONE:
the triple definition of prevention

PREVENT:
primary prevention / promoting wellbeing

Primary prevention is aimed at people who have no particular health or care and support needs. The intention is to help a person avoid developing needs for care and support, or help a carer avoid developing support needs.

Primary prevention includes universal policies such as health promotion, first aid learning, dementia-friendly communities, enhancing factors that are known to help protect all people (e.g. having a sense of belonging, enjoying good relationships, housing and good physical health), raising awareness initiatives such as National HIV Testing Week, universal services such as community activities that prevent social isolation, universal vaccinations (e.g. polio vaccine) …

REDUCE:
secondary prevention / early intervention

Secondary prevention is more targeted. Interventions are aimed at people who have an increased risk of developing health or care and support needs, or at carers with an increased risk of developing support needs. The goal is to help slow down or reduce any further deterioration, to prevent further needs from developing.

Secondary prevention includes short-term provision of wheelchairs, handyman services, 'social prescribing' services, telecare, earlier diagnosis, e.g. The NHS Health Check programme/ screenings etc., more targeted vaccinations (e.g.. the flu jab given to people over 65)...

DELAY:
tertiary prevention

Tertiary prevention is aimed at minimising the effect of disability or deterioration for people with established or complex health conditions. The goal is to support people to regain confidence and skills, and to manage or reduce need where possible. For people who have already reached the point of crisis, the goal is also to prevent that reoccurring.

Tertiary prevention includes reablement, rehabilitation, bed-based intermediate care, outpatient diabetic and vascular support, support to self-manage conditions, medical adherence programmes, home adaptations, assistive technology...

APPENDIX TWO:
research objectives and methodology

By doing this research, we specifically, wanted to answer the following questions:

- Is prevention a key consideration in local decision making, including commissioning?
- And if so, does the understanding of 'prevention' encompass all three tiers (primary, secondary and tertiary) including support services for people with lower-level needs?
- Since the Care Act came into force in April 2015, has there been an improvement in the prioritisation and understanding of prevention?
- How are local authorities, health and wellbeing boards and sustainability and transformation partnerships putting prevention into action?
- How well do local authorities' local approaches to prevention and their commissioning strategies reflect the Care Act's guidance on preventing, reducing and delaying needs?
- Whether local authorities' have identified preventative services and unmet need in their areas and if so, how?
- How local authorities, health and wellbeing boards and sustainability and transformation partnerships are putting integration into action?

We have previously undertaken a review of joint health and wellbeing strategies three years running. Each time we concluded that the term 'prevention' is understood differently across the country. In both 2013/14 and 2014/15 many strategies understood prevention only as minimising the risk of people developing care and support needs in the first place (primary prevention) or as targeting people at high risk of developing needs (secondary prevention).

In 2015/2016 we saw an improvement in the understanding and emphasis of prevention, as defined by the Care Act (2014). Nevertheless, 37 per cent of joint health and wellbeing strategies still did not incorporate a full understanding of prevention. With this in mind, we wanted to explore whether there has been a further improvement in health and wellbeing boards' understanding of prevention in light of the Care Act's triple definition of prevention now being in force for over two years as well as how well sustainability and transformation plans understand and emphasise prevention according to the Care Act.

Methodology

When reading the joint health and wellbeing strategies and sustainability and transformation plans, we wanted to know:

- Whether prevention was mentioned at all.
- Whether prevention was mentioned in the summary (if there was one).
- Whether prevention was mentioned in the vision/ aim.
- Whether prevention was mentioned as a priority.
- Whether prevention was mentioned as a principle, approach or value.
- Whether the Care Act (Care Bill), Better Care Fund or NHS Five Year Forward View were mentioned.
- How strong its focus on prevention was, and whether its focus was in line with the Care Act's statutory guidance (each strategy was labelled very strong, strong, neither strong nor weak, weak, or very weak).

The purpose of two to five was to determine whether there is any sort of emphasis on prevention. Generally, joint health and wellbeing strategies and sustainability and transformation plans have an overriding 'vision' or 'aim', a set of 'priorities' (usually between three and five but sometimes more) and some guiding 'principles', 'approaches' or 'values'. These tend to frame the strategies and indicate their main areas of focus.

The purpose of six was to help determine whether national policy and practice developments have translated into local plans.

The purpose of seven was to evaluate whether its

interpretation of prevention was in-line with the Care Act's statutory guidance. The labels (very strong, strong, neither strong nor weak, weak, very weak) were ascribed according to whether prevention was a key element of the strategy and whether prevention seemed to encompass lower-level/ tertiary types of support as well as primary and secondary examples.

