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Summary: Intervention & Options

Department /Agency:
Department of Health

Title:
Impact Assessment of the Health and Social Care proposals in the Carers' Strategy

Stage: Final

Version: 1.8

Date: 10 June 2008

Related Publications: Carers at the heart of 21st century families and communities

Available to view or download at:

<http://www.dh.gov.uk>

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What is the problem under consideration? Why is government intervention necessary?

Care provision can place a mental and physical burden upon some of the 6m carers in England, leading to poorer outcomes and health inequalities. A number of ambitions set out in the 1999 Strategy on Carers have not been fulfilled and the regulatory framework has altered since then. Some services for carers are available but imperfect information and externalities often mean services which may improve carer outcomes are below optimum. Government intervention is required to improve carer outcomes, decrease inequalities and to reduce the difficulties associated with imperfect information.

What are the policy objectives and the intended effects?

The strategy as a whole seeks to improve the support offered to carers in their caring roles whilst ensuring that they have the opportunities to lead a life outside caring, e.g. through the provision of breaks from caring. It seeks to ensure that carers do not have their health compromised by their caring role and to mitigate the financial burden involved in caring, which will contribute to the overall objective described above. Carers should, through better information and improved service provision, be able to have the same choice and control over their lives as any other person who does not have a caring role.

What policy options have been considered? Please justify any preferred option.

Option 1 - Do nothing.

Option 2 - Implement proposals 1 to 6 only.

Option 3 - Implement proposals 1 to 12.

Option 4 - Implement all of the proposals.

Following the analysis on proposals 7 to 15, option 2 is the preferred option, see evidence base for detail.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? This is set out in the implementation chapter of the strategy, see Annex 4. The Standing Commission on Carers will inform a new programme board and monitor the implementation of the strategy. A full review will take place in 2011.

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:

A handwritten signature in black ink, appearing to read "Ian Lewis". The signature is written in a cursive style with a large initial "I".

Date: 09 June 08

Summary: Analysis & Evidence

Policy Option: 2

Description: PREFERRED OPTION Implement proposals 1 to 6 only

COSTS	ANNUAL COSTS		Description and scale of key monetised costs by 'main affected groups' The key components of the £77 million average annual costs (in real terms, not PV) are: Information services £4m (9 years); Care breaks, including pilots £68m; Support for third sector £1m; Training for key professionals £4m. These are net costs after savings to the exchequer.
	One-off (Transition)	Yrs	
	£ 10 million	4	
	Average Annual Cost (excluding one-off)		
	£ 77 million	10	Total Cost (PV) £ 689 million
Other key non-monetised costs by 'main affected groups' Non-quantified costs include more services (other than those included in the strategy) being used by carers, which may also increase administration costs.			

BENEFITS	ANNUAL BENEFITS		Description and scale of key monetised benefits by 'main affected groups' The key components of the £139 million average annual benefits (in real terms) are: Information Services £2m (9 years), Care breaks, including pilots £141m; NHS pilots -£1m; Training for key professionals -£4m. These are net benefits after negative benefits (i.e. costs) to other parties.
	One-off	Yrs	
	£ -1 million	4	
	Average Annual Benefit (excluding one-off)		
	£ 139 million	10	Total Benefit (PV) £ 1,236 million
Other key non-monetised benefits by 'main affected groups' Non-quantified benefits include improved welfare of carers and people they support. Greater choice and flexibility of replacement care. Improvement in carers' physical health. Increased carer social interaction. Greater evidence on carers to help improve future policy and spending decisions.			

Key Assumptions/Sensitivities/Risks Costs, benefits and funding for year 2 onwards subject to funding decisions. Assumed carers largely demand in-home replacement care when given a choice. There may not be spare capacity in the replacement care market to meet demand. If capacity has to expand to meet demand higher wages will be required to attract additional staff into the care sector.

Price Base Year 2009	Time Period Years 10	Net Benefit Range (NPV) £ 221 to 806 million	NET BENEFIT (NPV Best estimate) £ 547 million
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What is the geographic coverage of the policy/option?		England	
On what date will the policy be implemented?		June 2008	
Which organisation(s) will enforce the policy?		LAs, PCTs	
What is the total annual cost of enforcement for these organisations?		£	
Does enforcement comply with Hampton principles?		Yes	
Will implementation go beyond minimum EU requirements?		Yes	
What is the value of the proposed offsetting measure per year?		£	
What is the value of changes in greenhouse gas emissions?		£	
Will the proposal have a significant impact on competition?		No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium Large
Are any of these organisations exempt?	Yes/No	Yes/No	N/A N/A

Impact on Admin Burdens Baseline (2005 Prices)		(Increase - Decrease)	
Increase of £	Decrease of £	Net Impact	£

Key:

Annual costs and benefits: Constant Prices

(Net) Present Value

Summary: Analysis & Evidence

Policy Option: 3	Description: Implement Proposals 1 to 12
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COSTS	ANNUAL COSTS		Description and scale of key monetised costs by 'main affected groups' As option 2 (£77m per annum), plus replacement care for hospital and screening appointments £59m and specialist carers' services £13m (net costs after savings to the exchequer, real terms average per annum for 7 years)
	One-off (Transition)	Yrs	
	£ 10 million	4	
	Average Annual Cost (excluding one-off)		
£ 148 million	10	Total Cost (PV) £ 1,270 million	
Other key non-monetised costs by 'main affected groups' As option 2 plus short run impact on NHS costs due to higher demand for screening and the costs of proposals 9 to 12.			

BENEFITS	ANNUAL BENEFITS		Description and scale of key monetised benefits by 'main affected groups' As option 2 (£139m per annum), plus hospital and screening appointments £63m (net benefits after negative benefits (i.e. costs) to other parties, real terms average per annum for 7 years)
	One-off	Yrs	
	£ -1 million	4	
	Average Annual Benefit (excluding one-off)		
£ 202 million	10	Total Benefit (PV) £ 1,766 million	
Other key non-monetised benefits by 'main affected groups' As option 2, plus reduction in GP appointments due to early identification of carers. Health benefits of replacement care for hospital appointments other than screening. Better use of NHS resources due to fewer appointments being missed. Benefits of proposals 9 to 12.			

Key Assumptions/Sensitivities/Risks As option 2, plus assumptions around take-up rate of replacement care for hospital visits and how many carers using this replacement care may have attended anyway (deadweight loss) and assumptions on how many areas already have specialist carers' services.

Price Base Year 2009	Time Period Years 10	Net Benefit Range (NPV) £ -125 to 859 million	NET BENEFIT (NPV Best estimate) £ 495 million
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What is the geographic coverage of the policy/option?			England		
On what date will the policy be implemented?			June 2008		
Which organisation(s) will enforce the policy?			LAs, PCTs		
What is the total annual cost of enforcement for these organisations?			£		
Does enforcement comply with Hampton principles?			Yes		
Will implementation go beyond minimum EU requirements?			Yes		
What is the value of the proposed offsetting measure per year?			£		
What is the value of changes in greenhouse gas emissions?			£		
Will the proposal have a significant impact on competition?			No		
Annual cost (£-£) per organisation (excluding one-off)		Micro	Small	Medium	Large
Are any of these organisations exempt?		Yes/No	Yes/No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)			(Increase - Decrease)	
Increase of £	Decrease of £	Net Impact		£

Key: Annual costs and benefits: Constant Prices (Net) Present Value

Summary: Analysis & Evidence

Policy Option: 4

Description: Implement all the proposals

COSTS	ANNUAL COSTS		Description and scale of key monetised costs by 'main affected groups' As option 3
	One-off (Transition)	Yrs	
	£ 10 million	4	
	Average Annual Cost (excluding one-off)		
	£ 148 million	10	Total Cost (PV) £ 1,270 million
Other key non-monetised costs by 'main affected groups' More services (other than those included in the strategy) being used by carers, which may also increase administration costs. Short run impact on NHS costs due to higher demand for screening. Costs of proposals 9 to 15.			

BENEFITS	ANNUAL BENEFITS		Description and scale of key monetised benefits by 'main affected groups' As option 3
	One-off	Yrs	
	£ -1 million	4	
	Average Annual Benefit (excluding one-off)		
	£ 202 million	10	Total Benefit (PV) £ 1,766 million
Other key non-monetised benefits by 'main affected groups' As option 3 plus benefits of proposals 12-15.			

Key Assumptions/Sensitivities/Risks As option 3, plus it is assumed that additional benefits from the additional proposals would be minimal because of the work that is already being undertaken across government detailed in the evidence section.

Price Base Year 2009	Time Period Years 10	Net Benefit Range (NPV) £ -125 to 859 million	NET BENEFIT (NPV Best estimate) £495 million
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What is the geographic coverage of the policy/option?			England	
On what date will the policy be implemented?			June 2008	
Which organisation(s) will enforce the policy?			LAs, PCTs	
What is the total annual cost of enforcement for these organisations?			£	
Does enforcement comply with Hampton principles?			Yes	
Will implementation go beyond minimum EU requirements?			Yes	
What is the value of the proposed offsetting measure per year?			£	
What is the value of changes in greenhouse gas emissions?			£	
Will the proposal have a significant impact on competition?			No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	Yes/No	Yes/No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)			(Increase - Decrease)	
Increase of	£	Decrease of	£	Net Impact £

Key: Annual costs and benefits: Constant Prices (Net) Present Value

Introduction

Background

The 2001 Census shows that there were over 5.2m carers in England and Wales. Future demographic changes imply an increase in demand for care. The consultations for the 2005 Green Paper¹, and 2006 White Paper *Our health our care our say*², observed calls for more action to support carers both from carers themselves and lobby groups. In addition, a number of the ambitions set out in the 1999 strategy have not been fulfilled. The legislative framework have also significantly altered since 1999 with the **Carers and Disabled Children Act 2000**, the **Carers (Equal Opportunities) Act 2004** and the **Work and Families Act 2006**.

Carers are the largest source of care for vulnerable people in England. Carers UK claim that carers save the government £87bn a year in terms of the care that they provide and the support for them in these often difficult roles is not at the right level. With the forecast demographic changes the need for care will grow and it is important that they are supported so that they can continue in their role whilst being able to lead a life outside caring. The family is the traditional provider of such care and future policy must ensure that family members are supported so that they continue to play their full part in this key social role.

The Standing Commission on Carers will have a role in monitoring the implementation of the strategy. In addition, a cross-government programme board is being set up to provide a lead on the work that arises from the strategy.

Rationale for government intervention

Some state and third sector services to support carers are available but these are below the optimum. Carers are often unaware of the potential benefits of these services and in some cases are unaware even of their existence. Providers, such as local authorities and the NHS, also do not recognise the full benefits of providing services to the carer either for them as individuals or for the people they support. In addition, there are major issues around imperfect information and the ignorance and uncertainty that this causes for carers. Government intervention is necessary to help correct for these market failures that lead to under-provision and under-utilisation of services

Government intervention is required to improve inequalities experienced by carers, i.e. in terms of their health, caused by the burden that caring can place upon them and the lack of opportunities caused by their caring role. In the absence of government intervention, there is no market mechanism that would enable carers to improve their outcomes. The strategy may also enhance beneficial positive externalities through improvements for both the carer and the person they support.

Outcomes

There are five outcomes cited in the Carers' Strategy to which each of the proposals is linked. They are:

¹ *Independence, well-being and choice*, Department of Health, 2005

² *Our health, our care, our say: a new direction for community services*, Department of Health, 2006

1. Carers will be respected as expert care partners and will have access to the integrated support and personalised services they need to support them in their caring role.
2. Carers will be able to have a life of their own alongside their caring role.
3. Carers will be supported so they are not forced into financial hardship by their caring role.
4. Carers will be supported to stay mentally and physically well and treated with dignity.
5. Children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive to enjoy positive childhoods and to achieve against all the Every Child Matters³ outcomes.

Benefits from achieving the objectives

- The term 'carer' covers a range of people of all ages and hours of care. The 2001 Census indicated that approximately one fifth of the carers in England care for more than 50 hours a week. Carers' need for support is often in direct proportion to the intensity of caring they provide. Carers do not usually switch in and out of caring, but the intensity of caring provided will vary greatly from carer to carer. Carers generally fulfil a caring role for long periods; on average, they care for around 8 years⁴.
- The key benefit of the strategy will be to reduce some of the negative impact on an individual's life which can be associated with caring, by both allowing carers more choice and control over the uses of their time and reducing the physical and psychological burden that caring can impose. The strategy aims to support carers more appropriately in their delivery of care, rather than to change the amount of care delivered by individuals. The support for carers through the strategy will directly substitute some hours of paid care for some hours of voluntary care, while conversely the provision of this support is likely to enable and encourage more people to continue with or to assume a caring role. The impact on the overall amount of care is ambiguous, but, within the overall total, the strategy will enable some carers to make changes to the use of their time and therefore be in a position better to control their own lives. The social value of any such changes are expected to be positive if they arise from the voluntary decisions of carers where they are given adequate support in recognition of the positive social externalities associated with caring.
- There is evidence to show, as the length of care increases, carers move from full-time to part-time employment and take more junior positions⁵. The decision to move into or out of employment, or between full- and part-time work, is a significant decision influenced by many factors. The Wanless review⁶ suggests the provision of formal services may not reduce the hours of informal care but there may be some change in the type of care that is provided. Therefore, one may not expect to observe any large substitution effect for proposals such as the relatively low levels of replacement care. This would lead to the suggestion that the health and social care proposals would be unlikely to change the employment status of carers in general, but may have an impact on some carers at the margins of these decisions.
- Evidence shows that carers' outcomes are poor compared to the rest of the population. For example, the 2001 Census highlighted that carers who provide a high level of care (50 or more hours) are twice as likely to suffer from poor health compared to the non-carer population. The objectives of the strategy are aimed at minimising the poor health outcomes of carers and hence reducing the health inequalities, which is a direct benefit to the carers and possibly to the NHS in terms of reduced demand for services. The equity considerations and benefits in terms of reducing inequalities are very important in the carers' strategy.

³ *Every Child Matters*, HM Government, 2003

⁴ General Household Survey 2000. Table 4.8.

⁵ *Stages and Transitions in the Experience of Caring*, Carers UK and Leeds University, 2007

⁶ *Wanless social care review: Securing Good Care for Older People*, Wanless D, 2006

Achieving the outcomes

The formulation of the strategy drew upon an initial package of 15 proposals from which the options were constructed.

Option 1:

Do nothing

Option 2:

Proposal 1: To provide improved and more consistent information and support targeted at all groups of carers and covering transitions.

