Commissioning for Carers
Disclaimer

Remember that legislation and guidance change and the advice obtained from this document should be considered as indicative only. Before using any of the information in this document, you should read, in full, the relevant legislation and any other source documents. Advice in this document does not give a full statement of the law and is not a substitute for professional advice. The authors cannot accept any responsibility for loss or liability occasioned as a result of any person acting, or refraining from acting, on information contained in this document.

Carers must... receive the recognition and status they deserve.
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Definition of carer
There is currently no single definition of ‘carer’. Building on the working definition proposed by the National Carers’ Strategy, this document proposes:

A carer spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.¹

Who is the guide aimed at?
This document is intended primarily for local NHS and council commissioners in England. It aims to cover the commissioning of adult services that impact upon adult carers. These can include services for the people who carers look after.

Commissioning support for young carers
Some children and young people also take on substantial caring roles, which can risk damaging their health, well-being or education. Every area should commission support for young carers under 18, and it should be noted that Putting People First commits adult services to reducing the likelihood of adults with ongoing support needs relying on the care of a child.

Commissioning for young carers brings distinctive challenges outside the scope of this document. There is information for commissioners at www.youngcarer.com (which includes DCSF-funded Principles of Practice) and at www.carers.org/professionals

This guide was developed by the following organisations:

ADASS
The Association of Directors of Adult Social Services is the professional association representing all 152 directors of adult social services in England.
www.adass.org.uk

Carers UK
Carers UK is the voice of carers. It supports health and social care professionals to develop services for carers and the people they care for through research, consultancy, information and training.
www.carersuk.org

Crossroads Caring for Carers
The Crossroads service is about giving time – improving the lives of carers by giving them a break from their caring responsibilities.
www.crossroads.org.uk
The Improvement and Development Agency
The Improvement and Development Agency works with councils in developing good practice and supporting partnerships. This is done through networks, online communities of practice, web resources and the support and challenge provided by councillor and officer peers.
www.idea.gov.uk

The Local Government Association (LGA)
The LGA is a membership organisation for councils in England and Wales, acting as the voice of the local government sector, and as an authoritative and effective advocate on its behalf.
www.lga.gov.uk

National Black Carers and Carers Workers Network (hosted by the Afiya Trust)
The aim of the National Black Carers and Carers Workers Network is to develop and maintain an effective network of black carers and carers workers that can facilitate the voice of black carers. This voice is implemented in the continuing improvement of services, policies and practice both locally and nationally to meet the evolving needs of black carers.
www.afiya-trust.org

NHS Confederation
The NHS Confederation is the only independent membership body for the full range of organisations that make up today’s NHS.
www.nhsconfed.org

The Princess Royal Trust for Carers
The Princess Royal Trust for Carers is the largest provider of comprehensive carers’ support in the UK. Through its unique network of 144 independently managed carers’ centres, 85 young carers’ services and interactive websites, the Trust currently provides quality information, advice and support services to almost 354,000 carers, including over 20,000 young carers.
www.carers.org

The partners are grateful for the support of the Department of Health in producing this resource.
Carers are a huge resource in our care and support system. For this system to be sustainable into the future, we need to increase every area’s capacity to encourage and enable families to make positive, informed choices about how they contribute to care. It doesn’t end there. Carers are individuals with their own aspirations. Alongside their role as a carer, they may need support so that they can live healthy and independent lives and pursue a career, an education or social activities.

The vision of the National Carers’ Strategy\(^1\) is that ‘the needs of carers must, over the next 10 years, be elevated to the centre of family policy and receive the recognition and status they deserve’. *Putting People First\(^2\)* sets out a commitment to transform the way in which care and support is delivered. Neither of these aspirations is deliverable without the other. Commissioning for care and support requires reform in order to place carers where they deserve to be.

Commissioning to support carers is complex because they are suppliers of care and individuals in their own right. Many of us will be carers or require care at some point in our lives. We owe it to carers, on whom we will increasingly rely, to shape a future where they know that their contribution is recognised and supported.

**How will commissioners succeed in doing this?**

To assist commissioners in both health and social care to succeed in delivering these ambitions, eight key organisations have developed this best practice guidance. Local commissioners may wish to use this when making commissioning decisions that could affect carers, including services for the people who carers look after.

Key recommendations in this guide include:

- think ‘carer’ in all your commissioning and area needs assessments
- improve outcomes, independence and choices for both carers and those they care for
- involve carers of all groups and communities in decision-making and planning processes
- strengthen the provider market, using a variety of funding approaches
- meet new NHS and social care inspection expectations and demonstrate that they meet key commissioning competencies.
We are grateful to the eight organisations that have produced this guide (details on pages 4 and 5).

David Behan
Director General – Social Care, Local Government and Care Partnerships
Department of Health

Gary Belfield
Acting Director General – Commissioning and System Management
Department of Health

‘The needs of carers must, over the next 10 years, be elevated to the centre of family policy and receive the recognition and status they deserve.’
National Carers’ Strategy
This introduction sets out what is meant by World Class Commissioning (WCC), its aims and aspirations. The WCC commissioning cycle helps to show how the process should be carried out by commissioners of carers’ support services, with the needs and wishes of carers driving the procurement and evaluation of local services.

**Vision and aims of World Class Commissioning**

WCC aims to deliver better health and well-being for the population, ‘adding life to years and years to life’.

**Eleven competencies**

The WCC vision is accompanied by a set of 11 competencies that underpin effective commissioning. Applied correctly and developed to a high level, these competencies will, over time, deliver improvements in health and social outcomes.

The competencies are:

1. Leadership
2. Work with community partners
3. Public engagement
4. Collaborate with practitioners
5. Manage knowledge and assess needs
6. Prioritise investment
7. Stimulate the market
8. Promote improvement and innovation
9. Secure procurement skills
10. Manage the local health system
11. Make sound financial investments.

The WCC vision is for commissioning to achieve three outcomes, set out below, with examples of what they might mean for carers:

**Better health and well-being for all**

- Carers and those they care for stay healthier for longer
- carers and those they care for live longer and health inequalities are dramatically reduced.

**Better care for all**

- Carers’ services are of the best quality and evidence based
- carers exercise choice and control over the services that they access so that these become more personalised.

**Better value for all**

- Informed investment decisions
- Primary Care Trusts (PCTs) and councils work across organisational boundaries to maximise effective care and support.

Think ‘carer’ in all your commissioning and area needs assessments.
How will commissioning for carers affect councils and PCTs?

- At the strategic level, carers should feature in each area’s Joint Commissioning Strategy and Local Area Agreement (LAA)

- at the individual level, carers already commission some services themselves using their own money or personal budget allocations

- commissioners will therefore need meaningful involvement with local carers to understand their needs and wishes in order to design responsive services, leading to improved experiences for carers in all communities.³

How this guide works

To make the guide easy to follow and as useful as possible, it is designed in sections that mirror the step-by-step process of the commissioning cycle in Figure 1. The guide is also cross-referenced to the 11 commissioning competencies, described in more detail in Appendix A.

Evidence base

For information on the evidence base for supporting carers and key health and well-being statistics, refer to Appendix B.

