

Appendix 1

Memorandum of Understanding

Supporting an integrated approach to the identification and assessment of carers' health and wellbeing needs

1. Introduction

This memorandum of understanding (MOU) sets out the agreed approach to supporting the implementation of an integrated approach to the identification and assessment of carers' health and wellbeing needs across Wiltshire. The document has been developed from a national template published by NHS England and others. It has been supported by key partners in the health and social care system who are committed to working together for carers of all ages.

2. What is a carer?

A carer could be someone of any age, including a child, who provides unpaid support (excluding voluntary work) to a family member or friend who could not always manage without help. This could be caring for a relative (a parent, grandparent, sibling, child, spouse, partner) or friend who is ill, frail, disabled or who has mental health or substance misuse problems.

Wiltshire carer definitions:

Carer: Someone (aged 18 or over) who helps another person in their day to day life, usually a relative or friend, who could not always manage without that support. This is not the same as someone who provides care professionally or through a voluntary organisation.

Parent Carer: A parent, or other adult with parental responsibility, who cares for a child or young person who requires more care and support than other children or young people of the same age.

Young Carer: A child or young person who cares for another person. This may be someone in their family who needs looking after because they have a disability or illness. It could be a brother or sister or a parent or grandparent. A young carer should not have to do so much caring that it makes them upset, unwell or miss school.

3. Key principles

The integrated approach to identifying and assessing carers' health and wellbeing needs rests on a number of supporting principles.

3.1 Principle 1 - Carers will receive an integrated package of support in order to maintain their physical health and emotional well-being

The role of the GP, as the one person all carers have access to, is recognised as being paramount in supporting carers and maintaining the capacity of carers to care. There is a need to improve the registration of carers, including young carers, in primary care so that the needs of carers can be identified more quickly and before their health and wellbeing deteriorates. Thus GPs have a unique opportunity to make a telling contribution to improving the lives of carers of all ages and regardless of the age of the person they are caring for.

3.2 Principle 2 - Carers are supported and empowered to manage their caring role and their life outside of caring

- Referral to the local carer support organisation is the best way to ensure that carers receive the support they need when they need it.
- Carers will be supported to exercise choice and make well-informed decisions about the support options available to them.
- The wellbeing needs of the carer's family will be taken into account when identifying suitable support.
- The carer will be supported to plan for life beyond caring.
- Young carers will be seen as children first.

3.3 Principle 3 - All health and social care staff will be aware of the needs of carers and of referral routes to access local support. NHS staff will recognise signs of distress and diminished capacity that may affect the ability or willingness of carers to continue caring, so that they can ask the carer if they are in need of support. NHS staff will also be aware of local carer support organisations so that the carer can be sign-posted.

In some cases it may be appropriate for health and social care staff and education professionals to make the referral on behalf of the carer. It is acknowledged that, in order to identify carers and any needs for support they have, health and social care staff and education professionals would benefit from carer awareness training. Provision of carer awareness training in health and social care induction and ongoing professional development programmes is acknowledged to be desirable.

3.4 Principle 4 - Carers will be supported by the improved sharing of information between health, social care, education professionals and carer support organisations.

One of the biggest risks to carers is the failure to share information sensibly. We will work to remove the burden of carers having to repeat information and will reduce the barriers to effective sharing of information.

Improved sharing of information will help to identify vulnerable carers earlier, improve the identification of carers and their support needs, and improve the responsiveness of support to the changing needs of carers.

3.5 Principle 5 - Carers will be respected as expert care partners and will be involved in the planning of care for the cared for, including being involved in shared decision-making, and in the planning and redesign of services.

- Carers will be involved in the planning of care for the person they care for in a way that is appropriate to their age, understanding and circumstances.
- Carers will have their views taken into account when planning care in advance.
- Carers will be fully engaged in the planning, redesign and shaping of services. Services will be continuously monitored and reviewed, with carers' inputs, in order to demonstrate where desired health and social care outcomes are being achieved and to identify those areas in need of improvement.

3.6 Principle 6 - The needs of vulnerable carers, particularly those at key transition points, will be identified early.

This will enable carers to access preventive and other support resources to meet their needs as they approach key transition points:

- Being identified as, or identifying themselves as, a carer
- Changes in the condition of the person they care for
- Young carers as they leave primary school and approach secondary school
- Young carers as they move from adolescence to adulthood
- Parents as carers, particularly parents of children with physical or learning disabilities as they leave the family home
- Changes in employment status (reducing hours, leaving work or going back to work)
- Changes in their own health
- Recognition of additional support needs towards the end of the caring role and of the needs of bereaved carers.