Proposal 2: Increase the availability and quality of care breaks.

Proposal 3: To improve the support offered by statutory services for carers.

Proposal 4: Improve quality measures and indicators and improve the evidence based for carers in commissioning.

Proposal 5: To ensure third sector organisations are funded to raise the quality and geographical coverage of carer support services.

Proposal 6: Training offered for key professionals to provide better support for carers.

Option 3 (includes all proposals in Option 2 and):

Proposal 7: Flexibility around hospital appointments so carers can attend.

Proposal 8: Provision of a specialist carers' service

Proposal 9: Legislation to place a duty on all public bodies to take account of carers.

Proposal 10: Modernise and streamline assessments.

Proposal 11: To ensure that there are good transition protocols between Adult and Children's services which recognise the role of carers.

Proposal 12: A named key worker for provided for each carer.

Option 4 (includes all proposals in Options 2 and 3 and):

Proposal 13: To provide information prescriptions for parents with disabled children.

Proposal 14: To ensure that funding for equipment such as hoists, pressure mattresses and telecare is available when needed.

Proposal 15: Social exclusion programmes to include all carers.

Option 1: Do Nothing

Substantively, the issues of poor carer outcomes and problems outlined previously will remain largely unchanged if no action focussed on carers is taken. Carers will benefit from the personalisation agenda and the work that has taken place to ensure carers become part of the NHS agenda, but without additional support, many carers will continue to struggle in their role and may become disillusioned.

Do nothing is the baseline to which all other options are compared.

Option 2: Proposals 1 to 6 only

Summary Table

<i>£k, 2009/10 prices</i>	PV	Constant prices	2009/10 0	2010/11 1	2011/12 2*	2012/13 3*	2013/14 4*	2014/15 5*	2015/16 6*	2016/17 7*	2017/18 8*	2018/19 9*
Ongoing Costs												
1 Information services	32,833	39,019	0	4,000	4,080	4,162	4,245	4,330	4,416	4,505	4,595	4,687
2 Care breaks	575,007	676,792	34,729	65,821	67,138	68,481	69,850	71,247	72,672	74,126	75,608	77,120
4 Omnibus surveys & questionnaire	3,165	3,500	1,500	0	0	250	0	1,250	250	0	0	250
5 Support for third sector	5,623	6,570	600	612	624	637	649	662	676	689	703	717
6 Training key professionals	35,344	41,249	4,000	3,819	3,895	3,973	4,052	4,133	4,216	4,300	4,386	4,474
Total Running Costs	651,972	767,130										
One-off costs												
1 Information services	580	600	0	600	0	0	0	0	0	0	0	0
2 Care break pilots	10,618	10,990	3,591	3,663	3,736	0	0	0	0	0	0	0
3 NHS and GP pilots	26,235	27,181	8,678	9,000	9,173	330	0	0	0	0	0	0
Total One-off Costs	37,432	38,772										
Total Costs	689,404	805,901	53,098	87,515	88,647	77,832	78,797	81,623	82,230	83,620	85,292	87,248
Quantified Benefits												
1 Information services	14,735	17,512	0	1,795	1,831	1,868	1,905	1,943	1,982	2,022	2,062	2,103
2 Care breaks, including pilots	1,266,893	1,414,003	75,744	144,437	146,006	144,724	146,324	147,957	149,621	151,320	153,052	154,819
3 NHS and GP pilots	-12,990	-13,907	-135	-4,500	-4,590	-4,682	0	0	0	0	0	0
6 Training key professionals	-32,284	-37,678	-3,652	-3,488	-3,558	-3,629	-3,702	-3,776	-3,851	-3,928	-4,007	-4,087
Total quantified benefits	1,236,355	1,379,930	71,956	138,244	139,689	138,281	144,528	146,124	147,752	149,413	151,107	152,835
NPV	546,950											

Discount rate 3.5% (except health benefits 1.5%), all costs in 2009 real terms; wages and value of time expected to rise above inflation so 2% added per year
 *No funding decisions have been taken for year 2 onwards, so all costs and benefits for these years onwards are subject to such decisions.

Proposal 1: To provide improved and more consistent information for carers about the support they can get at a local level.

Context

- The information helpline and website, part of the New Deal for Carers, will go a long way to ensuring that carers are able to access reliable and consistent information when they need to.
- In addition, Information Prescriptions will be available to all patients with long-term care needs and their carers from the end of the year.
- Information is a major part of *Putting People First*⁷ and the transformation grant which accompanies it.

Recommendation

To provide funding to enhance the service offered by the helpline and information provision in general to ensure that there is comprehensive, easy to access information available for carers about their locality. This class of information is specific to the individual and locality (i.e. what is available to a carer in their area, as distinct to national policies and entitlements).

This proposal is linked to all of the outcomes of the strategy. Information is central to giving carers' greater choice and control over not only the services they receive but over every aspect of their lives – from choosing to combine paid employment and caring to enrolling in training courses to help them in their caring role. Improved information provision is part of a government wide push to empower the citizen to make decisions for themselves and become more involved in choosing and even commissioning the services they receive. Furthermore, it is a major part of the personalisation agenda across social care. Improved information was one of the three key things called for by carers during the consultation. Stakeholders have identified specific gaps in information provision at a local level.

Costs

Based on advice from carers' charities and examination of existing services, we estimate that in an average size LA the cost of providing the type of information services envisaged would be about £130,000. This would mean that the total cost of these information services would be £20 million nationally, plus set up costs (recruitment and initial training) of approximately £3 million. However, information services for carers already exist in the majority of areas. Data on the extent to which these services already exist is limited. Based on the information available (primarily advice from carers' charities) we estimate that between £3 million and £7 million would be required to provide these services in the areas where it does not currently exist, plus set up costs (recruitment and initial training) of £0.4 million to £1 million. Care would need to be taken in the delivery of funding to fill in gaps, in order to avoid inequitable funding and distortion of incentives.

Benefits

It has not been possible to monetise all the benefits of improved access to information for carers. Expert views and a review of the literature suggests the following:

- Improved and/or more information for carers could improve the welfare of the people they support by informing their carers of services or other support that might be available but which would otherwise not have been accessed. The provision of these services implies that these have a net benefit which people being supported gain through accessing them;

⁷ *Putting People First: A shared vision and commitment to the transformation of adult social care*, HM Government, 2007

- Likewise, it may improve the welfare of carers by informing them of services or other support that might be available but which would otherwise not have been accessed. The provision of these services implies that these have a net benefit which carers gain through accessing them;
- Preventing harm to carers' physical or mental health by advising carers on 'health & safety' issues. Carers benefit in terms of their physical health as, for example, information on how to lift/transfer the person they support reduces the prevalence of injuries and strain. Evidence is mixed on the effectiveness of providing carers with information on the illness of the person they support, in terms of a reduction in mental health problems. However, it suggests there is no adverse psychological affects associated with providing such information but stress and anxiety are related with not having information available;
- Increasing carers resources by advising them on social security benefits will overall benefit carers financially as they are often unaware of their entitlements. These are transfer payments (i.e. payments from government to carers which do not use up real resources)⁸. The change in the distribution of income towards carers, who are generally at the low end of the income distribution, has distributional benefits, while receipt of these benefits may also indirectly reduce some of the psychological pressures associated with caring;
- Providing a range of information from a single source will save carers time;
- The limited local information currently available is particularly likely to impact adversely on rural carers who often have large barriers to overcome when trying to access information.

Essentially improved and/or more information benefits carers and the person they support by ensuring they have greater choice and control over every aspect of their lives. This may ultimately prevent a crisis in the caring role from which a number of non-monetised benefits are associated, for example, a reduction in stress, improved welfare and physical health improvements. These benefits accrue only where information is accessed that would not otherwise have been accessed, or in those cases where the same information is obtained more easily.

The benefit of saving carers time seeking information can be monetised. Assume 10% of carers per LA spend an hour less per year searching for information, because of the proposal. This saving in carers' time can be monetised using a value of the opportunity cost of carers' time. Carers are generally a disadvantaged group in terms of their income and outcomes such as health. Therefore, following the HMT Green Book guidance on distributional adjustments, all costs and benefits to carers need to be multiplied by 2.05⁹ to take into account the higher value of each marginal pound to those at the lower end of the income distribution, compared to those at the median. Given the opportunity cost of carers' time¹⁰ adjusted for the distributional impact, this produces a time saving equivalent of an average of £54,500 per LA.

⁸ Transfer payments are those for which no good or service is obtained in return. They may change the distribution of income or wealth, but do not give rise to direct economic costs.

⁹ This is an average of the illustrative weights for the bottom (2.2) and second (1.4) quintile of the income distribution, assuming that all pensioner carers are in the second income quintile due to pension income and all other carers are in the bottom quintile. See Green Book annex 5 for details:

http://www.hm-treasury.gov.uk/media/3/F/green_book_260907.pdf

¹⁰ Van Den Berg, Bernard and Ada Ferrer-I-Carbonell "Monetary Valuation of Informal Care: The Well-Being Valuation Method", Health Economics 16 1227-1244 (2007). This study estimated a Euro value for the Netherlands; converted into sterling using purchasing power parity of 1.35 Euro: £1. The central estimate used in the modelling here is £7.85 (which becomes £16.09 after the distributional adjustment).

Proposal 2: Increase the availability of care breaks

Context

The inclusion of supporting carers through the provision of breaks in both the NHS Operating Framework¹¹ and Practice Based Commissioning guidance¹² should see the NHS beginning to commission breaks for carers. In addition, the increased uptake of direct payments and Individual Budgets will allow service users to buy breaks for their carers using the money paid to them by local Authorities. These policy developments should result in an increase in the provision of planned breaks beginning in the short-term and building over the life of the strategy.

Recommendations

2i Increase the availability of care breaks:

This proposal is linked to outcome 2 and outcome 4. Carers often find it hard to lead any sort of life outside their caring role – they are unable to take up the opportunities many of us take for granted in terms of education, employment, leisure, training, etc. In addition, caring is often very stressful for the carers and there is evidence that carers who care for more than 50 hours a week are in poorer health than those who do not care¹³ – breaks are one way in which this stress can be alleviated. Improved break provision was one of the three key things called for by carers during the consultation.

Funding commitments for each year are detailed in the table below showing three types of replacement care and the amount that could be purchased:

	2009/10 £50m	2010/11 £100m ¹⁴
Equivalent of 3 hours break a week from caring for a year, OR	17,000 carers	33,000 carers
Equivalent of a weeks break from caring a year, OR	90,000 carers	173,500 carers
Equivalent of 1 night a week break from caring for a year	9,500 carers	16,500 carers

To put these figures in context, helping 100,000 carers represents around 2% of the total number of carers (as defined by the census 2001) and almost 10% of the carers who reported that they cared for 50 hours or more. See the annex for sensitivity analysis.

The proposal allows carers to choose their preferred type of replacement care. In the calculations of monetised benefits to follow, it has been assumed that funding will be used entirely for in-home replacement care by carers. Carers have a strong preference towards in-home replacement care so it is reasonable to assume a high demand for this type. If more overnight replacement care was used then it would lower the number of carers supported but this may not reduce the overall benefits since the individual benefits from overnight replacement care may outweigh the reduction in the number of carers supported. If more carers choose one week's break this would allow more carers to benefit, but individual benefits are expected to be lower for this type of replacement care.

¹¹ The NHS in England: The operating framework 2008/9, Department of Health, 2007

¹² Practice based commissioning - budget setting refinements and clarification of health funding flexibilities, incentive schemes and governance, Department of Health, 2007

¹³ In Poor Health, Carers UK, 2004

¹⁴ £100m in 2010/11 buys less than twice as much care as £50m in 2009/10 because the costs of care are expected to rise over time

Through traditional methods of delivery, replacement care is made available and carers will choose their preferred type based on the benefits they receive, not taking into account the cost of different types of replacement care. Greater personalisation, through personal budgets, imposes a budget constraint on the carer thereby allowing them to trade off costs and benefits. This should imply carers choose the method of replacement care that yields the greatest benefit to costs given their budget constraint. Within the timescales of this proposal, some carers will have personal budgets whilst others rely on traditional delivery, therefore the overall result will lie between these spectrums. However, over the life of the strategy (at least ten years), personal budgets will become more widely accessible and greater numbers of carers may use them for break provision.

Caveats

- The costs used to estimate the number of carers that would benefit in the table above are gross of any user contributions. Depending on the mechanism of provision of replacement care, users may meet a small proportion of the gross costs. Note that in the case of means tested services, people ineligible for funding because of substantial savings or incomes would not be affected by the proposal;
- The analysis assumes implicitly that capacity could expand to meet demand without any rise in unit costs. In practice, a large increase in demand is likely to require higher wages to attract additional staff into the care sector, at least in some parts of the country. This would put upward pressure on the unit costs of home care and residential care;
- If increased replacement care enabled some carers to increase their hours of paid employment or to take up paid employment, there would be (partially) offsetting savings to public funds in terms of increased tax revenues and possibly reduced benefit expenditure.

NHS saving

There are potential cost savings to the NHS through a reduction in GP appointments and medication due to stress and physical complaints associated with caring, which are expected, to some extent, to be alleviated by the provision of breaks. It is difficult to estimate the reduction in GP appointments due exclusively to replacement care. However, assuming just 1% of the carers receiving replacement care require one less GP appointment per year, the saving measured in GPs' time¹⁵ is £5,000 in 2009/10 - £10,000 in 2010/11. The scale of such savings may be considered as part of the pilots which are proposed in option 2 (ii) below.

Benefits

The benefits of providing breaks for carers can primarily be quantified in two distinct ways. Firstly, there are the benefits garnered by the carer in terms of being able to live a life outside caring, deal with health problems and combine paid employment with caring. Secondly, there are the benefits for the person the carer supports in terms of improved care for a carer who has been able to take a break and the delay in entering residential care as the carer is able to continue their caring role for a longer period.

In addition, there are benefits for employers, the NHS and the economy as a whole which are harder to quantify.

¹⁵ Unit Costs of Health & Social Care 2007 (PSSRU): GP unit costs £30 per surgery consultation lasting 11.7 minutes.

Psychological health

In the last few years there have been two major reviews of the effectiveness and cost-effectiveness of services to support informal carers of older people¹⁶¹⁷. The conclusions from these two pieces of research suggest the following:

- In general, there is evidence that replacement care for older people has a positive effect upon carers in terms of burden and mental or physical health although the extent of the positive effect varied across different research studies. One major study even concluded that there was no evidence of a detectable effect of replacement services on the psychological health of carers;
- The national and international literature shows that provision of breaks from caring is often associated with very high levels of satisfaction on behalf of carers, and that this can be associated with changes in their psychological health.