Policy drivers and funding streams

The White Paper, Our health, our care, our say and the concordat, Putting People First, are considered in detail below. Some of the other most relevant policy levers and funding streams are detailed in Appendix C:

• the National Stroke Strategy

• the End of Life Care Strategy

• the National Dementia Strategy

• the National Framework for Continuing Care

• Hospital discharge guidance

• Valuing People Now

• Equality legislation.
Figure 1: Applying the World Class Commissioning cycle to carers

Carer involvement

- Assess needs
- Design service
- Shape structure of supply
- Manage demands and performance
- Manage performance (quality, performance, outcomes)
- Support planning and decision-making
- Specify outcomes and procedure services

Strategic planning

Decide priorities

Review current service provision

Support planning and decision-making

Manage demand and ensure appropriate access to care

Manage performance (quality, performance, outcomes)
All services commissioned for disabled or older people should contribute to delivery of the five outcomes for carers.
This section describes how commissioners can use a model to assess their strategic needs, the importance of equality impact assessments, the role of Local Involvement Networks (LINks), key questions to discuss with carers, and personalisation of services.

The competencies that this covers in World Class Commissioning are:

1. Leadership
2. Work with community partners
3. Public engagement
4. Manage knowledge and assess needs
5. Prioritise investment.

1.1 Assess needs using a whole-area approach

Start planning by using a model of comprehensive support

A number of carer and improvement agencies have worked with local providers and commissioners (supported by DH) to develop a model of comprehensive carer support (Figure 2).

The model is based on achieving the outcomes of the National Carers’ Strategy, and it is hoped that it will aid local areas in carrying out their Joint Strategic Needs Assessment (JSNA). The model draws on the King’s Fund’s model of 2002, How good is your service to carers?

All services commissioned for disabled or older people will contribute to delivery of the five outcomes for carers. In addition, some carer-specific services will be needed. These could be delivered by public, private or third sector organisations.

How the range of interventions is provided, and by which agencies, will vary greatly from area to area. This may change over time as carers take advantage of personalised approaches. The evidence base for this model is being developed by carer and commissioner bodies. It will be available as a click-through online resource later in 2009.

How the model works (refer to Figure 2)

Inner circle

The five outcomes of the National Carers’ Strategy make up the inner circle of the model, with the carer at the centre.

Middle band

The middle band suggests that three underpinning approaches will be necessary to achieve the interventions in the outer band:

1. Identify and include: Services will need to be able to identify and include carers (refer to Figure 3 and page 22 for more information).
Figure 2: A model of comprehensive carer support
2. Carer-led: Services should be carer-led, with carers fully involved in service design and local decision-making.

3. Whole-area approach: There is a need for a service or partnerships that can provide carer expertise for the whole area.

**Outer band**

Around the outside of the wheel is the complete range of interventions needed to ensure that all groups can achieve the five outcomes.

1.2 Review current service provision in your area

Decisions need to be made about how the interventions around the outer band are delivered, and by which services. It is vital that each area involves carers in area needs assessments and the commissioning process. Involvement of carers, particularly those at risk of being overlooked, may require specialist services to be commissioned. Refer to the note in Appendix C on legislation for equality impact assessments.

**Carers may be overlooked because they:**

- come from a particular black, minority ethnic, traveller or refugee community
- belong to a particular age group, such as young carers under 18, older carers or young adult carers aged 18–25
- care for someone with a stigmatised long-term condition such as a mental health problem, a substance misuse problem, or HIV/AIDS
- care for a neighbour or friend rather than a family member, or for a same-sex partner
- care for someone who lives in a different local authority area
- have a disability or long-term condition themselves.

**What is the role of the LINk in the process?**

Each area has a Local Involvement Network (LINk) made up of patients, public, carers and other stakeholders in health and social care. The LINk has a role in identifying local challenges and health inequalities and should influence the commissioning of services.

1.3 Decide local priorities

The LAA contains targets for improvement across health and council services. It should be developed by adult and children’s services directorates, local health trusts and providers (through an area’s Local Strategic Partnership).
Carer support is an explicit target in many LAAs (using the carers’ indicator NI135 from the national indicator set of inspection indicators for local areas) and is implicit in others.

Some key questions for commissioners to discuss with carers
1. Do our services for older people and those with ongoing support needs meet the needs of carers?
2. Are the interventions in the model (Figure 2) being delivered?
3. Are any groups of carers not accessing the support they need?
4. How can we help individuals and communities to overcome those barriers?
5. Where are there gaps and under-provision?
6. Where is there over-provision or scope for better co-ordination between services?

The importance of personalising services for carers
Every area needs to commission for different kinds of service, such as:

- agencies designed to give carers a voice in local decision-making and make sure that all services in the area become more carer-aware and carer-friendly
- services with carer expertise able to raise the carer awareness of all agencies in an area
- services designed to find carers and help them to identify their needs and entitlements
- support services for carers with particular support needs and/or entitlements.

This range reflects the vision for the transformation of care and support services known as ‘personalisation’. Personalisation was first outlined in *Putting People First* and in the accompanying local authority circular, *Transforming social care.* There have been a number of useful documents since.

Great progress has been made in personalising support services for carers, offering them greater choice and control over the allocation of resources. Personalisation is, though, a much wider set of reforms than simply moving towards personal budgets and direct payments.

There are four strands for personalisation that are of equal importance:

1. Greater choice, control and independence for everyone who uses services and carers.
2. Everyone able to make informed choices through a ‘universal offer’ of advice and information.
3. Increasing an area’s ‘community capital’: people, their families and communities becoming experts in their own support and contributing to it.
4. Early intervention and prevention as well as support at the point of crisis.

Carers are a vital part of an area’s community capital. *Putting People First* expects that ‘family members and carers [are] to be treated as experts and care partners’ and should be involved in co-producing Workforce Development Strategies.
Personalisation of services is a much wider set of reforms than simply moving towards personal budgets and direct payments.

**Using a care pathway to personalise services**

There are many distinct categories of service that are needed in order for carers to be included, informed and supported according to their choices. The care pathway for carer support flowchart (Figure 3) considers the different strands of personalisation.

This pathway encompasses carers with entitlements to a high level of statutory support and those with few entitlements or whose entitlements are yet to be established.

The categories of support as shown in Figure 3 are:

1. The universal offer of advice and information for all carers
2. Assessment, advocacy and brokerage

The third category covers two distinct kinds of support:

- prevention and early intervention
- reactive/crisis support.

The overarching objective of these categories is the need to build community capacity and a local infrastructure that ensures carers are at the heart of every local area. Commissioners will need to make sure that:

- carers have a voice in decision-making
- awareness of carers is raised in all services in the area
- non-statutory organisations (such as local facilities and employers) are carer-friendly.

**Developing a sustainable provider market**

Each service may require a different approach to commissioning in order to develop a viable provider market. It is possible for one organisation to provide more than one kind of service. Providing all of these services to all communities in an area is likely to require input from many organisations. This could include generic and carer-specific organisations, including statutory services and third and private sector providers.

These services, their outcomes and how to commission for them are explored in Section 2: Specify outcomes and commission services.
Figure 3: Carers at the heart of communities and services – a care pathway for carer support
Give carers the opportunity to change their choice of provider or to complain about the quality or effectiveness of services.
2. Specify outcomes and commission services

This section looks at some of the issues that commissioners need to address when planning, supporting and buying services. It details some examples of commissioning activity that can build ‘community capacity’. Across the whole process it describes what successful provision – for communities and individual carers – will look like.