Very strong: Prevention is a key component of the strategy or plan. It is either part of the vision, appears as a priority, principle, approach or features in the summary. The prevention that is emphasised clearly encompasses lower-level/tertiary types of support as well as primary and secondary examples. These types of preventative services are available before, during and after crisis point for a range of people and health problems.

Strong: Prevention is a key component of the strategy or plan. It appears as either part of the vision, as a priority, principle, approach, or features in the summary. Prevention is in part understood as early intervention and lower-level support. Although there is recognition of the importance of these services, they are often focused solely on one stage of the person's illness, rather than before, during and after. A strong recognition of the importance of lower-level preventative services but often only to one group of people, e.g. people with dementia, rather than all people who may benefit.

Neither strong nor weak: Prevention is probably mentioned as a principle, approach, priority (or component of one) or features in the summary. However, it is not clear that prevention has been wholly emphasised or understood in Care Act terms. Although there may be an obvious commitment to shifting towards prevention and early intervention, it is unclear whether this encompasses preventative lower-level support.

Weak: Although prevention is mentioned, or may exist as a component of a priority, principle, approach, or may feature in the summary, it clearly only focuses on preventing a problem from arising through awareness raising or education (e.g. preventing underage pregnancy by investing in sexual education).

Very weak: No emphasis of any kind on prevention.

It's important to note that some joint health and wellbeing strategies were due to be reviewed while completing this project and were subject to change. Moreover, they ranged in length, detail and had different timeframes. The combination of these factors makes the labels attributed to the strategies subjective and presumably temporary. Therefore, these results are intended to provide a guide as to the strength of strategies' focus on prevention, as well as a guide to the year-on-year trend.

When reviewing the sustainability and transformation plans, we also checked whether health and social care integration was explicitly mentioned and analysed how each partnership plans to go about doing this.

In addition, FOI requests were sent to all local authorities to see how they are implementing Section 2 and Section 3 of the Care Act. The following questions were asked:

1. What actions has your council taken to comply with Clause 2 of the Care Act 2014 ('Preventing needs for Care and Support')?
2. a) Have you developed a 'local approach to prevention' as per Section 2.23 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support') updated in February 2017?
   - Yes
   - No
   - The council is in the process of developing one

   b) Does your local approach clearly specify a range of examples of all three types of prevention set out in chapter two of the Care and Support Statutory Guidance ('Preventing, reducing or delaying needs')?
   - Yes
   - No
3. a) Have you developed a 'commissioning strategy for prevention' as per 2.24 of the Care and Support Statutory Guidance (within 'Developing a local approach to preventative support')?
   - Yes
   - No
   - The council is in the process of developing one

b) Does this commissioning strategy clearly specify a range of examples of all three types of prevention set out in chapter two of the Care and Support Statutory Guidance ('Preventing, reducing or delaying needs')?

- Yes
- No

4. a) Have you identified 'services, facilities and resources that are already available in your area, which could support to prevent, reduce or delay needs' as per section 2.26 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support')?
   - Yes
   - No
   - The council is in the process of doing this

   b) If yes, how did you identify these services, facilities and resources?

5. a) Have you identified 'unmet need' as per section 2.30 of the Care and Support Statutory Guidance ('Developing a local approach to preventative support')?
   - Yes
   - No
   - The council is in the process of doing this

   b) If yes, how have you done this?

6. What actions has your council taken to comply with Clause 3 of the Care Act 2014 ('Promoting integration of care and support with health services etc.'). Please give details.

APPENDIX THREE:
other themes in responses to question one

Various other themes mentioned in responses to question one may enable local authorities to carry out their new prevention responsibilities but are not necessarily results in themselves. These include:

- Reviewing their guidance and training.
- Creating new prevention-focussed boards, teams and roles.
- Revising their procedures. For example how they carry out assessments to better incorporate prevention as well as be more person-centred or how they evaluate their services, with one local authority noting: 'Measuring outcomes for preventative schemes is not straightforward and involves long-term data collection.').
- In some cases, local authorities have entirely restructured adult social care, offering a single point of access for both service users and professional for adult health and social care enquiries, assessments, services and referrals.
- Developing new strategies or plans.
- Reviewing their existing services.
- Identifying local preventative services and needs (detailed further under questions four and five).

APPENDIX FOUR: how have local authorities identified preventative services, resources and facilities?

Allocating responsibility

Some local authorities have hired officers with a specific remit to look for new services and keep their directory up-to-date. Others have assigned this line of work to specific prevention-focused or 'community coordination-type' teams or existing bodies, such as Healthwatch. Elsewhere, new steering groups have been set up to carry out this work.

Stakeholder engagement

Responses highlighted the importance of on-going engagement with community and existing providers and groups. Several specific groups were repeatedly mentioned as important sources of information. These include local neighbourhood teams, community connectors/navigators, commissioning leads, community and faith groups and occupational therapists. Around a fifth of the responses also explicitly mentioned working closely with the voluntary sector on this line of work.