A further study, the Wanless review¹⁸, is able to provide an estimate of the monetised health benefit carers may receive from reduced stress levels associated with in-home replacement care. The report suggests that 3 hours of in-home replacement care per week is likely to provide a monetised health benefit from reduced stress levels of around £2,500 per carer¹⁹. To enable a comparison, 3 hours of replacement care per week costs annually around £2,900 per carer. Note this only applies to in-home replacement care, and not to the other methods outlined in this proposal. However, since the proposal is aimed at ensuring carers have flexible choice in the method of replacement care they receive, it is reasonable to expect they will choose the method that gives them greatest benefit. Therefore, the monetised health benefit for residential and overnight replacement care, if chosen by the carer, is assumed to be at least equal to that from in-home replacement care otherwise they would have opted for this method.

Implications for Care home admissions

There is some evidence that providing breaks for the carer, through enabling them to continue in their caring role for longer periods, may delay the entry of the person they support into residential care homes. Pickard (2004)⁷ concluded that “Day care, home care and residential respite care can be effective in delaying admissions to residential care. It should also be noted, however, that residential respite care can increase the probability of admission to residential care for some older people”, whilst Mason (2007)⁸ concluded that “no reliable evidence was found that respite ...delays entry to residential care”

For older people with cognitive impairment, one day a week of daycare increased the time spent in the community by approximately 200 days, while two days a week of daycare increased the time spent in the community by approximately 270 days (Davies and Fernandez 2000: 60, Figure 4.1). This indicates there are significant decreasing returns to scales associated with the ability of daycare to delay people’s admission into residential care. Assuming daycare is 7 hours and given the decreasing returns to scales, the analysis assumes 3 hours of in-home replacement care a week will increase the time spent in the community by approximately 100 days. Other evidence from Davies and Fernandez suggests that one day a week of institutional

¹⁶ Pickard L (2004) The Effectiveness and Cost-effectiveness of Support and Services for Informal Carers of Older People.

¹⁷ A Mason et al (2007) A systematic review of the effectiveness and cost-effectiveness of different models of community-based respite care for frail older people and their carers.

¹⁸ Wanless D (2006) Wanless social care review: Securing Good Care for Older People.

¹⁹ The Wanless Report suggested a benefit of 0.15 QALYS from 2 sessions of care per week, which is assumed to equal 9 hours per week (based on average 4-5 hour sessions). Assuming the benefit from each hour of care is equal (this assumes the potential lower impact of a shorter ‘session’ is balanced by the diminishing returns to care) the benefit from 3 hours of care would be one third of the benefit from 2 sessions i.e. 0.05 QALYs. Valuing a QALY at £50k (internal DH guidance derived from DfT empirical estimates of the value of a prevented fatality and other empirical literature, available on request) this gives a benefit of 0.05*£50,000 = £2,500.

replacement care, for a range of care recipients, increased the time spent in the community by 250 - 400 days, depending on the client group.

Assuming 3 hours of replacement care a week, the potential savings in terms of reduced spending on residential care for around 14 weeks at £550 per week, would be around £7,800 per care recipient. However, this is not a net benefit; as one would need to consider the costs of living outside the care home and the opportunity cost of the carer due to a longer period spent caring. Estimates by Netten et al (cited in Pickard 2004) were a cost to the carer of around £50 per week and to society of £48 per week. Allowances are made in these costs for direct financial expenditure on goods and services; forgone non-waged time; forgone waged time; forgone career prospects; and forgone accommodation costs. In addition, expenditure on the cared for including food, clothing, fuel etc needs to be considered. This is approximated by assuming living costs of £150 per week, which is roughly the amount of income disregarded in assessing user charges for domiciliary care (set at 25% above the pension credit guarantee level). After considering these factors, the raw net benefit would be approximately £4,300 per care recipient.

Carers on average care for around 8 years²⁰ so the benefits and costs of delayed institutionalisation are assumed to be distributed evenly across these years. This implies an annual reduction in exchequer spending on residential care of £980 per carer and a societal opportunity cost of £84 per carer. Also, an annual opportunity cost to the carer of £88 and additional expenditure on the cared for of £263 per carer. Hence, the best estimate of the raw monetised benefit per carer is £548 per year.

Employment

See page 6 on employment benefits, which applies to an increased provision of replacement care. Evidence on the expected scale of employment impact from replacement care is not available, but it is judged to be unlikely that low levels of replacement care would make a substantial difference for the majority of carers. Any difference to employment outcomes for carers would be positive, as we would not expect replacement care to lead to any negative impact on carers' employment. Therefore, replacement care may generate a small positive employment benefit, but this is unquantifiable.

Non-wage time

There is a benefit to carers arising directly from the provision of replacement care of reduced non-wage time foregone i.e. increased leisure time. Using a value of non-working time²¹ and assuming 3 hours of replacement care per week it implies an annual monetised benefit of increased leisure time of £1,225 per carer. The analysis implicitly assumes carers of 35+ hours are not in employment and hence the benefit from replacement care is not valued in terms of increased waged time.

Non-monetised benefits

Other benefits are expected to arise from this proposal, but we have been unable to monetise the following:

- Delayed care home admission may benefit the person they support in terms of their welfare, because people tend to prefer to live at home rather than in institutional care;
- Carers' physical health is expected to improve;

²⁰ General Household Survey 2000 Table 4.8

²¹ Van Den Berg, Bernard and Ada Ferrer-I-Carbonell "Monetary Valuation of Informal Care: The Well-Being Valuation Method", Health Economics 16 1227-1244 (2007). This study estimated a Euro value for the Netherlands; converted into sterling using purchasing power parity of 1.35 Euro: £1. The central estimate used in the modelling here is £7.85 (which becomes £16.09 after the distributional adjustment).

- Carers' social interaction is expected to increase;
- Flexibility in the provision of replacement care produces greater choice for the carer;
- The person supported may also benefit both from the receipt of formal care during a break from their carer and sometimes in having a break with their carer;
- Reduced health inequalities.

Cost effectiveness

On cost effectiveness Mason (2007)⁸ found that the evidence available was limited and based on evidence from five studies, only one of which was based in the UK, concluded that replacement day care was at least as costly as usual care. Pickard (2004)⁷ which draws more on evidence from a study based in England and Wales concluded that "it would be cost-effective to make much greater provision of day care, residential respite care, home care and social work/counselling for more carers of older people". The differences and lack of clear evidence in the literature is one of the reasons that the pilots below have been proposed.

The overall monetised benefit of replacement care is derived from reduced stress levels of carers, delayed admission to institutional care and increased non-wage time. Given the reasoning around flexibility ensuring carers choose the method that gives them the greatest reduction in stress, the annual monetised health benefit through reduced stress is expected to be no less than £2,500 per carer. There is an estimated annual net exchequer benefit of £900 per individual of delayed admission to a care home and with an estimated cost (opportunity cost and increased living expenditure) to the carer of £350. Furthermore, there is an estimated monetary value of £1,225 per carer from increased leisure time. This implies an estimated annual benefit of £3,400 per carer at a net exchequer cost of £2,000 per carer.

As explained in proposal 1, the disadvantaged position of carers means we need to apply a distributional adjustment. The costs of the provision of the replacement care remain unchanged from those set out above. The costs to carers increase from £350 to £720 in total (including direct costs and opportunity costs), the health benefits to carers remain at £2,500 per carer and the leisure benefits increase from £1,225 to £2,500 per carer. This implies an estimated annual overall benefit of approximately £4,300 per carer at a net exchequer cost of approximately £2,000 per carer, which is a net benefit of around £2,300 per carer and a benefit to cost ratio of: 2.2: 1. These figures will vary if more carers choose other forms of care (these estimates assume 3 hours of in home replacement care per week). There are also important un-quantified benefits associated with this proposal, which are outlined above.

2ii Pilots to evaluate the current provision of breaks for carers and to look at innovative approaches to providing cost-effective breaks.

The pilots will take place alongside the programme set out in 2i, and will be tailored to help address the evidence gaps highlighted here. They are linked to outcomes 1, 2 and 4. As described above there is a large demand for increased provision of breaks for carers. In addition, one of the complaints by carers and stakeholder groups is that where there is break provision it is often the case that the flexibility and quality of these breaks are not high enough to meet carers' needs. These pilots will examine innovative approaches and look at how breaks can be tailored to meet carers' needs. There are also concerns as to whether certain types of breaks are as cost effective as other methods and this needs to be explored. Further evidence needs to be gathered about using personal budgets to provide breaks for carers and how we can provide money directly to the carer to commission their own breaks.

Costs

We have assumed that pilots will be run in 13 sites over 3 years. Using existing DH pilot programmes as a model, we estimate the following costs per year over three years:

- National evaluation, CSIP support and DH programme management: around £800,000;
- Local project management and implementation in the 13 pilot sites: around £1.5 million;
- Local costs of providing replacement care to those included in the 13 pilots: around £1.5 million to £2 million.

The total cost per year for three years would be around £3.8 million to £4.3 million.

Benefits

The main benefit of the pilots is that it will inform decisions on main programmes of funding for replacement care. They will be designed to provide concrete evidence as to the cost-effectiveness of different types of breaks. This will help ensure that expenditure on replacement care is used in such a way to ensure that the best outcomes are achieved, and poorer outcomes are avoided by providing evidence on the more and less successful ways of delivering replacement care. This will allow the funding in 2i to be used more effectively in line with the emerging evidence, and will also inform all subsequent policy and funding decisions and guidance

Other benefits of the pilots include:

- Sharing of best practice in break provision across local authorities (LAs) and primary care trusts (PCTs);
- Gathering evidence about spend to save for the NHS;
- Will follow up on the wording in the Practice Based Commissioning guidance and Operating Framework;
- Break pilots will also help with the personalisation agenda;
- Assist LAs in the use of the carers grant and care budgets and in obtaining value for money from this funding;
- Empower carers and the person they support to take innovative approaches to the provision of breaks;
- Supports an evidence based practice agenda;
- Improving the quality of break provision.

The replacement care provided as part of the pilots will also have a direct benefit to the carers using the service. £1.5 million to £2 million per year can provide in-home replacement care of 3 hours a week for around 500 - 700 carers, one night a week for 280 – 380 carers or one week of residential care a year for approximately 3,100 – 4,200 carers. Given some innovative approaches may turn out to enhance or suppress benefits it is reasonable to assume the overall

benefit will remain close to the current figures. Adopting the same assumptions as in 2i (using the distributional impact figures), there is an estimated net exchequer cost of around £2,000 per carer/year and an estimated benefit of £4,300 per carer. This implies a ratio of approximately 2.2 : 1 and a net benefit of around £2,300 per carer/year. Therefore, the estimated overall annual benefit of the replacement care provided in the pilots is around £2.6m - £3.6m.

Proposal 3: To improve the support offered by statutory services for carers

Context

- The Transformation of Social Care Reform Grant supports *Putting People First* and provides funding for local authorities to redesign and reshape their systems around the individual – both users and carers.
- Work is being undertaken in the Department of Health to ensure that the profile of carers is raised within the NHS – through the Operating Framework, World Class Commissioning and Practice Based Commissioning.

These policy developments will result in service improvement taking place in the short-term and developing during the lifetime of the strategy.

Recommendations

1. To improve NHS support for carers through:
 - Evaluating existing services where there is health involvement for recognition and support for carers;
 - Establishing national pilot sites to develop services in primary and acute care which recognise and support carers and their contribution throughout pathways and to examine the benefits of health checks for carers;
 - Funding an evaluation of these pilot sites to establish whether there is a business case for these services nationally and also to develop tool kits and best practice guides.
2. To provide better training for GPs in working with carers
 - To develop, pilot, evaluate and, subject to a positive evaluation, roll-out nationally a training programme for GPs, in conjunction with the Royal College of General Practitioners (RCGP), to help them support and interact with carers in a more productive way.

To improve NHS support for carers

This is linked to outcomes 1 and 4. Carers made the point consistently throughout the consultation that NHS professionals do not engage routinely with them as partners in care, and involve them in care planning. Nor do they routinely consider carers' individual health problems.

Evaluating existing services

Assume 20 sites are reviewed with in depth studies of six of them.
The total cost is assumed to be around **£25,000 to £30,000**.

Establish pilot sites

It is envisaged that the pilot sites will cover both community and acute services and will be PCT/Acute Trust partnerships. It is assumed that the pilot sites will broadly cover a PCT area. We have assumed 12 pilots in total, with six looking at developing services in primary and acute care which recognise and support carers and their contribution throughout pathways and another six looking at health checks for carers. We have assumed that the pilots will run for 3 years including the set up time.

For the first set of pilots, the following resources will be required per year:

- A programme manager for each site;
- Additional posts to provide carer support services in every GP practice;
- Additional posts to provide carer support services in acute trusts;

- Additional posts to provide carer support in the third sector to complement the services put in place in the NHS;
- Support from CSIP to local sites and to share best practice.

The total cost of these six planned pilots is expected to be in the region of £2.5m per year for three years.

For the health check pilots, a unit cost of £75 per health check is assumed, and it is assumed that all carers caring for 35 hours or more per week in an average PCT take up a health check each year. Overheads are assumed to be minimal. The total cost of these six planned pilots is expected to be in the region of £4.5m per year for three years. There will also be costs from additional healthcare treatment following on from the health checks, where earlier and more comprehensive diagnosis picks up conditions that would otherwise go untreated. However, this same mechanism is expected to produce savings from conditions being treated at an earlier stage rather than reaching crisis or a severe level requiring more expensive treatment. The pilots will be examining this impact, but at this stage there is insufficient evidence to quantify and so they are implicitly assumed to balance out. The benefits of the health checks in terms of Quality Adjusted Life Years (QALY) gains can also not be estimated at this stage due to insufficient evidence. However, because medical interventions are expected to be cost effective, if conditions are picked up that would otherwise go undiagnosed we can assume that we would expect sufficient benefits to justify the interventions.

On this basis, we estimate the following costs per year over three years:

- Local project management and implementation in the pilot sites and provision of the piloted services: around £7 million;
- National evaluation, CSIP support and DH programme management: around £1.5 million;
- Cost of evaluation of existing services (one off cost): around £25,000 -30,000.

The total cost per year for three years would be around £8.5 million.