The competencies that this covers in World Class Commissioning are:

2. Work with community partners
3. Public engagement
4. Collaborate with practitioners.

The care pathway in Figure 3 (page 17) suggests that commissioners will need to develop services that respond to the needs of carers, that support other services and that develop the area as a whole:

- some services for older people or people with ongoing support needs will meet carers’ needs
- some services will be commissioned specifically to respond to carers’ needs
- some services will build the capacity of other existing services
- some services will ensure that formerly excluded groups and communities of carers have a voice that is heard by local decision-makers.

Work of this kind could include organisations which:

- train other agencies to be more carer-friendly and raise awareness in the area
- work with local employers to become more carer- and disability-friendly
- advocate for carers and help their voices to be heard by decision-makers
- work on the agenda for carers with specific communities.

The framework for assessing adult services includes many descriptors of outcomes that are relevant to carers at an individual and an area level. Table 1 shows how adult services will be required by inspectors to demonstrate these outcomes.

**Should one agency take on more than one service?**

In some areas a single agency may provide more than one category of service. This may give a smoother care pathway. However, it may bring about a risk of a conflict of interest, or of the carer feeling that they are denied choice, or independent advocacy.
Such risks can be reduced by providers and commissioners. This means being clear about the kinds of intervention on offer and giving carers the opportunity to change their choice of provider or to complain about the quality or effectiveness of services.

There are a number of examples of carers’ services providing personalised responses in a Department of Health-funded report from the Princess Royal Trust for Carers and Crossroads Caring for Carers, called Putting People First without putting carers second, at www.carers.org/professionals. This is accompanied by Putting People First and Supporting Carers: Some Key Messages for Local Leaderships, produced by ADASS, the Improvement and Development Agency, NHS Confederation, LGA, Carers UK, Crossroads Caring for Carers and the Princess Royal Trust for Carers, available at www.adass.org.uk

Table 1 shows how adult services will be required by inspectors to demonstrate their achievements against the seven outcomes and two domains described in the Performance Assessment Guide 2008–09. The guide categorises performance under seven outcomes (O1–O7) and two domains (D8 and D9): refer to Appendix D (page 43). More detailed references to grade descriptors describing adult services are in Table 2 on page 32.

Relevant descriptors from the guide are grouped below under the different categories of service set out in Figure 3 on page 17. Some outcomes are for individual carers and some for the whole area.

Notes in brackets indicate whether the outcome or domain descriptor listed in the table is:

a) part of the overall summary of a Performance Assessment Guide outcome or domain, or
b) one of the ‘performance characteristics’ for an outcome or domain (eg O1 PC).
Table 1: Outcomes for carers and for local areas as described in the Performance Assessment Guide 2008–09 and the Outcomes Framework (2008–09) for adult services

<table>
<thead>
<tr>
<th>Community capacity building</th>
<th>Universal offer</th>
<th>Assessment, advocacy and brokerage</th>
<th>Support</th>
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<tr>
<td>• Family members and carers are supported and treated as experts and care partners (O7 PC)</td>
<td>• People who use services and their carers enjoy the best possible quality of life (O2)</td>
<td>• People who use services and their carers are supported in exercising control of personal support (O4)</td>
<td>• Carers are able to balance caring with a life of their own (O2)</td>
</tr>
<tr>
<td>• People who use services and their carers have income to meet living and support costs. They are supported in finding or maintaining employment (O6)</td>
<td>• Carers are able to continue in employment or return to work if they choose to do so (O6 PC)</td>
<td>• People who use services and their carers have fair access to services (O5)</td>
<td>• Families are supported so that children do not have to take on inappropriate caring roles (O2)</td>
</tr>
<tr>
<td>• Carers are able to</td>
<td></td>
<td>• People who use services and their carers are safeguarded from all forms of abuse (O7)</td>
<td></td>
</tr>
<tr>
<td>Area outcomes</td>
<td>• Voluntary organisations contribute views and develop services that support people in all communities. They can show that people who use services and carers are involved in the work (O3 PC)</td>
<td>• People who use services and carers are able to commission the support they need (D9)</td>
<td>• Fewer people need care or treatment in hospitals and care homes (O1)</td>
</tr>
<tr>
<td>• Organisations for people who use services and carers are well supported (O3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Commissioners engage with people who use services, carers, partners and service providers, and shape the market to improve outcomes and good value (D9)</td>
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2.1 Advice and information for all carers

This section provides practical advice on putting carers at the heart of services and the factors that should govern decision-making. The focus is on enabling all carers to make informed choices and putting in place a seamless package that offers choice, care breaks and crisis support.

In order to promote meaningful choice and control for everyone (not just for those entitled to high levels of support), Putting People First expects that all 152 councils in England with responsibility for adult services will have most of the core components of service transformation in place. These include ‘universal, joined up information and advice available for all individuals and carers, including those who self-assess and fund.’

National advice services have an important role to play in helping carers to find information and advice. Carers Direct is the new telephone and online information service (0808 802 02 02 and www.nhs.uk/carersdirect). This service will reach carers who have no local service, have not contacted their local service, or who want to find out about their national entitlements. It will succeed through partnership working with effective local information services.

Act to identify carers who are hidden, overlooked or isolated

It will be important that every area maintains local services that can identify and include ‘hidden’, overlooked or isolated carers. Such services should be well publicised and accessible. Information for carers should be current, complete and accessible to all, including people who have to pay for their own support. This may require partnerships with small community groups. There are many examples of services. Some are delivered in carers’ own homes through outreach workers or co-located in GP surgeries, hospital wards, schools and other community settings.

As well as the Putting People First commitment to provide information, advice and advocacy services, councils are producing sustainable community strategies. They also have a ‘well-being power’ (introduced by Section 2 of the Local Government Act 2000), giving them considerable flexibility in commissioning for their whole population. Similarly, the NHS Next Stage Review: What it means for the Third Sector provides for each PCT to commission comprehensive well-being and prevention services specific to its local population.

[Councils have a] ‘well-being power’, giving them considerable flexibility in commissioning for their whole population.
2.2 A fundamental shift to deliver choice and control for carers

The highest priority for many carers is better services for the people they care for. Information, advice and advocacy will play a key part in this. Carers should be involved in support planning where they are likely to have a significant role in providing or arranging an individual’s support. It is common for carers to co-ordinate a relative’s care package.

- Moves towards personal budgets mean that many carers are now recognised as budget-managers and employers
- Carers have an important contribution to make to decision-making at all levels
- Many will need support to understand and participate in self-directed support and personal budgeting
- Brokerage services must identify caring situations and support carers in their caring and care-co-ordinating roles.

Offering a carer’s assessment

A carer’s assessment is a vital tool in delivering this objective. Councils have a statutory obligation to offer every carer over 16 who provides or intends to provide a substantial amount of care on a regular basis a carer’s assessment. This obligation cannot be narrowed to carers with high levels of need or to carers of people with particular conditions. Services should be in place to identify isolated carers and help them take up this right.14

2.3 Preventative support and early intervention

The White Paper *Our health, our care, our say*, interpreted for councils in Local Authority Circular (DH) 2008 (1),15 places a focus on prevention. ‘The direction is clear: to make personalisation, including a strategic shift towards early intervention and prevention, the cornerstone of public services.’ *Putting People First* contains a commitment that local areas will have a ‘Sustainable Community Strategy, utilising all relevant community resources especially the voluntary sector so that prevention, early intervention and enablement become the norm’.