Gathering information

Local authorities acquired this information in range of ways. Through, for example, consultations with service-users, providers, professionals, forums and steering groups, online searches, networking, hosting 'mapping prevention' stakeholder engagement events and workshops, call outs for information at relevant forums, a request to other local authority departments to also identify the activities they undertake that have a preventative aspect to them and, in a couple of cases, local authorities have linked up with social work students at universities to map local assets.

In addition, several local authorities have set up online sharing points, where providers can post details about their own services. It was noted this still involves ongoing engagement with stakeholders, promotion and encouragement to submit information.

Finally, several local authorities have drawn on their existing joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies carried out by health and wellbeing boards. As instructed within the Department of Health's statutory guidance on joint strategic needs assessments and joint health and wellbeing strategies, JSNAs should 'consider what assets local communities can offer in terms of skills, experience, expertise and resources.'[129]

129 Department of Health (2012) Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies: gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

APPENDIX FIVE: how have local authorities identified unmet need?

Primary research

A couple of local authorities have carried out qualitative research to identify unmet need, including Walsall that told us they have carried out a number of 'Deep Dive' initiatives looking at significant numbers of cases of unmet need in detail. These 'Deep Dives' have followed a rigorous panel process that seeks to identify unmet need on a case by case basis.

Drawing on local and national data

Several local authorities reported drawing on national and local datasets and sources. At a national level, these include: the census, the English Longitudinal Study of Ageing, Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI). As part of a two pronged approach to identifying unmet need, involving both an analysis of population needs as well as the needs of service-users known to the local authority, **Oxfordshire** commissioned the London School of Economics to provide a model of needs in their area that they use as their basis and update it accordingly:

'The model looked at needs based on information from the census and other national sources (such as the English Longitudinal Study of Aging). We then looked at provision of care including local authority provision (from our own records) and informal provision (estimated from national sources such as the Census and private provision based on local intelligence. This identified the proportion of care needs met by each sector (and the proportion of unmet needs).'

For service-users known to the local authority, they use the figures generated by the national social care users' survey, which asks service recipients if, after they have received services, they still have needs across eight different areas (personal care; food and drink etc.) They then monitor this and compare the results with previous years and other councils.

In keeping with section 2.329 of the Care and Support Statutory Guidance that instructs local authorities to 'draw on existing analyses such as the Joint Strategic Needs Assessment', a fifth of the 92 responses also mentioned drawing on their JSNAs as part of this identification. A tenth of the responses mentioned using their market position statements to identify unmet need.

Working in partnership

Most responses involved some sort of partnership working to help identify unmet need, most commonly with the voluntary sector as well as GPs. This is in accordance with the Care and Support Statutory Guidance that recommends local authorities 'work with the NHS to identify carers, and work with independent providers including housing providers and the voluntary sector, who can provide local insight into changing or emerging needs beyond eligibility for publically-funded care.'[130]

Partnership working has enabled some local authorities to capture projected levels of need they might have otherwise been unable to do. For example, Luton reports working with clinical commissioning groups (CCGs) and partners to track frailty amongst their GP registered population to assess future need.

The importance of on-going stakeholder engagement was also consistently highlighted as an important way to understand unmet need. Some reported carrying out co-production workshops with stakeholders such as carers, service-users, the voluntary sector and small enterprises. In addition to attending relevant partnership board meetings, forums, and events, other examples included, holding information hubs in hospital canteens to better engage with staff with caring responsibilities and hosting a prevention-specific conference.

Another important source of information highlighted was feedback directly from a range of providers, professionals and service-users. For example, providers are being asked to share their knowledge

130 Department of Health (August 2017), Care and Support Statutory Guidance, Chapter 2 (2.31)

of unmet need via contract monitoring processes and to include an analysis of unmet need as part of the rationale for their commissioning proposals. Customer services were identified as an important source of information as were service-users' surveys. In addition, social workers are often being asked to feedback on needs that they cannot meet, sometimes in a dedicated space on assessment forms.

A few spoke solely about identifying unmet need as part of the assessment process. While this is no doubt an important source of information, it may not be sufficient to identifying unmet need alone. Not least because this responsibility is supposed to extend beyond those already known to the local authority. In addition, a recent TLAP survey found that only around a quarter of their respondents felt that the council always or frequently listened to their wants and needs.[131]

131 TLAP (June 2017) Care Act 2014 survey results: Exploring the impact of the Care Act on the lives of people with care and support needs: thinklocalactpersonal.org.uk/_assets/Resources/TLAP/CareActSurveyResults-002.pdf

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