Benefits

The main benefit of the pilots is that it will inform decisions on main programmes of funding for NHS support for carers. They will be designed to provide concrete evidence as to the cost-effectiveness of different types of support. This will help ensure that expenditure on NHS support for carers is used in such a way that the best outcomes are achieved, and poorer outcomes are avoided by providing evidence on the more and less successful methods of support. This will inform subsequent policy and funding decisions and guidance.

Other benefits include:

- Greater integration of carers support into PCT workplans;
- Sharing of good practice across PCTs;
- Increased investment by PCTs into support for carers;
- Greater partnership working between PCTs, LAs and the third sector in supporting carers – Joint Strategic Needs Assessments (JSNAs) and Local Area Agreements (LAAs);
- Support the inclusions around supporting carers in the Operating Framework;
- Integration of health and social care support for carers and service users.

To provide better training for GPs when dealing with carers

This proposal is linked to outcomes 1 and 4. GPs are often the first point of call for carers during their caring role. The Royal College of GPs have identified this module as filling a gap in their Continuing Professional Development programme and hope that the small number of GPs trained can disseminate best practice working in their surgeries and into the local community.

Initial costs – It is estimated that it would cost around £90,000 to run a pilot scheme to deliver six training workshops across the country. A further £60,000 would be required to evaluate this pilot scheme. This evaluation would be designed to test whether the training yields sufficient benefits to justify the cost of rollout (see below). Assuming around 150 GPs attend this training, the cost in terms of their time for attending the workshops is around £135,000. This training will be part of GPs' existing programme of Continuing Professional Development (CPD) so DH funding for their time will not be required. In total, the cost of piloting the training would be around £285,000 and the funding requirement from DH would be £150,000.

Rollout – If the pilots were deemed successful additional funds would be required to roll out the scheme nationally as part of the GP programme of CPD. The costs of the roll out would depend on the model of training that was assessed to be most effective making it difficult to provide costings for this. However based on broad brush estimates of costs made for other programmes of training which may be similar we estimate that around £1 million would be needed over three years, which is around £330,000 per year and an opportunity cost of GP time of roughly £4.5 million per year.

Benefits

- Greater satisfaction with GPs' services for carers;
- Improved support for GPs in providing services and support for carers;
- Sharing of best practice across health and social care;
- An improvement in carers health;
- Benefit other staff within GPs surgeries – practice nurses, receptionists, etc;
- Carers notice boards in surgeries which are very important in certain areas.

Proposal 4: Improve quality measures and indicators and improve the evidence based for carers in commissioning

Context

Funding has been made available for a question on carers to be recommended to parliament for inclusion in the 2011 Census. In addition, data on carers is collected through the Family Resources Survey (FRS) and English Longitudinal Survey of Ageing (ELSA).

Recommendations

- Collect information on carers via one of the annually run Omnibus surveys.
- Introduce a robust national survey of carers to assess their experience and satisfaction. This would entail each LA carrying out a survey locally and feeding the information back to the Information Centre to disseminate.

This is linked to proposal 1. A lack of national data on carers has been identified both within government and by external stakeholders. Data on carers and their experience of services is required to improve the quality of service provision in the future, commission better services for carers and policy planning at both a national and local level. In addition, there are no up to date baseline figures or monitoring points for the strategy.

Costs

Omnibus surveys

The estimated cost of including a module on carers in an Omnibus survey is £250,000. It would be desirable for the module to be repeated at least every 3 years.

Carers' Experience survey

One of the key gaps in the current availability of information on carers relates to their experience of services and is directed towards qualitative rather than quantitative measures. A national survey to measure carers' experiences of the services provided to them is being proposed. It would be desirable for this to be repeated at least once more during the life of the strategy.

Assuming the survey is based on postal questionnaires various different models have been costed. These suggest a Carers' experience survey would cost between £750,000 and £1,250,000 each time it is conducted on a mandatory basis.

Benefits

- Increased levels of data with which to make spending decisions;
- Greater evidence available to improve policymaking;
- Monitoring points for the strategy to help ensure its implementation and measure its impact;
- Assist with planning for JSNAs and LAAs;
- Extending information on the carer experience beyond health and social care.

Proposal 5: To ensure third sector organisations are funded to raise the capacity and reach of carer support services.

Recommendation

Provide support to third sector Carers' organisations to build the capacity and reach of the services they provide. In particular, this support will enable them to build capacity in areas where their presence is not as strong as in others. In addition, they will look at ways in which support for marginalised groups, such as BME carers and those looking after people with substance misuse problems, can be better targeted.

This is linked to outcomes 1 and 2. One of the consistent messages coming from the consultation was that carers often relied on the third sector for support. In addition, the third sector often works in partnerships with LAs and PCTs to great effect and this is to be encouraged.

Costs

The Department of Health will work with the major third sector carer organisations to deliver the above recommendation. Indicative costings for how the proposal could be delivered in a more formal fashion are detailed below.

In order to meet this aim it is proposed that the following resources should be made available: In each of the 9 Government Office Regions:

- 1 manager;
- 2 development officers.

Nationally

- 1 director;
- 3 policy officers.

Taking into account the level of staffing that is already available to support local third sector organisations, it has been estimated that an additional **£600,000** will be needed in any given year.

Benefits

- Helping to ensure more effective services and better value for money;
- Increased reach, including reaching those discouraged from statutory services by perceived stigma, and more even geographical spread of third sector support for carers;
- Increased partnership working between the third sector and LAs to improve effectiveness of services;
- Services available directly to carers without eligibility issues and confusion.

Proposal 6: Training offered for key professionals to provide better support for carers

This is linked to outcome 1 and 2. Carers often find that they cannot access the services that they want and receive the support they need from the range of agencies that should be concerned with providing them with help, from health to housing. Training for key professionals on carers is required as they are often unaware that carers are a client group with specialist needs. Because of this, they underestimate the full benefit of training, as it does not affect their ability to perform their job (as currently measured). Hence, in the absence of intervention the key professionals would not purchase training. Training for professionals was highlighted as being of great importance throughout the consultation.

Recommendation

A programme of training aimed at providing professionals working across a range of agencies with the knowledge and skills they need to support and provide services for carers. It is envisaged that the programme will have intensive courses with refresher sessions for staff, such as health and social care staff, who routinely come into contact with carers and shorter training and awareness raising for those staff, such as Pensions and Ambulance service staff, who see carers less often but still have an important role to play in providing services.

Costs

- 1) Using an external provider for a full days training and a half-day refresher session aimed towards staff working directly with carers.

The cost for a full day of training on carers is around £169²² per person and a half-day refresher session is around £101¹¹ per person (catering is only included for full day training). This implies an annual cost of £270 per person for a full days training and a half-day refresher session. Funding of £2 million per year enables approximately 7,400 staff to receive a full day of training and for all these staff to attend a half-day refresher session, which is around 50 staff in each LA. See annex for sensitivity analysis on training costs.

- 2) Using an external provider for general carer awareness training aimed towards staff whose work brings them indirectly in contact with carers.

The cost of a full day of training on general carer awareness is approximately £1,300²³ for a maximum of 20 people. There can be practical difficulties in having an external provider giving a 2 hour briefing but it is assumed to be possible to have three 2 hour sessions on a given day with a maximum of 20 (different) staff in each session. This would imply an increased cost to the external provider through additional training material and handouts. Therefore, assuming an additional cost of £150 the total cost of three 2 hour sessions on general carer awareness is approximately £1,450 for which a maximum of 60 staff can be trained. Funding of £2 million per year enables an estimated 82,500 staff to be trained each year, which is around 550 per LA. See annex for sensitivity analysis on training costs.

Benefits

- Improved service provision for carers;
- Increased satisfaction from job holders so that they are equipped to do their job;

²² Based on average cost from Carers UK.

²³ Based on average cost from Carers UK.

- Greater uptake of services by carers;
- Increased awareness of carers;
- Awareness raising at various points in “the system” ensures carers become ‘everyone’s business’;
- Carers within the workforces of these agencies may be recognised and supported;
- Greater inter-agency working.

For both types of training, there is an opportunity cost of the attendees’ time, which is viewed as a negative benefit and assumed to be forgone output equal to the average England wage rate²⁴. A full day’s training of around 8 hours, including travelling, and a half-day refresher of around 5 hours, including travelling, yields an estimated opportunity cost of £138 per attendee. This implies an estimated overall opportunity cost of £1 million per year. For the general carer awareness training of 3 hours, including travelling time, the opportunity cost is estimated at £32 per attendee, or £2.6 million in total. This implies an estimated overall opportunity cost of £3.6 million per year.

²⁴ 2007 Annual Survey of Household Earnings. Median wage rate in 2009 prices of £10.60.

Option 3: All previous proposals with the addition of proposals 7 to 12.

Summary Table

<i>£k, 2009/10 prices</i>	PV	Constant prices	2009/10 0	2010/11 1	2011/12 2*	2012/13 3*	2013/14 4*	2014/15 5*	2015/16 6*	2016/17 7*	2017/18 8*	2018/19 9*
Ongoing Costs												
1 Information services	32,833	39,019	0	4,000	4,080	4,162	4,245	4,330	4,416	4,505	4,595	4,687
2 Care breaks	575,007	676,792	34,729	65,821	67,138	68,481	69,850	71,247	72,672	74,126	75,608	77,120
4 Omnibus surveys & questionnaire	3,165	3,500	1,500	0	0	250	0	1,250	250	0	0	250
5 Support for third sector	5,623	6,570	600	612	624	637	649	662	676	689	703	717
6 Training key professionals	35,344	41,249	4,000	3,819	3,895	3,973	4,052	4,133	4,216	4,300	4,386	4,474
7 Screening & hospital appointments	479,270	589,356	0	0	0	79,275	80,861	82,478	84,128	85,810	87,526	89,277
8 Specialist carers' service	102,651	126,229	0	0	0	16,979	17,319	17,665	18,019	18,379	18,747	19,121
Total Running Costs	1,231,042	1,482,715										
One-off costs												
1 Information services	580	600	0	600	0	0	0	0	0	0	0	0
2 Care break pilots	10,618	10,990	3,591	3,663	3,736	0	0	0	0	0	0	0
3 NHS and GP pilots	26,235	27,181	8,678	9,000	9,173	330	0	0	0	0	0	0
8 Specialist carers' service	1,804	2,000	0	0	0	2,000	0	0	0	0	0	0
Total One-off Costs	39,236	40,772										
Total Costs	1,270,278	1,523,486	53,098	87,515	88,647	176,087	176,977	181,766	184,377	187,809	191,565	195,647
Quantified Benefits												
1 Information services	14,735	17,512	0	1,795	1,831	1,868	1,905	1,943	1,982	2,022	2,062	2,103
2 Care breaks, including pilots	1,266,893	1,414,003	75,744	144,437	146,006	144,724	146,324	147,957	149,621	151,320	153,052	154,819
3 NHS and GP pilots	-12,990	-13,907	-135	-4,500	-4,590	-4,682	0	0	0	0	0	0
6 Training key professionals	-32,284	-37,678	-3,652	-3,488	-3,558	-3,629	-3,702	-3,776	-3,851	-3,928	-4,007	-4,087
7 Screening & hospital appointments	529,224	633,599	0	0	0	86,373	87,708	89,070	90,459	91,875	93,320	94,794
Total quantified benefits	1,765,578	2,013,529	71,956	138,244	139,689	224,654	232,236	235,194	238,211	241,288	244,428	247,629

NPV	495,300
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Discount rate 3.5% (except health benefits 1.5%), all costs in 2009 real terms; wages and value of time expected to rise above inflation so 2% added per year

*No funding decisions have been taken for year 2 onwards, so all costs and benefits for these years onwards are subject to such decisions.

Proposal 7: Flexibility around hospital appointments so carers can attend

Context

NHS Choice is aimed at ensuring that patients have as much choice as possible when it comes to booking their outpatient appointments and any procedures that need to be carried out in terms of both time of appointment and venue. From April 2008, Choose and Book will allow every patient choose at which hospital they would like to have their operation performed (across the country). It is important to recognise that flexibility in appointments does not fully correct the problem of carers who care continually being unable to attend, although cover may be able during certain times. Therefore, replacement care services are required to enable carers who have high intensity caring roles to attend hospital and screening appointments.

Recommendation

Carers should be offered replacement care (another individual – normally a care worker – will take over the caring responsibilities of the carer whilst they attend the hospital appointment) and flexibility around appointments so carers can attend health promotion planning programmes and hospital outpatient appointments.

This is linked to outcome 4. Carers have often said that they are unable to attend hospital appointments due to difficulties in taking time out from their caring role. This contributes to the health inequalities they experience and may result in a breakdown in the caring relationship should the carers' health deteriorate to a great degree.

Costs

Replacement care

The base case has been generated based upon expert opinions from carers' charities. The information provided enabled a number of assumptions to be made:

- Carers who care for 1-34 hours a week will not demand any replacement care to attend appointments;
- Carers who provide care for 35+ hours a week should be granted 4 hours of replacement care on average to attend an appointment. Screening for cervical cancer is likely to require less time whereas screening for diabetic retinopathy may require longer;
- Expected take-up of replacement care will be between 40% - 70%. This might vary depending on the current number of carers already receiving replacement care and the willingness of the carers and the people they care for to use replacement care.

Based on these assumptions, replacement care will be required for between 810,000 and 1.4 million hospital and screening appointments at a cost of £64-£88 (best estimate of £74) per appointment. This implies the total annual cost of providing replacement care for hospital and screening appointments is between £52 million and £125 million. The figures for each screening programme considered are shown in more detail in the table overleaf.

The caveats to the analysis set out for proposal 2 also apply to these estimates.

Screening Programme	Replacement required	Annual cost
Breast cancer	37,500 – 66,000	£2.4m - £5.8m
Cervical cancer	47,000 – 82,000	£3m - £7.2m
Diabetic retinopathy	13,000 – 23,000	£1m - £2m
Total	97,500 – 171,000	£6m - £15m

See annex for wider sensitivity analysis around unit costs and the take-up rate.

Screening programmes have the capacity to cover the whole population so an increase in attendance should not increase NHS costs significantly in the long run, but there may be a short run impact due to higher demand.

Benefits

The first and obvious benefit from this proposal would be improved health of carers from attendance at appointments. However, many carers taking up the free replacement care if it becomes available would already have attending the appointment, perhaps arranging for a relative or friend to care for the person whilst they attend an appointment or attending in their leisure time. Carers who would have attended anyway will not obtain any additional health benefits from the appointments, but are assumed therefore to obtain a benefit in terms of additional leisure time, as the replacement care allows them to attend the appointment on 'caring time' instead.