There is a need to demonstrate that preventative approaches target the groups that are likely to benefit from them. By their nature, groups of people who do not yet have high levels of need are difficult to define.

Commissioners and providers need to act to understand:

- Which undesirable outcomes for individuals an intervention is designed to prevent

The highest priority for many carers is better services for the people they care for.
• what positive outcomes for services are expected (e.g., lower uptake of crisis support)
• how helping a carer to care will be balanced by helping them to explore other options
• how these outcomes will be measured in terms of impacts on individuals or services.

2.4 Reactive and crisis support

Carers are not a static group, and their needs vary. Despite an increased desire to move resources ‘upstream’ into preventative services (see page 23 for details), there will remain a need for reactive and crisis support.

Carers may need intensive one-to-one emotional support, higher levels of breaks or more practical support with caring tasks. These services may be funded by personal budgets. A flexible and responsive system is needed so that carers can access help quickly in emergencies.

Since 2007-08, councils have received an additional £25 million per annum for emergency planning and support. This need was first identified in the White Paper Our health, our care, our say. Many areas already commission such services.¹⁶

The eligibility criteria in Fair Access to Care Services¹⁷ state that councils must intervene when a carer’s needs are critical and this includes:
• the risk of an extensive loss of autonomy
• the development of major health problems
• an inability to look after their own domestic needs and other daily routines
• a risk to employment or other responsibilities
• a risk to significant social support systems or relationships.¹⁸

These criteria have been interpreted with regard to carers in the practice guidance to the Carers and Disabled Children Act 2000.¹⁹

2.5 Commissioning breaks services

For many carers, replacement care and the provision of breaks are high priorities. Councils have received a Carers Grant to identify carers and provide breaks for some years. The operating framework for the NHS in England 2009/10 sets out national priorities for the NHS, including to keep adults and children well by improving their health and reducing inequalities. In paragraph 37 of Section 2, PCTs are encouraged to consider the expectation in the Carers’ Strategy that they publish joint plans with their local authority partners, to set out how they will spend their combined funding on breaks for carers in line with the personalisation agenda (see National Carers’ Strategy commitments).

A flexible and responsive system is needed so that carers can access help quickly in emergencies.
NI 135 (see 1.3 Decide local priorities), one of the National Indicators, is a measure of the proportion of carers who get a specific break or service. Vital Signs, which sets out how PCTs should approach the national priorities and select local measures of progress, gives NI 135 as a locally-decided indicator. PCTs and councils, with their partners and local people, can choose whether to use NI 135 as part of the Local Area Agreement or PCT Operational Plan, but PCTs are advised to track their performance against all of the Vital Signs and all councils self-assess their performance against NI 135.

Carers should have choice and control over how and when services that help them take a break are provided. For example, one carer may choose to use their break each week on a specific day and at a specific time, while others may need short-notice replacement care because of work commitments.

Some carers may wish to take a holiday in a supported environment with the person they care for. Carers of people with non-physical conditions may require non-traditional solutions for breaks. The National Carers’ Strategy includes funding for holiday sites to demonstrate the options they can offer for innovative breaks.

Carers take up and benefit from breaks when they are confident that the support for the person they care for meets their needs. A ‘whole-family’ approach should be adopted to do this. The service should aim to be preventative and supportive, where risk is not just assessed but managed.

Key aspects of successful regular breaks services include lead-in time for the provider to build up a relationship with both people, and continuity of appropriately trained support staff. This time should be recognised in any commissioning processes. Long-term funding using a variety of methods is required, so that breaks services are able to deliver a wide variety of planned and emergency breaks. These include spot purchase, individual commissioning and wider contracts (refer to page 44).

A personal care service is likely to be an essential component of many breaks services. However, commissioning personal care for a disabled or ill person does not in itself constitute a break for the carer.

Questions to consider when commissioning a breaks service

Does the proposed break service:

- give the carer the freedom to do what they wish (such as stay in or go out)?
- give the person needing support a positive experience tailored to their wishes?
- ensure that the carer is in control of the break they receive?
- provide the carer and the person they support with a sense of security and confidence?

For many carers, replacement care and the provision of breaks are high priorities.
2.6 Transitions

If the caring experience is to be a positive one, it needs smooth transitions between one part of the care system and another. Achieving this requires joint commissioning across these boundaries and transitions, which include:

- people becoming carers for the first time
- the transition to adulthood for children with disabilities and for young carers
- transition from adult to older people’s services
- hospital admission/discharge
- the caring role ending, through choice, carer ill health, bereavement or the carer’s own death
- returning to work post-caring.

2.7 Developing a sustainable provider market

This section provides a framework for developing a viable, durable market when buying support for carers. It explains how European Union (EU) law informs the process, the importance of securing value for money (VfM), but also possible policy pitfalls and how these could have an adverse effect on providers.

The competencies that this covers in World Class Commissioning are:

2. Work with community partners
3. Public engagement
7. Stimulate the market
8. Promote improvement and innovation
9. Secure procurement skills.

Introducing more choice and control for carers can bring opportunities for providers to innovate and reach excluded groups. It may also bring risks for providers, particularly small local organisations with less experience of tendering for contracts. For example, carer-specific support is patchy and fragile in some areas. So it is an important time for commissioners to develop relationships with existing and potential providers from all sectors.21

Commissioners can choose between several approaches:

- grant giving
- putting services out to tender
- relying on individuals to fund a service through their own money or a personal budget.

More details are set out in Appendix E, along with details of EU rules on open tendering.

Value for money and competition

Commissioners generally use competitive tendering to get better VfM or encourage competition. Opening up a service to
competition must be done with a careful focus on outcomes to avoid the risk of a counterproductive result. Questions for commissioners to consider include:

- Is the tender document likely to result in more partnership working and give carers more service providers to choose from?
- Do we risk encouraging providers to ‘cherry pick’ attractive services at the expense of the organisations that provide more complex or challenging services?
- Will the services specified reach all groups and communities, including the smallest minority groups?
- Will carers have access to an independent advocacy service when their needs or choices conflict with those of the person they care for?
- How will we assess a potential provider’s credibility with local carers and its reach into local carer communities?

**Putting a value on community capital**

Considering questions like these will allow commissioners to test whether they are likely to achieve VfM. ‘VfM is not the lowest price – it is defined as the optimum combination of whole life costs and quality to meet the user’s requirement.’

For instance, while a large national organisation may be able to offer a particular support service at a lower cost, a local or grass roots organisation may be able to demonstrate a greater reach into, or co-production with, local communities. Community capital of this kind can be hard to replace once lost. The use of social clauses in tenders is one approach to putting a value on community capital (for more information refer to Appendix E).

Where individuals commission a service themselves through personal budgets, individual budgets or direct payments, commissioners perform a crucial role in ensuring that individuals have a wide range of providers on which to spend their budget allocation. Contracts or grants can be used to develop and support services with the potential to reach excluded groups or meet specific needs.

Using personal budgets as a funding mechanism is not the only way of increasing people’s choice and control. Some services may be better funded through alternative methods, such as services that:

- are aimed at people who have no entitlement to a care budget
- deliver very low-cost interventions, such as some information services
- provide something for which people do not expect to pay, such as services whose aim is the involvement of carers in decision-making.