4. Understanding the duty of co-operation

The Care Act 2014 introduces a number of reforms to the way that care and support for adults with care needs are met. It requires local authorities to adopt a whole system, whole council, whole-family approach, co-ordinating services and support around the person and their family and considering the impact of the care needs of an adult on their family, including children.

In several places, the Act makes provision for all carers, including young carers. This “whole system” approach bestows a duty of co-operation on local authorities and all agencies involved in public care.

What is the duty of co-operation?

The Care Act now makes integration, co-operation and partnership a legal requirement on local authorities and on all agencies involved in public care, including the NHS, independent or private sector organisations, housing, and the Care Quality Commission (CQC).

Who has the duty to co-operate?

Relevant partners of a local authority include any other local authority with which they agree it would be appropriate to co-operate and the following agencies or bodies who operate within the local authority’s area including:

- NHS England
- Clinical Commissioning Groups
- NHS trusts and NHS Foundation Trusts
- Any NHS-funded service
- Job centres
- Justice - the Police, prisons and probation services
- Education services
- Housing.

Source: Chapter 15 of the statutory guidance

The NHS England Planning Guidance, *Five Year Forward View into Action*, sets out how the NHS will seek to implement its duties under the above acts, including a clear expectation that, “CCGs alongside local authorities...draw up plans to identify and support carers and, in particular, working with voluntary sector organisations and GP practices, to identify young carers and carers who themselves are over 85, and provide better support”.

Further, “In developing plans, CCGs should be mindful of the significant changes to local authority powers and duties from April 2015 under the Care Act 2013[sic]. Plans

should focus on supporting young carers and working carers through the provision of accessible services, and services for carers from vulnerable groups”.

Copies of the NHS England Planning Guidance can be accessed by clicking on the icon below:



NHS England
forward-view-
planning.

5. Understanding the duty to promote wellbeing

The general duty of a local authority towards individuals, under Section 1 of the Care Act 2014 is “to promote that individual’s well-being”. Local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person, and that person should be enabled to participate as fully as possible in decisions at every stage in their care.

What is “wellbeing”?

Wellbeing is a broad concept and it is described as relating to the following areas in particular:

- personal dignity, including treatment of the individual with respect
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation.
- the individual’s contribution to society.

Source: Chapter 1 of the statutory guidance

There is no hierarchy to these areas, and all should be considered of equal importance when considering “wellbeing” in the round, for the individual concerned.

Further, wellbeing cannot be achieved simply through crisis management; it must include a focus on delaying and preventing care and support needs from developing and escalating, and on supporting people to live as independently as possible for as long as possible.

It is recognised that social care and voluntary sector care practitioners may not always be qualified to clinically assess a carer’s physical or mental health. Where a health need is identified as part of the assessment, the carer should be referred back to their GP so

that this health need may be addressed.

6. Understanding the duties to address the needs of Young Carers, Parent Carers and to adopt a “whole family approach”

Both the Care Act 2014 and the Children and Families Act 2014 address the needs of young carers clearly and directly. The Children and Families Act 2014 sets out new rights to improve how young carers and their families are identified and supported, and extends the right to an assessment of their support needs to all young carers under the age of 18 regardless of who they care for, what type of care they provide or how often they provide it.

This change also introduces a requirement to make an assessment on the appearance of need. The new provision works alongside measures in the Care Act 2014 to enable a “whole-family approach” to assessment and support, for example in addressing the inter-related needs of young carers and their families.

The intention of the whole family approach is for local authorities and their partner agencies to take a holistic view of the person’s needs, in the context of their wider support network. The approach must consider both how the adult or their support network or the wider community can contribute towards meeting the outcomes they want to achieve (see above), and whether or how the adult’s needs for care and support impacts on family members or others in their support network.

There is a particular need for NHS bodies and the local authority to work closely when planning to support the discharge of patients from hospital and this is covered by Schedule 3 of the Care Act 2014.

7. Delegation of authority for carers’ needs assessments

The Care Act 2014 provides for local authorities to delegate some, but not all, of their care and support functions to other parties. This power to delegate is intended to allow flexibility for local approaches to be developed in delivering care and support, and to allow local authorities to work more efficiently and innovatively, and provide better quality care and support to local populations. However, as with all care and support, individual wellbeing should be central to any decision to delegate a function.

Delegation does not absolve the local authority of its legal responsibilities. When a local authority delegates any of its functions, it retains ultimate responsibility for how the function is carried out.

The Care Act is clear that anything done (or not done) by the third party in carrying out the function, is to be treated as if it has been done (or not done) by the local authority itself. This is a core principle of allowing delegation of care and support functions.

Where a local authority delegates its responsibility for carers' needs assessments, it needs to assure itself that these assessments are compliant with the Care Act.