The replacement care provided to carers in order to attend hospital and screening appointments will be only occasional (perhaps once or twice per year) and for this specific purpose, therefore the benefits such as improvements in psychological health or delay in entry to residential care arising from replacement care as posited in proposal 2 will not apply. Any such effects are expected to be negligible because of the occasional and limited nature of the replacement care provided here. However, the provision of replacement care under proposal 2 may in part supplement or replace the proposal here, because if carers can access regular replacement care they can use this time as they choose, including to attend medical appointments.

Given the range of reasons for a carer needing to attend a hospital appointment it has not been possible to produce a monetised health benefit for hospital appointments. A monetised value of health benefits for those carers attending screening appointments can be estimated, but this must be applied only to those carers who would not have attended anyway. This is a significant gap in the current available evidence, so assumptions on this must be made. We have assumed in the base case 30% of carers using replacement care are attending when they would not otherwise have done so (and the remaining 70% would have attended in any case, so obtain no health benefits but do benefit from an increase in their leisure time). Because this is an uncertain assumption, we have also carried out sensitivity testing using figures of 20% and 40%.

Evidence suggests that the monetised net health benefit of attending a breast cancer or cervical cancer screening appointment is about £620 per patient. An equivalent figure for attending a diabetic retinopathy screening is not available. However, people with diabetes will be required to attend a number of appointments given their health status. Therefore, it is reasonable to assume carers with diabetes would not usually miss a diabetic retinopathy screening due to replacement care being unavailable, so the deadweight loss is likely to be substantially large

enough to assume the overall health benefit of providing replacement care for diabetic retinopathy is close to zero.

Examining the ranges of take up (40%-70%) and the proportions of these carers who would not have otherwise attended a screening (20%-40%) we obtain an estimated monetised health benefit of around £18 million to £21 million per year. If more of the carers using replacement care would not otherwise have attended the screening, the benefits will be greater. These monetised health benefits of the programme are likely to be an underestimate, because they do not include any health benefits from hospital appointments. The interaction of this proposal with proposal 2 on replacement care is important. If proposal 2 is carried out, those carers receiving regular replacement care will be more likely to be able to attend hospital and screening appointments. This would reduce the proportion who would not otherwise have attended, so the extra health benefit we would expect from this proposal would be lower after implementation of proposal 2.

There is also an overall estimated monetised benefit from increased leisure time. Using the same value of carers' leisure time²⁵ as in previous proposals yields a monetised benefit per appointment (4 hours) of approximately £58 - £65. Assuming that all those carers who would have attended the appointment in the absence of replacement care obtain this leisure benefit, and using the assumptions set out above, this suggests an overall benefit of £50 million to £80 million per year from leisure benefits.

Overall, the total monetised benefits from the provision of replacement care for hospital and screening appointments are estimated to be approximately £70 million to £100 million, at a cost to the exchequer of £52 million to £125 million. The best estimate, using the base case assumptions, gives a cost of £75 million and benefits of £83 million, which leads to a net benefit of £8 million and a benefit: cost ratio of 1.1: 1.

Non-monetised benefits

Replacement care should lead to an increase in the number of carers receiving healthcare at an early and possibly preventative stage, hence spend now to save higher costs in the future. It may ultimately ensure the carer is able to continue in their caring role. Furthermore, it should ensure a better use of NHS resources as fewer appointments are missed. Through this point of contact with the health service, it presents an opportunity for health professionals to recognise the role of the carer and provide advice on services and support.

²⁵ Van Den Berg, Bernard and Ada Ferrer-I-Carbonell "Monetary Valuation of Informal Care: The Well-Being Valuation Method", Health Economics 16 1227-1244 (2007). This study estimated a Euro value for the Netherlands; converted into sterling using purchasing power parity of 1.35 Euro: £1.

Proposal 8: To ensure provision of a specialist carers' service

Recommendation

To ensure provision of a specialist carers' service in every area where one does not already exist. The exact nature of service delivery would be decided locally, the minimum outcomes of establishing specific support for carers in every area would be:

- early identification of carers;
- advocacy, empowerment, involvement;
- ongoing emotional support (as distinct to counselling which is very specific, expensive and only applicable to some carers).

This is linked to outcome 1. Currently the level of service provision for carers is variable across LAs. Carers have consistently called for one point of call where they can access services, information, advice and training, etc. and the Princess Royal Trust for Carers (PRTC) carers centres have been described as a strong model to base any additional provision upon.

Costs

Based on advice from carers' charities and existing models of service provision, we estimate that on average a minimum of 15 FTE staff are required to provide the services described, including managers, carer support workers, a health liaison officer, an involvement officer and an administrator. This is an "average" model and will vary from area to area based on size and other factors such as urban/rural areas, etc. The cost of this average model is about £540,000. This would mean that the total cost of these services would be just over £80 million nationally, plus set up costs (recruitment and initial training) of approximately £12 million. However, services for carers already exist in the majority of areas. Data on the extent to which these services already exist is limited, and advice suggests that the level of service provision is variable. However based on the information available (primarily advice from carers' charities) we estimate that between £11 million and £27 million would be required to provide these services in the areas where it does not currently exist, plus set up costs (recruitment and initial training) of between £2 million and £4 million. Care would need to be taken in the delivery of funding to fill in gaps, in order to avoid inequitable funding and distortion of incentives.

Benefits

It has not been possible to monetise the benefits of specialist carers' services. However, expert views and a review of the literature suggest several areas of benefits. The specialist carers' services will in themselves improve access to services for carers and reduce variability in service provision. They aim to lead to greater continuity of care as carers are identified at an early stage and supported to continue in their caring role rather than falling out of caring.

Early identification of carers

A report on Carers First GP Pilot Scheme²⁶ refers to the importance of the identification of carers in primary care and the use of a carers register. The benefit of maintaining the carers register was that carers "*were informed of local carers services*". The report suggested that "*if carers are fully supported there are benefits not only to carers, but to cared for patients and in the long term it may mean that better supported carers make fewer demands on practice staff*".

This implies that early identification of carers could mean carers receive support that they previously did not access, such as replacement care and preventative health services, and monetary benefits that they previously did not claim, such as Carers Allowance, which may

²⁶ Report on Carers First GP Pilot Scheme May – June 2007. Provided by The Princess Royal Trust for Carers.

reduce the physical and psychological burden on carers by increasing delivery and hence expenditure on these services and benefits. The outcome could be a future reduction in GP appointments from carers with physical strains and mental health problems, thus a future saving to the NHS. However, these benefits are only for people who do not realise they are carers, which is a difficult number to estimate.

Advocacy, empowerment, involvement

Greater advocacy and involvement will allow carers to shape services around their needs and influence commissioning decisions made in local areas to benefit both them and the person they support. Improved satisfaction for carers with services should mean services meet carers' needs better. The methods by which the specialist carers' services will aim to achieve these outcomes are through:

- *“Helping carers who have a voice with health professionals;*
- *Ensuring the carer’s voice is heard in Individual Budget RAS processes which affect their caring role.”²⁶*

Ongoing emotional support

The methods by which the one stop shop will aim to achieve these outcomes are through:

- *“Peer support groups and activities;*
- *Pampering days, alternative therapies, stress busting;*
- *Regular visits at home during vulnerable periods;*
- *Pre- and post- bereavement counselling.”²⁶*

It would be expected that the service might benefit carers in terms of a reduction in the psychological burden, especially through stress busting and pre- and post-bereavement counselling. Other associated benefits may be to the exchequer, in the form of taxes and National Insurance contributions, and greater output. For example, pre and post-bereavement counselling may prove to be one of the key factors that enable carers return to the workforce after their caring role ends.

Proposal 9: Legislation to place a duty on all public bodies to take account of carers

Any costs would be dependent on the scope of the legislation

Proposal 10: Online self-assessments for all carers

A number of local authorities already offer online self-assessments. Those local authorities which do not have online self-assessments may feel that they would not be of benefit to carers in their area as many do not have access to the internet or, due to the high proportion of elderly carers, may not find an online assessment user friendly.

A review of the carers' assessment procedure may take place after the Common Assessment Framework is in place.

Proposal 11: To ensure that there are good transition protocols between Adult and Children's services which recognise the role of carers.

The proposal was deemed to not be within the scope of the strategy and a similar policy, Aiming high for disabled children²⁷ has a £19m transition programme in place. Therefore, costing work has not been undertaken as part of this strategy.

Proposal 12: A named key worker for each carer

It is hoped to base a system of key workers on that of the Early Years Programme which offers training and guidance for someone who is already in contact with the family/carer, physiotherapist, care worker, GP, to take on a key worker role. The role would involve ensuring that there is joint planning between all services accessed by the carer and cared for person, facilitating meetings between the carer and health professionals, arranging appointments for the carer/person supported to ensure they are fitted around the carers' needs, providing the carer and person supported with appropriate information and a number of other services.

An initial assessment suggested the costs of the proposal exceed the likely benefits. Therefore, the proposal has not been developed further in the short term. However, the strategy may explore possibilities around providing support to carers through a lead professional – possibly as part of proposal 8.

Proposals 7 to 12 were dropped for a variety of reasons. For the two proposals where costs and benefits could be partially quantified, there remains considerable uncertainty around the costs and benefits for substantial investment. The interaction of proposal 7 (flexibility of hospital and screening appointments) with the increase in regular replacement care in proposal 2 adds to the uncertainty on the size of the expected benefits, as proposal 2 could help increase carer attendance at appointments. In total, on the basis of current assumptions the addition of these two proposals led to a reduction in the estimated NPV as compared to the preferred option 2 and so investment in these does not appear justified at this stage. There are a number of proposals in the short-term which are seeking to gain evidence as to the best ways in which to support carers and the evidence from these will help us to assess or reassess the costs and benefits of the proposals above and examine whether investment in these might be worthwhile in future. In addition, in some cases the work is already been taken forward by other government initiatives. Finally, there it is difficult to quantify the costs and nature of other proposals until the results of other policy commitments have been analysed.

²⁷ *Aiming high for disabled children*: better support for families, Her Majesty's Treasury and the Department for Education and Skills, 2007

Option 4:All previous proposals with the addition of proposals 13 to 15.

Proposal 13: To provide Information Prescriptions for parents with disabled children

By the end of the year, everyone with a long-term condition or social care need and their carers should be given an information prescription after meeting with a health or social care professional.

The proposal is already occurring so has not been included as part of the strategy. Pilots have been running in 20 sites and the evaluation report will be available later in 2008. An interim report (released in January) is available at www.informationprescription.info

Proposal 14: To ensure that funding for equipment such as hoists, pressure mattresses and telecare is available when needed.

The proposal is part of the Telecare and Transforming Community Equipment and Wheelchair Services Programme and service users with carers cannot be singled out as a priority in the programme. Therefore, the proposal has not been included as part of this strategy.

Proposal 15: Social exclusion programmes to include all carers.

The current social exclusion programmes were investigated to consider the inclusion of carers but were deemed not appropriate to expand them to carers. The National Social Inclusion Programme (NSIP) is specifically focused at looking at issues around social inclusion for people with mental health problems and there did not seem to be a strong read across with the problems faced by carers.

The Social Exclusion Task Force at the Cabinet Office released its latest report in January 2008 – Think Family: Improving the life chances of families at risk²⁸. This focused in on the proliferation of young carers in families at risk (with a specific focus on substance misuse families). The focus of the Task Force in the next year will be on implementing these reports and it was deemed that there was no real scope to expand this remit to cover adult carers currently although this may be something that could be explored in the future.

It is not felt that it is necessary to invest resources in the proposals in Option 4 given the work that is already being undertaken across government detailed above.

Think Family: Improving the Life Chances of Families at Risk, Cabinet Office, 2008

²⁸ Think Family: Improving the Life Chances of Families at Risk, Cabinet Office, 2008

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	No	Yes
Small Firms Impact Test	No	Yes
Legal Aid	No	Yes
Sustainable Development	No	Yes
Carbon Assessment	No	Yes
Other Environment	No	Yes
Health Impact Assessment	No	Yes
Race Equality	No	Yes
Disability Equality	No	Yes
Gender Equality	No	Yes
Human Rights	No	Yes
Rural Proofing	No	Yes

Annexes

Annex 1: Unit costs for replacement care

- **Replacement care in the home**

The table below provides a summary of the cost of providing replacement care in the home to a selection of client groups. This has enabled an estimate of the unit cost of providing replacement care in the home to be established.

Type of care	Average cost	Costs include	Level of service	Average cost per hour	Source
Older people: Very low intensity care (3 activities)	£19 (per week)	-	1 hour (per week)	£19	PSSRU ²⁹
Older people: Low intensity care (3 activities)	£74 (per week)	-	4 hours (per week)	£18.50	PSSRU ²⁹
Older people: Regular care (4 activities)	£186 (per week)	-	10 hours (per week)	£18.60	PSSRU ²⁹
Older people: High intensity care (7 activities)	£558 (per week)	-	30 hours (per week)	£18.60	PSSRU ²⁹
Adults and older people	-	-	-	£14.50	PSS EX1 Return ³⁰
Learning disabilities: Replacement care	£81 (per session)	Salaries, salary oncosts, expenses due to sessions, training, capital costs of equipment and transport, direct and indirect overheads	4.25 hours (per session)	£19	PSSRU ³¹
Home care worker (weekday)	£126 (per week)	Salaries, salary oncosts, direct and indirect overheads	6.6 hours (per week)	£19	PSSRU ³²
Home care worker (weekday)	£18 (per week)	Salaries, salary oncosts, direct and indirect overheads	0.8 hours (per week)	£22	PSSRU ³²

Based on the evidence in the table, it appears reasonable to make an estimate of the unit cost of providing replacement care in the home at £18.50. However, it should be noted that a

²⁹ Unit Costs of Health & Social Care 2007: PSSRU. Community care package (pg 38-42)

³⁰ Unit cost for adults and older people receiving home care - NHS Information Centre, PSS EX1 Return for 2005-2006

³¹ Unit Costs of Health & Social Care 2007: PSSRU. Voluntary sector activity-based replacement care for people with learning disabilities (pg 72)

³² Unit Costs of Health & Social Care 2007: PSSRU. Home care worker (pg 136)

number of sources, Carers UK and Crossroads, quote lower figures of £14.50 and £13-15 respectively. The estimated unit cost of replacement care in the home does not include evening replacement care which, based on the table, is estimated to be £22. Furthermore, both estimates are for weekday replacement care in the home and do not incorporate the higher cost of providing weekend replacement care in the home.

- **Residential replacement care**

The table below provides a summary of the unit cost of providing residential replacement care for the main client groups.