Opening up a service to competition must be done with a careful focus on outcomes to avoid the risk of a counterproductive result.
A key question is: what evidence do commissioners and providers have of need, including unmet need?
3. Managing demand and performance

This section helps commissioners to negotiate a wide range of interlocking performance measures across the health and social care sectors. It brings together measures of outcomes for carers with methods that can help to define supplier performance and purchasing effectiveness.

The competencies that this covers in World Class Commissioning are:

3. Public engagement
10. Manage the local health system
11. Make sound financial investments.

As well as complying with nationally set indicators, outcomes-based contracts require agreement between commissioners and providers on:

- the desired outcomes
- how success will be measured
- how outcomes will be reviewed and adjusted over time to meet changing individual and community needs.

3.1 Issues to consider on managing demand

With scarce resources, commissioners need to target them carefully. A balance is needed between consideration of the needs of people with extensive support needs and:

- commissioning for the universal offer
- commissioning preventative and early intervention services
- encouraging and supporting sustainable caring contributions from people with few support needs.

A key question is: what evidence do commissioners and providers have of need, including unmet need? Provider organisations may have other sources of funding for their work, which carry their own target groups or outcomes, so targets should be set in proportion to the level of activity funded.

3.2 Managing and measuring performance

The Performance Assessment Guide 2008–09 for inspections of adult services gives increased prominence to carer support. It was made clear that performance assessment has a strong focus on delivering the National Carers’ Strategy. Inspectors will consider a wide range of evidence including ‘the experience of people who use social care and their carers’.

The most relevant broad descriptions of local areas described by the seven outcomes and two domains are listed in Table 2 on pages 32–34. ‘Grade descriptors’ describe the more detailed characteristics that an area must be able to show in order to achieve a grade of ‘adequate’, ‘performing well’ or ‘performing excellently’ for each outcome and domain.
Some of the most relevant grade descriptors are listed in Table 2, cross-referenced where relevant to the National Carers’ Strategy outcomes. Refer to Appendix D for a list of the outcome and domain headings.

The national indicator set of inspection indicators for local areas includes a carers’ indicator (NI135), which measures the area’s success in providing carer’s assessments and services arising from those assessments. The Care Quality Commission is reviewing the national indicator set and has documented concerns about the effectiveness of NI135.

Here are some additional measures that commissioners might find useful:

- under-reached carer groups/communities identified in JSNAs
- numbers of carers identified and supported by non-carer specific services
- carer satisfaction with relatives’ care planning processes
- carer take-up of personal budgets, direct payments or individual budgets
- the number of adults with long-term conditions relying on children for care
- the number of unplanned care home placements due to carer emergency
- uptake of and satisfaction with breaks
- ethnic and equality monitoring of carers accessing information and breaks services.

Outcome measures for NHS commissioners

There is some evidence that health services which do not consider carers’ needs can risk poorer health outcomes for carers and those they care for. Key questions for NHS commissioners include:

- Do primary health and social care teams link up to identify and support caring contributions?
- Could better-commissioned health services reduce health inequalities experienced by carers and reduce barriers to healthcare?
- Could hospital-based carer support result in speedier or more successful discharges?
- How can support for their carers aid individuals’ re-enablement and independence?
- Have carers been sufficiently involved? Have outcomes been measured? Are any groups overlooked?

Measures of outcomes include:

- measures of the speed and success of hospital discharge and carer-related reasons for this
• measures of admissions of people with long-term conditions precipitated by their carer’s ill-health

• numbers of admissions of carers themselves and the impact on the person receiving care.

The importance of confidentiality for some carers

In designing monitoring and audit processes, it is worth noting that reaching some excluded groups can hinge on a service guaranteeing a level of confidentiality. Any information-sharing requirements should be negotiated with providers from the start and built into the assessment processes.

This allows providers to support carers who do not want personal information shared. Contracts should avoid perversely incentivising providers to work only with the easiest carers to reach, or only those likely to have low support needs.

Measuring the success of an intervention

Demonstrating that an intervention achieves a result is likely to require establishing baseline data before the work commences. It will be necessary to measure carers’ (or an area’s) level of need, resilience and well-being both before and after an intervention. Nottingham University has developed an academically validated outcome measuring tool for use with young carers at www.carers.org/professionals, and a similar tool for use with adult carers is being developed in 2009.

Alongside evidence of outcomes (changes in people’s lives or the area’s infrastructure), it will be useful to consider measures of carer satisfaction and to encourage the use of Quality Assurance systems. Carers and their families should be involved in reviewing the success of services.

Could hospital-based carer support result in speedier or more successful discharges?
<table>
<thead>
<tr>
<th>Strategy outcomes</th>
<th>Relevant grade descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role</td>
<td>• Social care workers support choice and control by the person using services and, where these conflict with family views, work to resolve the issue (O7.4 adequate)</td>
</tr>
<tr>
<td></td>
<td>• Carers are treated as expert partners and their quality of life is supported equally to those they care for (O2 performing well)</td>
</tr>
<tr>
<td></td>
<td>• Social care workers treat carers and families as partners. They have skills and knowledge to do this, even where needs are complex (O7 performing well)</td>
</tr>
<tr>
<td></td>
<td>• Carers are provided with training opportunities to promote their skills and knowledge (O7 performing well)</td>
</tr>
<tr>
<td></td>
<td>• Families and carers have support that is based on partnership (O7.4 adequate)</td>
</tr>
<tr>
<td></td>
<td>• All people who use services and their carers have a copy of their support plan with a review date and contact (O4 performing well)</td>
</tr>
<tr>
<td></td>
<td>• People who use services and their carers are confident that making a complaint will not prejudice the support they receive (O4 performing well)</td>
</tr>
<tr>
<td></td>
<td>• People and carers can get personal advice about support options, and what the criteria on entitlement mean for them (O5 performing well)</td>
</tr>
<tr>
<td></td>
<td>• Carers report that their health and well-being needs and wishes are carefully taken into account (O1 performing well)</td>
</tr>
<tr>
<td>Carers will be able to have a life of their own alongside their caring role</td>
<td>• People who use services and carers feel that support helps them achieve an acceptable quality of life (O1 adequate)</td>
</tr>
<tr>
<td></td>
<td>• Adult carers are supported so that they can balance caring with a life of their own (O1 adequate)</td>
</tr>
<tr>
<td></td>
<td>• People who use services and their carers are helped by local transport and mobility schemes to have a social life and to use local services (O2 adequate)</td>
</tr>
<tr>
<td></td>
<td>• People who use services and carers are supported in a range of roles within their community (O3 adequate)</td>
</tr>
<tr>
<td>Strategy outcomes</td>
<td>Relevant grade descriptors</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------</td>
</tr>
</tbody>
</table>
| **Carers will be supported so that they are not forced into financial hardship by their caring role** | • Carers are supported to have choice and opportunity where they wish to maintain employment (O6 adequate)  
• Carers’ needs for income and employment are recognised in planning support. They are offered skilled advice to help reduce financial hardship caused by their caring role (O6 adequate)  
• Carers are offered choices about breaks, and these help some carers to balance their caring role with employment (O6 adequate)  
• The council’s own employment conditions are supportive to employees who are also carers (O6 adequate)  
• Where they choose it, carers have opportunities to combine work with their caring responsibilities. Many local employers recognise their needs and have flexible working conditions (O6 performing well)  
• Skilled advice helps many carers to maximise income available to them to reduce financial hardship caused by their caring role (O6 performing well)  
• Support schemes are flexible and help carers to work around individual employment and family needs and preferences (O6 performing well) |
| **Carers will be supported to stay mentally and physically well and treated with dignity** | • Assessments and support plans focus on the whole person’s needs, those of their carers and the family. They are sensitive to different cultural backgrounds (O4 adequate)  
• At the end of life, people who use services and carers are supported sensitively, and treated with dignity and respect (O1 adequate)  
• People who are lonely, isolated or at risk can contact social care workers and/or third sector organisations, who help maintain their quality of life (O2 adequate)  
• Carers can ask for assistance and are supported at times of crisis (O7.4 adequate)  
• Carers have well-developed support and a greater than average range of options to choose from (O2 performing well)  
• People who use services and their carers find that care and health workers are skilled in helping families who support people with more complex or intensive needs (O7.4 performing well)  
• (There are also a number of descriptors referring to reductions in care home admissions and reductions in delays to hospital discharge) |
<table>
<thead>
<tr>
<th>Strategy outcomes</th>
<th>Relevant grade descriptors</th>
</tr>
</thead>
</table>
| Children and young people will be protected from inappropriate caring and achieve the Every Child Matters outcomes | • Children are supported so that they do not have to take on inappropriate caring roles in families (O2 adequate)  
• Children and young people are supported so that their education and development do not suffer as a result of caring responsibilities (O2 adequate) |