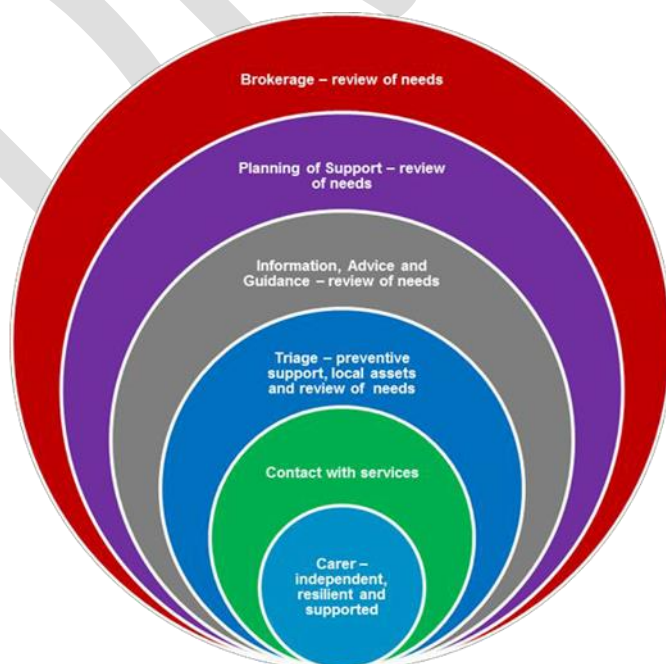
8. An integrated approach to the identification and assessment of carers' health and wellbeing needs across health and social care

The aim of this work is to develop an integrated approach to the identification and assessment of carers' health and wellbeing needs across health and social care to:

- a. Maintain the independence, physical health and emotional wellbeing of carers and their families
- b. Empower and support carers to manage their caring roles and have a life outside of caring
- c. Ensure carers receive the right support, at the right time, in the right place
- d. Respect the carer's decision about how much care they will provide and respect the carer's decision about not providing care at all

This pathway was co-designed with input from regional ADASS Carer Policy Network meetings, national and local carer support organisations, NHS England regional nursing staff and members of individual clinical commissioning groups. The proposed combined pathway sits on a number of supporting principles which are discussed more fully below and which will be used to support and promote the implementation of a combined process across health and social care.

The proposed integrated approach for identifying and assessing carers' and wellbeing needs



The central aim is to keep the carer at the centre, or core, of the “onion”. This preserves the carer’s independence, their family and social network relationships, and their ability to undertake their caring role. The carer’s GP has a crucial role in supporting and maintaining carer health and wellbeing and to initiate the discussion about the carer’s support needs.

9. Benefits of the integrated approach

- Focus is on supporting the independence of carer and the wellbeing of the carer and their families
- Needs of carer and their families are identified as, or before, they arise
- Fast track to preventive and low-level support, including wellbeing checks
- Safeguarding issues highlighted more quickly
- Reduced carer/family crisis and breakdown
- Avoids placing the carer in a potentially lengthy bureaucratic process that might not meet their actual needs
- Avoids unnecessary referral to more complex services and reduced unnecessary demand on these more complex (and more costly!) services
- Identification of other local assets available to support the carer
- Emphasis on meeting the needs of the carer as, or before, they arise
- Support needs of the carer are continually reviewed
- The carer is supported at key transition points, including as they approach the end of their caring role

10. Moving forwards

The commitment made by organisations who sign this Memorandum of Understanding will support the implementation of the Wiltshire Carers Strategy. The implementation of the strategy will be led and monitored by the Wiltshire Carers Action Group.

Implementation of the strategy will include improving awareness and understanding of carers, their families, and local carer support. This will include ensuring that professionals in the local authority and partner agencies are aware of the specific requirements concerning carers of the Care Act 2014 and amendments to the Children and Families Act and accompanying Guidance and Regulations. It will also include raising awareness and understanding of carers and the caring role in the wider community to contribute building resilient communities where carers feel understood, respected and supported within and by their community.

11. Thinking Carer across the system

By supporting carers we are also supporting the person they care for. No one should have to care alone. In order to ensure that carers receive the right support at the right time and in the right place, carers should be referred to the local carer support organisation to have their immediate wellbeing needs addressed, regardless of which service or agency is contacted first.

Partnership working and co-operation is key to providing joined up seamless services. This will include joint working between the local authority, the NHS, voluntary organisations, education, public health, housing and local communities to support carers.

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Signature	Name and Role	Organisation	Date
		Wiltshire Council	
		NHS Wiltshire Clinical Commissioning Group	
		Salisbury Hospital Foundation Trust	
		Bath Royal United Hospital	
		Great Western Hospital	
		South West Ambulance Service NHS Foundation Trust	
		Avon and Wiltshire Mental Health Partnership	
		Healthwatch Wiltshire	
		Carer Support Wiltshire	