Type of care	Level of service	Average cost per week	Costs include	Source
Private residential care: Older people	1 week (Short-term care)	£475	Fees	PSSRU ³³
Voluntary residential care: Older people	1 week (Short-term care)	£469	Fees	PSSRU ³³
Local authority residential care: Older people	1 week (Short-term care)	£899	Building and oncosts land, equipment, revenue and agency overheads	PSSRU ³³
Local authority residential care: Mental health	1 week (Short-term care)	£561	Building and oncosts land, equipment, revenue and agency overheads	PSSRU ³⁴
Private sector residential care: Mental health	1 week (Short-term care)	£388	Building and oncosts land, equipment, revenue and agency overheads	PSSRU ³⁴
Voluntary sector residential care: Mental health	1 week	£493	Building and oncosts land, equipment, revenue and agency overheads	PSSRU ³⁴
Learning disabilities: Group home	1 week	£1,075	Capital, salary, agency overheads	PSSRU ³⁵
Supported living: Learning disabilities	1 week	£1,228	Capital, salary, agency overheads	PSSRU ³⁵

³³ Unit Costs of Health & Social Care 2007: PSSRU. Private, voluntary and local authority residential care for older people (pg 28-30)

³⁴ Unit Costs of Health & Social Care 2007: PSSRU. Local authority, voluntary and private residential care for people with mental health problems (pg 45, 47, 49)

³⁵ Unit Costs of Health & Social Care 2007: PSSRU. (pg 67, 70)

Given approximately 75% of all carers are caring for older people³⁶, it seems reasonable to estimate the unit cost of providing residential replacement care by placing more weight to this group. The most suitable type of care to consider is private residential since the majority of residential care provision is currently from this sector. This provides an estimated unit cost of £475. For the remaining carers if one assumes the cost is higher, as in the case of learning difficulties, but a lower weight is attached. Therefore, an average weighted unit cost of residential care is approximately £550.

It should be noted that the unit costs in the table are gross of user contributions. Users of Local authority funded home care contribute on average some 10% of the gross costs (PSS EX1).

- **Overnight replacement care**

We have used a range of £85 to £110³⁷ per night. These ranges are based upon the two rates of overnight care, sleep rate and wake rate, plus whether this is delivered on a weekday or weekend.

³⁶ Linda Pickard, The effectiveness and cost-effectiveness of support and services to informal carers of older people (pg 4), 2004

³⁷ Crossroads, Based on a LA in Hertfordshire, which is believed to be representative of the national average.

Sensitivity Analysis – Unit costs of replacement care

Replacement care in the home

	Unit Costs	
	(Low) £16	(High) £22 ³⁸
£50m	20,000 carers	14,500 carers
£100m	40,000 carers	29,000 carers

Residential replacement care

	Unit Costs	
	(Low) £388 ³⁹	(High) £899 ⁴⁰
£50m	148,000 carers	55,000 carers
£100m	295,000 carers	111,000 carers

Overnight replacement care

	Unit Costs	
	(Low) £85 ⁴¹	(High) £110 ⁴²
£50m	11,500 carers	8,500 carers
£100m	23,000 carers	17,000 carers

³⁸ Unit Costs of Health & Social Care 2007: PSSRU. Home care worker (pg 136). Evening care.

³⁹ Unit Costs of Health & Social Care 2007: PSSRU. Private residential care for people with mental health problems (pg 49)

⁴⁰ Unit Costs of Health & Social Care 2007: PSSRU. Local authority residential care for older people (pg 30)

⁴¹ Information from Stephen Moon at Crossroads. Unit cost based on weekday sleep rate.

⁴² Information from Stephen Moon at Crossroads. Unit cost based on weekend wake rate.

Sensitivity Analysis – unit costs and take-up rate of replacement care for screening and hospital appointments

Base case

Replacement care for Breast Cancer screening

Expected take-up rate	Unit costs			
	(Low) £16		(High) £22	
	Replacement care required	Cost	Replacement care required	Cost
(Low) 40%	37,500	£2.4m	37,500	£3.4m
(High) 70%	66,000	£4.2m	66,000	£5.8m

Replacement care for Cervical Cancer screening

Expected take-up rate	Unit costs			
	(Low) £16		(High) £22	
	Replacement care required	Cost	Replacement care required	Cost
(Low) 40%	47,000	£3m	47,000	£4.1m
(High) 70%	82,000	£5.3m	82,000	£7.2m

Replacement care for Diabetic Retinopathy screening

Expected take-up rate	Unit costs			
	(Low) £16		(High) £22	
	Replacement care required	Cost	Replacement care required	Cost
(Low) 40%	13,000	£0.85m	13,000	£1.2m
(High) 70%	23,000	£1.5m	23,000	£2m

Replacement care for hospital appointments

Expected take-up rate	Unit costs			
	(Low) £16		(High) £22	
	Replacement care required	Cost	Replacement care required	Cost
(Low) 40%	712,500	£45.6m	712,500	£62.7m
(High) 70%	1,247,000	£79.8m	1,247,000	£110m

Sensitivity Analysis – Unit costs of training key professionals

Full day of training and a half-day refresher session.

	Low cost (£209 per person⁴³)	High cost (£331 per person⁴⁴)
Total staff trained/year (Funds of £2m/year)	9,500	6,000
Staff trained/LA (Funds of £2m/year)	64	42

Three 2 hour sessions of training on general carer awareness.

	Low cost (£1,201⁴⁵)	High cost (£1,827⁴⁶)
Total staff trained/year (Funds of £2m/year)	100,000	65,500
Staff trained/LA (Funds of £2m/year)	650	435

⁴³ Based on full day training of £130 per person and half-day training of £79 per person, from Carers UK.

⁴⁴ Based on full day training of £206 per person and half-day training of £125 per person, from Carers UK.

⁴⁵ Based on a full day training of £1,101, from Carers UK, and additional costs of £100 per day.

⁴⁶ Based on a full day training of £1,627, from Carers UK, and additional costs of £200 per day.

Annex 2: Specific Impact Tests

Competition Assessment:

Do the proposals directly limit the number or range of suppliers?

No. Proposal 9 on legislation may have an effect however, a full assessment of the effects of this proposal will have to be carried out if this proposal is to be implemented.

Indirectly limit the number or range of suppliers?

No

Limit the ability of suppliers to compete?

No

Reduce suppliers' incentives to compete vigorously?

No

Small Firms Impact Test:

In general, we do not forecast that any of the proposals will have any major impact on small firms. Care homes may see increased demand in their services due to the increased funding provided for breaks for carers. However, as described above, the move away from traditional provision of breaks will lessen this impact.

Legal Aid:

It is not anticipated that proposals will have any impact on legal aid.

Sustainable Development:

The proposals take account of and supports the five principles of sustainable development:

- Living within environmental limits;
- Ensuring a strong, healthy and just society;
- Achieving a sustainable economy;
- Promoting good governance; and
- Using sound science responsibly.

Carbon Assessment and Other Environment:

No impact has been identified

Health Impact Assessment:

One of the five outcomes of the strategy is:

“Carers will be supported to stay mentally and physically well.”

All of the proposals throughout the strategy are seeking to improve the health of the carer and the main body of the impact assessment reflects this.

We believe that there will be no adverse effect on the health of the person being supported as a result of extra support for the carer. The vision of the strategy sets out that whatever added support is given to the carer the person being supported must be allowed to live life as a full and active citizen. Indeed, it is hoped that, by supporting the carer in their caring role and enabling them to stay in that role for longer and by ensuring that their health does not suffer as a result of caring, the health of the person being supported will improve. This would be a result of the increased continuity in the care provided and better care provided by a carer in good mental and physical health.

Race Equality:

- See Annex 3

Disability Equality:

- See Annex 3

Gender Equality:

- See Annex 3

Human Rights:

- See Annex 3

Rural Proofing:

Although there are, no proposals aimed at specifically benefitting carers in rural settings, the Carers' Strategy recognises the importance of enabling carers in rural settings to access the same level of services and support as are available to carers in the rest of the country. It is hoped that all of the proposals will benefit these carers as they are seeking to improve services and support for carers across the board.

More specifically, benefits will be accrued by rural carers from the two proposals to try and improve the provision of local information and the reach of third sector support services. Gaps in these services, often in rural settings, will be identified as part of the work done for these proposals and funding provided to fill them. In addition, by providing greater funding for breaks to be delivered in a more flexible way, carers in rural settings will be able to take advantage of these monies without having to rely on care homes, which are located far from their place of residence.

Annex 3: Equality Impact Assessment

1. Introduction

The 2001 Census confirmed previous evidence (from the General Household Survey) suggesting that the numbers of carers far exceeded the numbers of people receiving specific carers' benefits and services or in touch with service providers supporting older, sick or disabled people. There are now known to be almost 6 million carers in Great Britain, among whom 4.3 million are people of working age, including 1.23 million carers of working age who care for 20+ hours per week.

Carers are a diverse and changing group. Thus with regard to age, although caring often occurs in the middle years of life, and **3,637,856** carers are people of **working age**, the Census also revealed (all data in this paragraph are for England) the existence of:

- 140,000 **young** carers (aged under 18 years old, including 90,348 aged under 16),
- 1,316,154 **older** carers (aged 60+, and including 299,673 carers aged over 75), and
- at least 153,327 carers in households containing a child under 16 who has a limiting long-term illness⁴⁷ (many of whom will be aged under 40).

About half of carers live with the person they care for; **about a quarter (24%) of carers themselves have a limiting long-term illness** (this figure rises to 30% in some local authorities, and falls as low as 19% in others); and around 47% of carers live in a multi-carer household. The majority of carers are women (57% of those of working age), but among older carers more are men (52% of those aged over 75 are men).

Overall, among people of working age, caring is most prevalent among people in the **Bangladeshi, Pakistani, Indian and White British** population groups. However due to the specific geographical concentrations of people from BME groups, and to the different age structure of some ethnic minority populations, both the absolute numbers of BME carers, and their numbers relative to the local White British population, fluctuate enormously from one locality to another⁴⁸. This produces different kinds of challenges for delivering culturally sensitive services and for meeting different needs in different localities. Table 1 shows the numbers of carers in each ethnic group: note that socio-economic and age differences may explain some of the % variation.

Table 1 Carers by ethnicity: England

Ethnic group	Number of people (all ages) who are carers	% of specified population group who are carers
White British	4,704,279	10.3
Indian	106,035	10.2
Other White	92,411	6.9
Pakistani	67,476	9.4
White Irish	65,010	10.1
Black Caribbean	44,675	7.9
Black African	26,822	5.6
Bangladeshi	24,815	8.8
Any other Asian background	20,970	8.7
Chinese	12,905	5.7

⁴⁷ This number is estimated from the number of carers in households with a person aged 01-15 with a LLTI; '2 or more carers' has been taken as 2, and therefore the number is likely to be an underestimate.

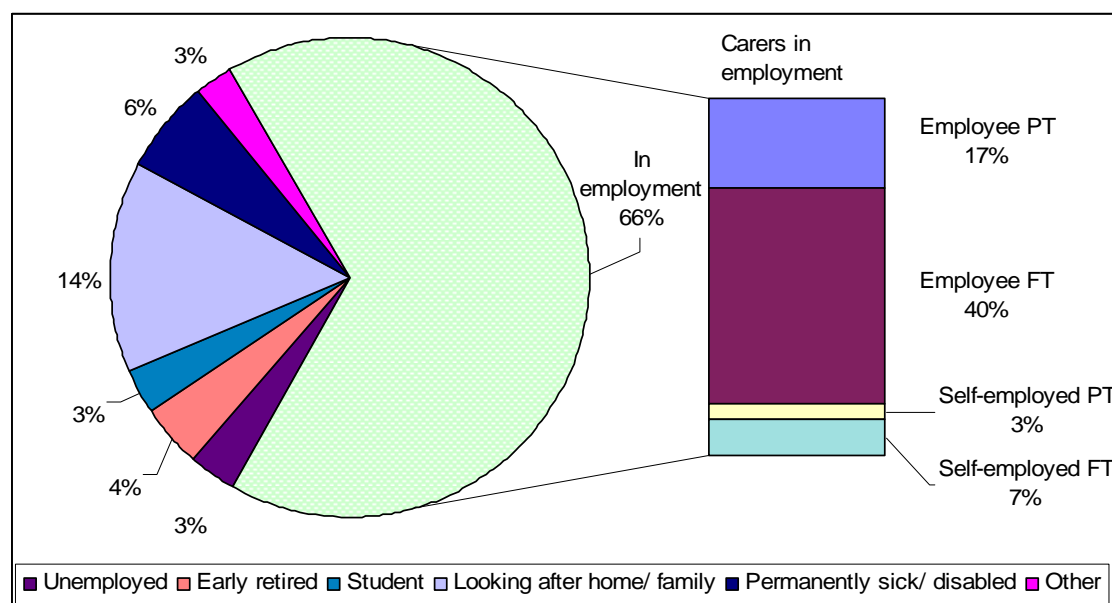
⁴⁸ Analysis of the 2001 Census (Yeandle et al 2007, *Carers, Employment and Services Report Series*, London: Carers UK), shows, for example, that in the London Borough of Southwark, 40% of carers belong to a range of different BME groups, whereas in West Sussex, the figure is just 5% (with only 2% of West Sussex carers belonging to non-White BME groups, compared with 31% in Southwark).

White and Black Caribbean	10,355	4.4
White and Asian	10,048	5.3
Any other mixed background	8,782	5.6
Any other black background	6,053	6.3
White and Black African	4,161	5.3
Any other background	13,008	5.9

Source: 2001 Census Commissioned Tables, Crown Copyright 2003

Carers are also differentiated by two other important factors: their *relationship* to the person they care for; and the *condition* of the person they care for. Recent research demonstrates that male carers are rather more likely than female to care for a spouse or partner; while female carers are rather more likely than male to care for a son or daughter, or for a parent. Some carers support a friend or neighbour or a more distant relative. Some carers care for more than one person, sometimes supporting people living in different places. Most carers find that the care they need to give changes over a period of months or years, sometimes becoming more intensive over time, sometimes changing (e.g. if the cared for person moves into residential care or becomes able to live independently or in supported housing). Carers may support sick and disabled children; people with substance misuse problems; people with learning disabilities, autism, mental health difficulties, or dementia; people with long-term conditions or terminal illness; people with mobility difficulties and physical disabilities; people recovering from acute illness or accidents. Their caring role may develop gradually or it may be thrust upon them unexpectedly and suddenly. In studies, most carers indicate that they care willingly, but often comment on the way the limited support they get in their caring role prevents them from participating in everyday life as they did before their caring role began, or in the same way as other people.