Some relevant grade descriptors are not easily linked to a single National Carers’ Strategy outcome:

• Organisations led by people who use services and their carers are well supported and their views make a difference (O3 performing well)

• Carers have specific opportunities to contribute and influence services (O3 performing well)

• Commissioners engage with people who use services and their carers, local people, partners and service providers, and respond to their views (D9 adequate)

• Knowledge of population needs and the views of people who use services and their carers is comprehensive and up to date (D9.2 performing well)
## Appendix A: World Class Commissioning competencies and carers

<table>
<thead>
<tr>
<th>Competency area</th>
<th>Sections in guide</th>
<th>Demonstrating the competency in commissioning better support for carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leadership</td>
<td>2</td>
<td>Health trusts and councils lead by example in highlighting the centrality of supporting carers as care partners and a group that face barriers to inclusion.</td>
</tr>
<tr>
<td>2. Work with community partners</td>
<td>2, 3, 4</td>
<td>Work collaboratively with community partners to commission services that optimise health and well-being gains and reduce inequalities for carers.</td>
</tr>
<tr>
<td>3. Public engagement</td>
<td>2, 3, 4, 5</td>
<td>Seek and build continuous and meaningful engagement with carers that enables them to shape services and their local area as co-producers.</td>
</tr>
<tr>
<td>4. Collaborate with practitioners</td>
<td>3</td>
<td>Work with frontline professionals in all sectors to inform commissioning strategy that improves quality, service design and use of resources.</td>
</tr>
<tr>
<td>5. Manage knowledge and assess needs</td>
<td>2</td>
<td>Work with all stakeholders to understand the current and future needs of local carers.</td>
</tr>
<tr>
<td>6. Prioritise investment</td>
<td>2</td>
<td>Prioritise investment to support carers in most need as well as to promote prevention and early intervention. Invest in the carer support capacity of the whole area.</td>
</tr>
<tr>
<td>7. Stimulate the market</td>
<td>4</td>
<td>Stimulate and sustain a diverse provider market able to meet the National Carers’ Strategy and other health and well-being outcomes, reaching all carer groups and communities.</td>
</tr>
<tr>
<td>8. Promote improvement and innovation</td>
<td>4</td>
<td>Promote and specify improvements in quality and outcomes through provider innovation and reaching new groups and communities of carers.</td>
</tr>
<tr>
<td>9. Secure procurement skills</td>
<td>4</td>
<td>Secure commercial and procurement skills that enable a range of delivery options best suited to deliver on a range of carer support services and whole-area interventions.</td>
</tr>
<tr>
<td>10. Manage the local health system</td>
<td>5</td>
<td>Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes for carers.</td>
</tr>
<tr>
<td>11. Make sound financial investments</td>
<td>5</td>
<td>Make sound financial investments to ensure sustainable development of carer services and value for money.</td>
</tr>
</tbody>
</table>
Appendix B: The evidence base for carers’ support needs

Facts about carers in England

- Nearly five million people are carers
- One million people care for 50 or more hours per week
- Of the five million carers, 145,000 are children
- Young carers miss out on school and childhoods
- In the UK, two million people move in and out of caring each year.

With such high numbers of people acting as carers, this is a significant and fluid part of any area’s population, but one that requires constant effort to engage with. An approach across children's and adult services is required.

Some key statistics on the risks and inequalities that carers face

- More than half have given up work to care and, on average, carers retire eight years early.
- In Leicestershire, 3 per cent of carers reported that they had lost their homes as a direct result of caring. If reflected nationally, this would equate to 177,000 carers.
- Only 25 per cent of carers receive a carer’s assessment; 14 per cent of carers say it led to positive change.
- At least one in ten patients in the average GP practice are carers. The 2001 census found that carers caring more than 50 hours per week are twice as likely to report that they are not in good health as non-carers.
- In one study, 52 per cent of carers providing substantial care had been treated for stress-related disorders. In another, over half the sample said they were in good health. But General Health Questionnaires indicated that 94 per cent could be identified as having psychiatric disorders.
- Some 28 per cent of young carers have serious attendance or achievement problems in secondary school.

The health case for supporting carers is further developed in An Action Guide for Primary Care produced by the Royal College of General Practitioners and the Princess Royal Trust for Carers.

Research shows that different groups of carers share many basic needs. However, some groups face particular challenges. For example, the parent of a disabled child, the partner of a substance misuser and the working adult whose elderly parent has dementia will require very different service responses.
There is a huge range of research on the challenges and risks facing carers. Many research reports can be found at the Carers UK website, www.carersuk.org – and the evidence base is also outlined in the National Carers’ Strategy.

The Department of Health is funding local demonstrator sites for innovative approaches to breaks provision, better NHS support for carers and health checks for carers, which will generate new evidence.
Appendix C: Understanding the policy drivers and funding streams

The vision of the National Carers’ Strategy is that, by 2018, ‘carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals’ needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen.’

Analysis of an area’s achievement against these outcomes will be an important part of any Joint Strategic Needs Assessment (JSNA). JSNAs and impact assessments should consider the impact on carers of a wide range of services. Table 2 (pages 32–34) relates council performance assessment to these outcomes.

In addition to councils’ and health trusts’ core fundings, there are specific sources of funding linked to specific support for carers. These are:

- The Carers Grant (£240 million for 2009–10, £256 million for 2010–11). This is a non-ring-fenced allocation intended to ensure that carers are identified, informed and supported so they can take breaks. It now includes £25 million intended for emergency planning and support for carers.

- £150 million nationally (£50 million in 2009–10 and £100 million in 2010–11) has been included within PCT allocations, for breaks for carers. The operating framework for the NHS in England 2009/10 (paragraph 37, Section 2) highlights the expectation in the Carers’ Strategy that PCTs publish joint plans with their council partners for their combined spending on breaks.

- A further £105 million of new funding commitments are set out for 2008–11, including up to £38 million through Jobcentre Plus to help carers return to work.