Figure 1 Carers of working age (both sexes) by economic activity status: Great Britain



Source: 2001 Census SARs, Crown Copyright 2005.

In most cases, caring arises in the context of relationships within families and households; it is also associated with stage in the life course and the incidence of poor health and disability in a population. The differential distribution of caring responsibilities between different ethnic groups is undoubtedly in part explained by the higher incidence of poor health and disability found in some BME groups, and by the different age profiles of people in different BME groups.

Many analysts, and most relevant voluntary sector groups, already consider carers to be a disadvantaged group *in their own right*, facing social exclusion and discrimination (especially in relation to work and education) as well as a deterioration in their health and financial situation,

both of which tend to worsen with length of caring and with the intensity of caring. The case for including carers in UK equalities legislation has been outlined in several recent documents⁴⁹; the *Equalities and Human Rights Commission* has identified carers as an important ‘cross-cutting theme’ in its work; and carers in part of the UK already have protection (as persons with dependants) under the Northern Ireland Act 1998 Section 75. Depending on its outcomes, the Coleman case⁵⁰, currently ongoing, may also have significant implications for carers.

The four Task Forces meeting in 2007-8 developed a range of policy recommendations, spanning a range of different types of carer support. The proposals they made are intended to offer improvements for carers in relation to the following:

- Carers’ incomes and the costs of caring
- The availability of breaks for carers, including help with costs
- Carers’ entitlements to flexible working opportunities
- Information about carers and awareness of their circumstances – to render carers’ contribution more visible in society and to service providers and employers
- The accessibility and quality of services available to carers (education, back-to-work support, health and social care, the whole span of local public services)
- The advice, information and guidance available to carers to support them in managing their caring role
- Funding for the third sector in providing support for carers

2. Aims and Purposes

2.1 The aim of this Equalities Impact Assessment is to indicate the likely impact on different sections of the population of the proposals put forward for the *Carers Strategy*. In Section 4 the assessment explores the *likely impact* of the different proposals on improving support for carers differentiated as follows: men and women; people of different ethnicity; disabled people; people of different ages; people of different religions and none; people of different sexual orientation. It also examines the potential impact of the proposals on human rights. (Note: where information is missing or proposals lack specificity, it is not possible to assess equalities impact.)

2.2 For the purposes of the assessment it has been assumed that the measures taken would (except where stated) be directed at all carers (i.e. the population of people who identified themselves as carers in the 2001 Census). The assessment does NOT take into account the cost or wider benefits of each of the proposed developments, and considers only whether, on the basis of existing knowledge, it is possible to make an estimate of impact with regard to equalities. It should be emphasised that if carers are regarded as a disadvantaged group in their own right, any measure which offers them improved support (or reduces pressures on them which damage their wellbeing with regard to: financial situation; access to employment, education or training; health; or social inclusion) will be positive from an equal opportunities point of view.

⁴⁹ Whose Rights Are They, Anyway?: Carers and the Human Rights Act (2006, London: Carers UK)

⁵⁰ A European (ECJ) judgment, on whether discrimination by association with a disabled person is illegal, is awaited in relation to the case brought by Sharon Coleman; this is expected to clarify the law on this point.

3 The Equalities Impact of the Proposals on specific groups

Impact on Health Inequalities

The 2004 Carers UK report “In Poor Health: the impact of caring upon health” shows, through analysis of the census, nearly 21% of carers providing over 50 hours of care say they are in poor health compared to nearly 11% of the non-carer population with nearly 700,000 carers reporting that they were not in good health in the census. The proposals in the strategy seek to mitigate the impact that caring has upon the health of the carer and so reduce the inequality that carers face.

Race Equality Impact Assessment

Carers are found in disproportionate numbers in some ethnic minority groups, and research evidence from a range of sources suggests that their needs are sometimes poorly met by ‘mainstream’ provision for carers or indeed by services to sick or disabled people. The age structure of most BME groups has historically been younger than the White population, and as a result provision of services for older people and their carers has only recently begun to take adequate account of their needs. Some illnesses and conditions are more prevalent among people from certain BME groups; and there is some evidence of variation according to cultural and religious preferences in caring arrangements and choices. All of the proposals in the strategy aimed at improving the reach of services will benefit BME groups.

Disability Equality Impact Assessment

Because most carers support a person with a disability, it can reasonably be assumed that most effective measures to support carers will also be of some benefit to disabled people. Furthermore, over a quarter of carers of working age themselves have a limiting long-term illness. Virtually all measures of value to carers will therefore have the potential to exert a positive impact on the disabled population and are likely to contribute to reducing inequalities between disabled and non-disabled people.

Gender Equality Impact Assessment

Among people of working age, there is a higher incidence of caring among women than men in all ethnic groups. On average, women provide slightly longer weekly hours of unpaid care than men. After age 75, however, the incidence of caring is higher among men than women. Measures to support *working* carers, especially measures to support those in full-time employment, will be of benefit to more men than women; this is desirable as men’s needs as carers have not always been well understood or recognised. Those proposals which encourage a view that caring is a normal part of everyday life, for both men and women, and which facilitate carers’ participation in all forms of social and economic life, will contribute to wider gender equality, as the historical assumption that all caring labour should be performed unpaid at home by women is gradually replaced by the current view that shared roles in relation to care, family life and economic participation benefit all members of society

Age, Religion and Sexual orientation

It is very difficult to assess what impact one or more or all of the proposed measures would have on inequality in relation to these factors. Insofar as carers are unfairly or inequitably treated as carers, it is relevant to note that since they are disproportionately found among people aged 45-74, people in this age group would be likely to benefit more from the measures proposed than people in other age groups.

There is very limited information available about religion (except in association with ethnicity) and even less about sexual orientation. However it is worth noting that the 2001 Census showed that people of Muslim religion have slightly higher rates of caring (possibly related to other linked factors), and that they therefore should, if appropriately included in the policy measures proposed, benefit from them.

No robust data is available on carers by sexual orientation, and indeed this is a generally under-researched topic where more information is required. At present it is impossible to make an evidence-based assessment of impact, and it is not clear from the way they are specified whether the proposed new measures relating to information about carers would be capable of addressing this issue.

Human Rights Impact Assessment

Under the Human Rights Act 1998, carers (with others) were accorded three important rights. These were: under Article 2, the right to life; under Article 3, the right to be free from inhuman or degrading treatment; and under Article 8, the right to respect for private and family life. (The last of these is a 'qualified' right, which needs to be balanced against the rights of others.)

Many of the measures proposed can be expected to have a positive (usually indirect) impact on the human rights of those people who are carers, by enhancing their access to information, services and appropriate treatment in relation to their caring situation, most especially where their caring role, or the conditions under which it is carried out, threaten one of these rights. Carers' lives are sometimes put at risk through the conditions in which they carry out their unpaid caring roles; and there is evidence that some carers feel they have been treated in degrading ways, or that their private and family life has not been appropriately respected, by agencies and professionals. The measures proposed can be expected to have a positive impact on this situation, notably where they offer improved access to services, support and information, and may therefore be assessed as likely to be positive from a human rights perspective.

Annex 4: Implementation Chapter from Carers Strategy

Chapter 7 - Implementation

Context

- 7.1 We need to make sure that robust arrangements are in place to help both us and our delivery partners to form a strategic overview of progress in taking forward this strategy. These arrangements need to fit within the new performance arrangements set out in Local Government White Paper *Strong and Prosperous Communities*⁵¹.

Maintaining a strategic overview at national level

- 7.2 We need to maintain a strategic overview of the carers' agenda at a national level if we are to ensure progress on implementing the strategy. We will do this through a number of measures.
- 7.3 In December 2007, we established a Standing Commission on Carers. The Commission will play a key role in advising us on progress in implementing this strategy, including a specific overview on equalities issues, and will advise on ways that carers can be further supported in the light of longer-term demographic changes and changing expectations of society. The Chair of the Standing Commission will publish an annual report that will be shared widely.
- 7.4 We will also establish a programme board to complement the work of the Commission. The programme board will include senior representatives from across Government and key delivery partners. It will be responsible for ensuring that the necessary preparatory work is undertaken to support the delivery of the longer-term proposals contained in this document as well as ensuring that the commitments made for the next two years are implemented.
- 7.5 Both the Commission and the programme board will be informed by the results of the carers' surveys detailed in this chapter, the findings of the pilots announced in the strategy, and other research evidence, for example from the individual budget pilots for children and other key strategy documents such as the Care and Support Green Paper.
- 7.6 Together the evidence will provide a strong base, in terms of offering innovative, outcome-based solution, for commissioners when commissioning services for carers in the future.

Maintaining a regional and local overview

- 7.7 Regional and local oversight of progress will take place within agreed performance frameworks. A number of new arrangements and mechanisms have recently been put into place, or are in train, that will strengthen the development of a multi-agency approach and partnership working and are particularly relevant in achieving delivery of this strategy. These are detailed throughout the chapter.

Local performance framework

Fact Box: Joint Strategic Needs Assessments and Local Area Agreements

A Joint Strategic Needs Assessment (JSNA) describes the future health, care

⁵¹ *Strong and Prosperous Communities* – the Local Government White Paper, CLG, 2006

and wellbeing needs of the local population. A Local Area Agreement (LAA) is an agreement between central government, local authorities and their partners on the priorities for a three-year period for improving services and the quality of life in a geographical area. Together they form a major part of the new local performance framework which seeks to deliver better outcomes for service users and carers through more joined-up services.

- 7.8 The **Local Government and Public Involvement in Health Act (2007)** changes the statutory landscape upon which the new local performance framework is founded. It places a number of duties on local authorities and primary care trusts (PCTs) – including a duty on local authorities and PCTs to undertake a Joint Strategic Needs Assessment of the health and well-being needs of the whole community. This will highlight the diversity of those using care services and their carers and identify the needs of those funding their own care or caring for people who are not eligible for statutory services. The JSNA will inform local commissioning strategies to ensure that the necessary services are in place or locally available.
- 7.9 The new local performance framework offers a major opportunity for carers to feature more prominently as a client group in their own right and as part of the general social care user population. LAAs must be approved by Ministers and each LAA includes up to 35 priority targets selected from the National Indicator Set, which identifies the indicators to help measure priority outcomes. Local authorities and their partners can also agree additional local targets. The current indicator on carers (N1 135 - *Carers receiving needs assessment or review and a specific carer's service, or advice and information*) is one of the most popular targets and it is identified as a priority in over half of LAAs in England.
- 7.10 Although N.I.135 is a useful output measure and sends a powerful message about the priority we place on meeting carers' needs it does not give a clear enough indication of carers' experience of the way that services are provided, and it counts only those carers who have received an assessment and service of some sort from their local authority.
- 7.11 As part of a wider review of social care indicators to be considered for inclusion in the next iteration of the National Indicator Set (which will be agreed through the next Spending Review), we will be reviewing the effect of the current carers' indicator within the context of the aims and outcomes of this strategy. Where a need for further development is identified, we will consider options for creating a new outcome-focused indicator based on carers' experience.
- 7.12 We will explore further options to measure carers' experience of services in a shorter timeframe, during the current Spending Period. One option may be to include carers' experience within the local authority survey programme for NI127 (self-reported experience of social care users), as part of the work to develop proposals for populating this indicator.
- 7.13 **New commitment:** To support this move towards greater measurement of carers' experience of services we are working with the Information Centre (a special health authority that provides facts-and-figures to help the NHS and social services run effectively) to develop a carer experience survey for local authorities to undertake on a voluntary basis in 2009-10.
- 7.14 This survey will provide both local authorities and central government with vital data on whether carers are receiving the services they need and what they think of the quality of those services. It will benefit local areas when commissioning services for carers and help to identify harder to reach groups who are currently not accessing services.

Improving data:

- 7.15 The inclusion of a carers question in the 2001 Census was a major achievement; it allowed data about carers to be collected down to a sub-ward level, providing reliable and tailored data sources with which local authorities and PCTs can plan services. The data can be used to make a number of comparisons between caring and poor health, for example, and between carers and BME communities. An example of the benefits of this data source can clearly be seen from the six reports released by Carers UK and Leeds University in 2007⁵².
- 7.16 Although, the 2001 census provided vital information, stakeholder groups and academics both within and outside Government have highlighted the lack of basic up to date data on carers; their overall numbers, the details of their caring role, and the numbers of them in work, for example, as well as basic characteristics such as age, gender, ethnicity, disability and health status.
- 7.17 **New commitment:** Bearing in mind the concerns raised, we have secured additional funding to ensure that the question on carers is included in recommendations to Parliament for the 2011 census. One of the major benefits of having the question in the 2011 census is that it will provide a 1-year comparison with 2001 for the number of carers in the country in each local area and the number of hours of care they provide.
- 7.18 Data and information about carers, over and above that provided by the Census, was provided between 1985 to 2000 by the General Household Survey.
- 7.19 **New commitment:** In recognition of the importance of this information, the Government is committing to fund a module in an Omnibus survey in 2008/9 on carers. The module will contain a number of questions about carers and will be tailored around the strategy – going beyond the usual questions about carers and the health and social services they receive, it will ask questions about employment, income and housing.
- 7.20 This information will be vital for central and local government and the third sector and will allow them to map service provision and commission services for better effect.

Putting people first – transformation process

- 7.21 As earlier chapters of this document make clear the transformation of adult social care will require a shift to a more personalised holistic approach to care and support. We need to work with family members and other carers as partners to make sure support solutions address the needs of all those involved and that they help carers to develop their skills and confidence. Over the next three years we will provide £520m through the Social Care Reform Grant to support councils to redesign their systems so they can deliver this transformation.⁵³
- 7.22 Key elements of this transformation process of specific relevance to carers and carers' organisations include:
- a new skills academy to improve the commissioning of services and leadership in social care, and local workforce development strategies to raise skills levels;
 - The development of forums, networks and tasks groups, actively involving people who use services and their carers, to design and oversee the change to a personalised system;

⁵² Carers, Employment and Services Report Series, Leeds, Yeandle Sue et.al for Carers UK, 2006/7

⁵³ Transforming Social Care - (LAC(DH)(2008)1, pp25).

- support for third sector innovation and social enterprise.