The National Stroke Strategy

The National Stroke Strategy promotes carer support throughout the patient journey. The Strategy focuses on early supported discharge, which it has been argued is often unachievable without carer support. There are a number of quality markers (QMs) for NHS bodies to work towards, including:

- people who have had a stroke, and their relatives and carers, have access to practical advice, emotional support, advocacy and information throughout the care pathway and lifelong (QM3)

- individuals and their carers are involved in developing and monitoring services (QM4)

- a range of services needs to be locally available to support the individual long-term needs of people who have had a stroke and their carers (QM13)

- assessment and review of the needs of those affected by stroke (QM14).

QM 14 specifies that ‘People who have had strokes and their carers… are offered a review from primary care services of their health and social care status and
secondary prevention needs.’ This should be done within six weeks of discharge, and again within six months of leaving hospital, followed by an annual health and social care check (p45 of the Strategy). One of this quality marker’s measures is ‘greater proportion of carers receiving assessments’ (p46 of the Strategy).

To support implementation of the Strategy, and in addition to extra funding that has gone to PCTs, the Department of Health has announced £105 million over three years (2008–09 to 2010–11) for three priorities:

- local demonstration sites to help accelerate improvements in acute and community services
- the training of stroke physicians, nurses and allied health professionals
- improving public and professional awareness of the symptoms of stroke and the need to act quickly.

The Department of Health is encouraging PCTs to explore solutions offered by third sector organisations such as the carers’ charities, Connect, The Stroke Association, Different Strokes and Speakability.

**The End of Life Care Strategy**

There are around half a million people caring for the terminally ill at any one time and researchers found 84 per cent of them scoring over the threshold for psychological distress.\(^3^4\)

The End of Life Care Strategy\(^3^5\) sets out three key principles about how carers should be involved and supported in end of life care:

- carers should be treated as ‘co-workers’ with the health and social care team
- carers have their own needs and should be offered an assessment and a formal ‘carers care plan’, which should be subject to regular review
- the condition of the person who receives care should not affect how the carer is treated, or the services the carer may be able to access (p107).

Practically, this means that carers should be:

- closely involved in decision-making, alongside recognition of their own needs
- offered information about the person’s condition and services which are available
- offered support in their caring role
- offered practical and emotional support both during the life of the person receiving care and after bereavement.

**The National Dementia Strategy**

*Living well with dementia* (the National Dementia Strategy)\(^3^6\) states that ‘Family carers are the most important resource available for people with dementia’ (p12). The Secretary of State’s foreword states that ‘we must develop a range of services for people with dementia and their carers which fully meets their changing needs over time’ (p4). Information for carers on the condition
and support available should be offered at the point of diagnosis and throughout their caring role (p11), with specialist dementia advisers able to advise both those with dementia and their carers. ‘Implementing the Carers’ Strategy’ is one of the key objectives of this Strategy (p12).

**National Framework for Continuing Healthcare**

Increasing numbers of people with complex long-term medical needs are being offered care packages from NHS Continuing Care. In some cases, the needs of carers have been overlooked. The Framework\(^\text{37}\) includes:

‘35. Assessments of eligibility for NHS continuing healthcare and NHS-funded nursing care should be organised so that the individual being assessed and their representative understand the process, and receive advice and information that will maximise their ability to participate in informed decision making about their future care. Decisions and rationales that relate to eligibility should be transparent from the outset: for individuals, carers, family and staff alike.’

and

‘45. PCTs and LAs should bear in mind that a carer who provides (or intends to provide) substantial care on a regular basis has a right to have their needs as a carer assessed (Carers and Disabled Children Act 2000, as amended by the Carers (Equal Opportunities) Act 2004). Should a PCT identify a carer in the course of its assessment process, it should inform them of their right to a carer’s assessment and advise them to contact their LA – or, with their permission, refer them for this purpose. PCTs and LAs should be mindful of the approaches set out in the national strategy for carers – *Carers at the heart of 21st century families and communities.*’

Councils have a legal obligation to offer carers a carer’s assessment, whether the person they care for receives their support package from the council or the NHS. Personal budgets are being piloted by PCTs as a way of co-ordinating continuing care entitlements with other funding sources. In a number of cases, the success of these approaches has hinged on the carer acting as a care co-ordinator or even being paid for some of their caring from continuing care budgets.

**Hospital discharge guidance**

Support for carers can aid swift and successful hospital discharge. Statutory guidance to the Community Care (Delayed Discharges etc.) Act 2003 puts in place a number of steps to ensure that carers:

- are involved in discharge planning
- can ask for an assessment (under the Carers and Disabled Children Act 2000) of any services they need to support the discharge of the person they care for
- are given such an assessment if they are already receiving carers’ services or have had a carer’s assessment in the previous 12 months
receive the services, or direct payments for the services, they need to support the safe discharge of the person they care for, ‘within the same timeframe as any community care services which are provided to the person being cared for’ (p37 of the statutory guidance).

Councils and the NHS share responsibilities at the point of discharge. Single assessment process (SAP) guidelines require older people’s discharge assessments to be delivered jointly by health trusts and councils. They state that ‘The perceptions of family members and carers’ and any risks to carers must be established by the SAP.38 This is one of the many areas of carer support where joint commissioning between health trusts and councils should be considered.

Valuing People Now

It is estimated that over half of all adults with a learning disability (approximately 1.2 million people in the UK) are supported by family carers across all age ranges.39 In addition, there are many parent carers of children and adolescents with learning disabilities.

Valuing People Now: a new three-year strategy for people with learning disabilities40 (HM Government, 2009) highlights one of the recommendations of Healthcare for All41, ‘family and other carers should be involved as a matter of course as partners in the provision of treatment and care’ (p65).

Among other actions, the Valuing People Now strategy intends to achieve this at a national level by:

- ensuring that Department of Health Deputy Regional Directors in each Government Office Region improve capacity and capability of local planners in working with family carers
- investing in carers’ organisations to build their capacity for family carers of people with learning disabilities, and carers who have a disability
- exploring how to introduce carers’ impact assessments on all new government policies relevant to family carers of people with learning disabilities (pp 47–48).

Activity encouraged at a local level includes ensuring that Regional Valuing People Boards support their local Learning Disability Partnership Boards (LDPBs) in assessing areas’ needs and existing service provision.

What will be the likely impact of the new Equality Bill?

Subject to Parliamentary approval, the new Equality Bill will require commissioners to use Equality Impact Assessments to make sure that services do not directly discriminate against carers.
### Appendix D: Outcomes and domains from the Performance Assessment Guide for adult services

<table>
<thead>
<tr>
<th>Outcome 1:</th>
<th>Improved health and emotional well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 2:</td>
<td>Improved quality of life</td>
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<tr>
<td>Outcome 3:</td>
<td>Making a positive contribution</td>
</tr>
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<td>Outcome 4:</td>
<td>Increased choice and control</td>
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<td>Outcome 5:</td>
<td>Freedom from discrimination and harassment</td>
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<td>Outcome 6:</td>
<td>Economic well-being</td>
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<tr>
<td>Outcome 7:</td>
<td>Maintaining personal dignity and respect</td>
</tr>
<tr>
<td>Domain 8:</td>
<td>Leadership</td>
</tr>
<tr>
<td>Domain 9:</td>
<td>Commissioning and use of resources</td>
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</table>
Appendix E: The EU laws on open tendering and types of funding

All public bodies must comply with EU procurement law, which stipulates opening up many funding arrangements to competition through open tendering.42 However, this applies in full only to contracts over the current threshold (in 2008, service supply contracts totalling £139,893 or more).

Carer support services usually fall into Part B of the EU Directive which does not require advertisement of tenders.43 So commissioners can choose the best combination of funding arrangements to put in place, providing they follow the principles of ‘non-discrimination, equal treatment, transparency, mutual recognition and proportionality’.44

Treasury guidance states that ‘funding bodies need to decide on which form of funding is most likely to generate the desired outcome, and how the basis of funding chosen will best support the funded organisation.’45

The use of grant giving

Grant giving is not subject to EU procurement law, but most councils have standing orders setting the (usually low) maximum amounts that can be given out as grants. Where a grant is made for a specific purpose (‘restricted funding’), there is a fine line between this and a public procurement contract.46 To ensure the stability or development of an essential long-term strategic partner organisation, ‘Grant in aid’ can be given without conditions.

Most grants, however, have conditions attached. Ideally, these conditions should specify a set of deliverable and measurable outcomes which are likely to be seen as important by commissioners in years to come. Grants can be used to build an organisation’s capacity to compete on an equal footing for future contracts, providing this is done in advance of tenders being advertised.47,48

The use of tendering

There are four main types of tendering:

- open tendering, where a contract is widely advertised and all can apply
- restricted tendering, where a contract is advertised and a ‘preferred provider’ list is made
- ‘Competitive dialogue’, where the contractor enters into a number of rounds of discussions with potential bidders from its preferred provider list, progressively defining the terms of a contract
- negotiated tendering with one or more selected bidders. This method is usually only acceptable when there are only one or two contractors capable of meeting the contract.49

EU public sector directives will also soon recognise ‘framework agreements’ which are a variety of ‘preferred provider agreement’. These establish the terms and conditions under which specific purchases (‘call-offs’) can be made during a given period, particularly with regard to price and quantity.
These are likely to be applied in some areas to breaks services, but can limit the flexibility of those services in setting prices according to current needs and market conditions.

**Full cost recovery and social return on investment (SROI)**

Whatever the funding methods used, the provider market in an area will only be sustainable in the long term when contracts recognise the need for providers to meet their core costs, and costs directly related to a particular service or project.\(^{50}\)

Considering a potential provider’s SROI\(^{51}\) is one of the ways in which commissioners can assess their wider value. Social clauses\(^{52}\) in tenders assess how an organisation’s delivery methods benefit the target community, for instance by engaging ex-carers as volunteers or employees to support carers.

Similarly, the ‘co-production’ principle requires that the recipients of services and their carers participate in every stage of service design, delivery and evaluation. It is increasingly written into tender specifications.

The Compact with the third sector\(^{53}\) is the Government’s national framework for how relationships between government and the voluntary sector should be conducted. Most local areas have developed a local compact.\(^{54}\) General principles for commissioning from the third sector are set out in the Compact Funding and Procurement Code.\(^{55}\) In addition, the Compact’s Commissioning Guidance sets key points to consider at each stage in the cycle.
Appendix F: Sources of help and further reading


- World Class Commissioning: www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/DH_083204


3 Commissioning for Personalisation: A Framework for Local Authority Commissioners, Department of Health, 2008, sets out a multi-level approach to commissioning which illustrates that, in order to allow individual commissioning to be successful and represent real choice, there is a need for commissioning activity at individual but also at operational and strategic (local and regional) levels. At http://networks.csip.org.uk/Personalisation/PersonalisationToolkit/Blueprint/Commissioning/?parent=3110&child=3241

4 WCC competency 3 (Engage with public and patients) states that a good commissioner routinely ensures ‘that patients and the public can share their experiences of health and care services and uses this to inform commissioning’. No excuses. Embrace partnership now. Step towards change! Report of the Third Sector Commissioning Task Force, Department of Health, 2006, advocates ‘systematic involvement of health and social care service users at all stages of the commissioning process’ and ‘understanding among commissioners about the third sector, and its potential to add value to needs assessment, strategic planning, and to empowerment of service users and community capacity building, as well as the delivery of services.’ At www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137144

5 For example, the We Care Too reports on black and minority ethnic carers at www.afiya-trust.org.uk


8 Putting People First: A shared vision and commitment to the transformation of Adult Social Care, HM Government, 2008.

9 Full details can be found at www.cqc.org.uk/guidanceforprofessionals/socialcare/councils/performanceassessment/performanceassessmentguide2008-09.cfm

10 Putting People First: A shared vision and commitment to the transformation of Adult Social Care, HM Government, 2008.

11 See good practice examples in Putting People First without putting carers second and the Action Guide for Primary Care at www.carers.org/professionals


13 Assessment rights are explained in Luke Clements, Carers and their rights: The law relating to carers, Carers UK, 2009, at www.carersuk.org/Professionals/ResourcesandBriefings/Carersandtheirrights


16 See Putting People First without putting carers second at www.carers.org/professionals


18 This is also explained in Clements, Carers and their rights: the law relating to carers, pp24–6 and 31.

21 See WCC competency 7 (Stimulate the market).
23 UK Census 2001, except where separately referenced.
25 Real change, not short change: Time to deliver for carers, Carers UK, 2007.
26 National Carers’ Strategy Consultation, submission from CLASP Carers Centre in Leicestershire, 2007.
30 Unpublished 2002 research from Torbay Care Trust and Manchester Personal Social Services Research Unit.
34 Caring for someone with a terminal illness – some facts and figures, Help the Hospices, July 2008, p1.
SingleAssessmentProcess
41 Independent inquiry into access to healthcare for people with learning disabilities, at www.iahpld.org.uk
43 Ibid: ‘Some degree of advertising, which is appropriate to the scale of the contract, is likely to be necessary to demonstrate transparency’ (paragraph 7.1).
44 Ibid.
45 Guidance to Funders: Improving funding relationships for voluntary and community organisations, HM Treasury 2003 updated in 2005, particularly chapter 4 (Wider Funding Context), at www.hm-treasury.gov.uk/spend_ccr_guidance.htm
Think Smart… Think Voluntary Sector! Good Practice Guidance on Procurement of Services from the Voluntary and Community Sector explicates the fine line between procurement: ‘the acquisition of goods and services from third party suppliers under legally binding contractual terms’ (paragraph 4.1), and grant giving: ‘The grant giver is not contracting for a service which forms part of its own business. It is offering financial support to a VCO in an area of work, designed and proposed by the VCO, which it wishes to sponsor’ (paragraph 4.2).


Think Smart… Think Voluntary Sector! Good Practice Guidance on Procurement of Services from the Voluntary and Community Sector (p6).


Funding and Procurement: Compact Code of Good Practice (Appendix D), Home Office Active Communities Unit, 2000 (revised 2005).


There is a definition of ‘social clause’ in the Office of the Third Sector’s Report of the Social Clauses Project 2008, at www.cabinetoffice.gov.uk/thirdsector

See www.thecompact.org.uk

The Compact Mediation Scheme is available to help in conflicts. This is backed up by recourse to the Local Government Ombudsman.

Funding and Procurement: Compact Code of Good Practice (Appendix D), Home Office Active Communities Unit, 2000 (revised 2005).