7.23 This transformation will be delivered by local partners working together through the new local performance framework outlined above and through local leadership and regional leadership. Organisations working together to achieve transformational change will include:

- the Association of Directors of Adult Social Services;
- the Association of Directors of Childrens' Servies;
- the Local Government Association;
- the NHS Confederation;
- the Care Services Improvement Partnership;
- the Care Services Efficiency Directorate;
- the Improvement and Development Agency for Local Government (IDeA)

7.24 The strengthened role of the Department of Health in the regions together with the Regional Improvement and Efficiency Partnerships will have a key role in supporting improvement locally and co-ordinating support with Joint Improvement Partnerships and other relevant organisations including IDeA.

Assessment and regulation

7.25 Subject to the enactment of the Health and Social Care Bill an integrated regulator for health and social care, the Care Quality Commission, will be created replacing the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. We believe strongly in the importance of engaging the public, people who use services and carers in the work of the Care Quality Commission and recognise the good work the existing commissions have done in this area.

7.26 A new independent assessment and inspectorate regime, Comprehensive Area Assessment, (CAA), will be introduced from April 2009. This will put greater focus on the public's experiences and perspectives than has hitherto been the case.

Short term: Commitments
Establishing a cross government programme board
Module on carers in an Omnibus survey
Inclusion of a question on carers in the 2011 Census
A national carers experience survey

Longer term: Identified Priorities
Review the National Indicator Set to ensure carers experience of services is measured.

Annex 5: Partial Impact Assessment for Young Carers proposals

Summary: Intervention & Options

Department /Agency: DCSF	Title: Impact Assessment of Young Carers proposals carried out by the Department of Children Schools and Families	
Stage:	Version:	Date:
Related Publications:		

Available to view or download at:

<http://www>.

Contact for enquiries:

Telephone:

What is the problem under consideration? Why is government intervention necessary?

Excessive or inappropriate caring can adversely affect children's education and other outcomes [section 7, Annex A]. Due to they or their families being unable to afford to access sufficient caring services privately through the market, a worrying number of children fall into such roles. This is inequitable as these children, whose families are often relatively deprived, are denied educational and social opportunities that other children enjoy. Further, society loses the wider economic benefits of these children fulfilling their educational potential.

What are the policy objectives and the intended effects?

Policy objective/outcomes over the 10 year lifetime of the strategy: all young carers able to participate fully in education and achieve against all the Every Child Matters outcomes. Where problems do still arise, they are identified and addressed earlier and more effectively across all areas of the country.
Outputs/outcomes to 2011: universal and targeted services better equipped to identify problems early and lend effective support; new approaches to joining up support around families and protecting young carers from inappropriate caring tested and evaluated and learning shared.

What policy options have been considered? Please justify any preferred option.

The Carers Review considered a number of ideas for change in relation to young carers. Changes in legislation were not proposed: the focus was on supporting local delivery partners to improve the operation of the current system, in particular by doing more to build skills and capacity across the three main levels of support – universal and targeted support for young carers themselves; and more specialist support for the person cared for and their broader family. Funding more formal care to substitute for that by children was considered, but the review concluded that this needed to be informed

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

Progress will be monitored through the Standing Commission for Carers. DCSF will review interim progress and cost benefits prior to 2011.

Ministerial Sign-off For SELECT STAGE Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:

.....Date:

Summary: Analysis & Evidence

Policy Option:	Description:
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COSTS	ANNUAL COSTS	Description and scale of key monetised costs by 'main affected groups' The costs of the proposal are the expenditures by central government on the proposals to raise awareness of young carers in universal services, provide targeted support for young carers and strengthen support around the family of the young carer to reduce the numbers falling into inappropriate caring.			
	One-off (Transition) Yrs		£		
	Average Annual Cost (excluding one-off)		£ 2.15million	Total Cost (PV)	£ 6,022,225
	Other key non-monetised costs by 'main affected groups'				

BENEFITS	ANNUAL BENEFITS	Description and scale of key monetised benefits by 'main affected groups' The impacts are not easily monetised. Given the lifetime returns to A*-C grade GCSEs (£85000) and A-Levels (£105500), the benefits would outweigh the total costs if, as seems likely, 71 extra young carers gained GCSE grades at C or above or if 57 extra young carers stayed on post-16 to achieve A-Levels.(see Annex).			
	One-off Yrs		£		
	Average Annual Benefit (excluding one-off)		£ 2.15 million	Total Benefit (PV)	£ 6,022,225
	Other key non-monetised benefits by 'main affected groups' The estimate of the educational benefits is conservative as outlined at the end of Annex A. In addition to educational outcomes, there will be positive impacts on the non-educational outcomes of young carers, their social, emotional and physical well-being which are very difficult to monetise.				

Key Assumptions/Sensitivities/Risks Central Government to fund these developments. Risks: generally low. Raising awareness across front line settings may possibly increase demand for local support but benefits of earlier intervention and new investments to strengthen targeted support should help off-set this.

Price Base Year	Time Period Years	Net Benefit Range (NPV) £	NET BENEFIT (NPV Best estimate) £
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What is the geographic coverage of the policy/option?	England			
On what date will the policy be implemented?	June 08 onwards			
Which organisation(s) will enforce the policy?	DCSF/DH			
What is the total annual cost of enforcement for these organisations?	£			
Does enforcement comply with Hampton principles?	Yes/No			
Will implementation go beyond minimum EU requirements?	N/A			
What is the value of the proposed offsetting measure per year?	£			
What is the value of changes in greenhouse gas emissions?	£			
Will the proposal have a significant impact on competition?	Yes/No			
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	Yes/No	Yes/No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)		(Increase - Decrease)	
Increase of £	Decrease of £	Net Impact	£

Key: Annual costs and benefits: Constant Prices (Net) Present Value

Evidence Base (for summary sheets)

[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]

The Carers review national consultations – what young carers told us

- Many young carers are deeply attached to, and protective of, their caring roles. They want to see this respected. But they also want the time to learn, socialise and have the opportunities other young people have. They believe more needs to be done to ensure this.
- Many feel GPs, hospitals and schools fail to recognise their needs as children and as young carers, adding to the pressures and challenges they face. Many value the more specialised help which young carer projects and other face-to-face services provide. They feel more support of this kind should be provided.
- However, the priority identified by most young carers was securing better, more reliable support around the person they care for and the family as a whole. Young carers want this for the well-being of the person cared for; they also want it for themselves - so they too have the time to learn and to have the opportunities which other children do.

What the broader evidence tells us [further detail – see Annex A]

- Precise national data on the scale of formal caring by children and the extent to which this limits young carers' opportunities or contributes to negative health and other outcomes over the longer term is not available.
- The private and sometimes hidden nature of caring within the family has precluded systematic identification and tracking.
- Broad estimates suggest that between 2% and 4% of children have been carers to some extent during their childhood. The 2001 Census day "snap-shot" indicated that some 139,000 children across England were offering some care to family, neighbours, or friends. Of these, some 22,000 (16%) were reported to be caring for substantial periods of time - between 20 and 50 hours or more per week. However, because of the survey's methodology (further details Annex A) these figures could be either an over- or under-estimate.
- Some caring by children is not automatically a cause for concern. Children can derive benefits from lending some care and support within their families.
- However, a growing body of research and other evidence underlines the difficulties and disadvantages which many young carers face:
 - Among young carers in touch with projects, some 22% are experiencing educational difficulties. For children of secondary- school age the figure is 27%, while for those in families affected by substance misuse the figure is 40%. Indicative data from one LA has pointed to substantial differences in attainment of 5 A*-C GCSEs between young carers and local young people as a whole.
 - Young carers can be particularly disadvantaged when making the transition to adulthood and post-16 learning. Although some do go on to further and higher education, many feel their caring responsibilities limit their choices and options or impede their ability to progress.
 - Young carers are often in families living in relative poverty and affected by other factors which, particularly when combined, are known to be associated with disadvantage and poorer outcomes for families and the children in them (worklessness; lone parent

households; parental mental ill health; substance misuse).

- The reasons young carers fall into inappropriate or harmful caring roles are complex. A primary cause appears to be the lack of health and social care support around the person cared for and their families and weaknesses in the join-up between adult and children's services. However, family factors such as a families' willingness to engage with services can play a part. So too can the changing nature of illness or disability and shifts in a family's circumstances and the level of support which the wider family can offer.

Support currently made available – extent and nature

- While dedicated projects offering personal support, respite breaks and other activities for young carers have grown significantly over the last decade, levels of support still vary from area to area. Better access to support of this kind was a major theme among young carers responding to the review.
- A small-scale sample survey of projects across the regions indicated that the majority of young carers who access help through projects have established problems, with around a quarter considered by their projects to have high levels of need.
- A wealth of experience has developed across the projects and other targeted services now available. However, detailed and systematic evaluation to identify the approaches which work best and to share that more widely has been lacking.
- Despite pockets of good practice, systems for earlier identification and support through universal/front-line settings are not working as well as they should. Some schools do provide tailored support through their pastoral and other support systems, but young carers and local project leaders indicate a number do not. Young carers and other stakeholders report that GPs and hospital discharge teams dealing with ill or disabled parents focus on the patient in front of them but do not always consider the support and information needs of the broader family, including dependent children who may be carers.
- Where problems are picked up on responses often involve the young carer being referred to local projects for personal support and respite. Action to address the root causes of the problem – particularly gaps in support around the person cared for and the family as a whole – is less in evidence though some local authorities and projects are moving in this direction.

Further detail on the research and broader evidence-base is attached at Annex A.

Options considered: the review's recommendations

The review proposed further action and investment in three key areas:

Recommendation 1. Building better, more joined up support around the person cared for and the family so that youngsters are better protected from inappropriate caring

Recommendation 2. Ensuring universal/front-line settings have the skills and understanding to lend effective support

Recommendation 3. Ensuring young carers in all areas can access the face-to-face, targeted support they need.

The Review's Equalities Task Group also endorsed the view that children should be protected from inappropriate caring and offered the support they need to ensure all have equality of opportunity and can access education as other children do.

These priorities are consistent with the broader evidence on where the main gaps and problems are in relation to young carers. They also closely reflect the main views and concerns which emerged during the review.

But while further progress against Recommendations 2 and 3 may be warranted, our view is that the balance of effort and further action in this area needs to be clearly weighted towards prevention – helping to ensure that young carers are protected from falling into inappropriate caring roles in the first place. This will bring greater benefits for young carers and their families, providing better protections for their well-being. Over the longer term it should also reduce the need for more costly intervention and intensive remedial support.

New action – key assumptions/assessment of costs

1. Universal services

- £500K to be invested over the next three years to embed support and guidance on young carers through our Healthy Schools Programme and to ensure tailored and up-to-date resources are available for staff to draw down as part of their SEAL and PSHE programmes.
- £250K over next three years to support broader awareness raising across schools and other children's settings on caring in families and the issues this raises. This to link into broader awareness raising on caring over the early (to 2011) phase of the new strategy.
- £100k to support the development of materials and other training resources focused on young carers for use with GPs and hospital discharge teams, complementing the broader investments in training and awareness-raising planned for GPs and other health staff under the new Carers Strategy

Assumptions: £500K over three years will enable Healthy schools co-ordinators in every region to be trained and materials produced and used in a new programme of promotional work with local schools. £250K over two years will ensure the issues and challenges surrounding caring by children can be disseminated and issues of stigma and lack of understanding addressed.

Why intervene: Without new targeted investment, hard to secure greater levels of understanding on young carers issues that front-line settings need. Though some schools and settings have developed effective responses, children themselves are often loathe to reveal their difficulties so are not driving the development of support targeted in this area. An estimated 2-4% of children care at some point in their childhoods but without greater sensitivity and awareness and supportive environments within school many will continue not to come forward for the help they need.

Who bears costs: Central Government

Benefits: By 2011 universal services will be better equipped to identify young carers and to lend early and more effective support. More supportive environment within schools will encourage more youngsters to come forward for the help they need and ensure they stay attached to learning and to the important support and companionship networks which those settings can provide. Over time this is likely to reduce the need for more intensive remedial support. GPs, PCTs and hospital discharge teams will also be better placed to take early account of children's needs, looking beyond the patient to broader impacts on children and the family as a whole. Potential of new developments – extended schools, Healthy Schools Programme – fully developed and exploited to the benefit of young carers and their families.

Benefits outweigh costs? Benefits difficult to quantify in precise monetary terms but earlier identification is likely, over the longer term, to reduce recourse to more costly interventions further down the line.

2. Targeted support

- Research to be conducted in 08/09 to capture information on best practice and forms of support which deliver the greatest benefits so that provision continues to grow in quality and impact.

- £300K investment over 09/10 and 10/11 to ensure this best practice (i) informs/helps shape development of provision within extended schools and targeted youth support and opens up access to these services and sources of support to more young carers (ii) is used to support LAs in developing/commissioning an effective, evidence-based range of young carer support services

Assumptions Cost of national development lead to work with national policy makers & local delivers of services, plus operating budget = approximately **£150K** in both 09/10 & 10/11.

Why intervene? Some 22,000 children are currently supported through local projects, at an average cost per place of over £500 per year, but there is a lack of hard data on the impact and relative cost-benefits of the interventions currently in place. Research to collate this will help ensure best possible return on current and future investments. Some small scale work is underway but a clear national picture is needed. Building that learning across new settings like extended schools will, with limited additional investment, substantially increase local areas' potential to support young carers appropriately and cost-efficiently.

Who bears costs Central Government

Benefits Young carers get the best possible benefits from new developments. All local areas are able to strengthen the range, quality and cost effectiveness of the support they make available to meet young carers' needs.

Benefits outweigh costs? Highly likely. Quantifying this is difficult but this intervention offers potential for far more efficient use of existing resources in support of young carers.

3. Protecting young carers from inappropriate caring: strengthening prevention and whole family support

- An additional £5m to be invested in the development of up to a further 15 Extended Family Pathfinders for young carers, expanding on the 6 currently underway. The investment to run over two years from 09/10-10/11.
- £300K to be invested in an expanded programme of local and regional training on whole family working for staff in local services. Teams within adult mental health and substance misuse services to be particularly targeted.
- Research to investigate the patterns of support needs in families with young carers. Research to help identify where and to what extent further service change may be needed beyond 2011

Assumptions. On the expansion of the family pathfinders, costs assume £300K over two years for each new extended pathfinder area. On local and regional training, £100K of the funding in 08/09 would provide for the development of tailored training materials for use with mental health and substance misuse teams. The further £200K over the subsequent two years would fund an expanded programme of regional training for lead staff, with those in mental health and substance misuse teams to be particularly targeted (one extra large scale event per region reaching approximately 100-150 people in each region in both 2009-10 and 2010-11).

Why intervene/benefits? Gaps and weaknesses in support around the family are seen to be one of the key triggers for young carers falling into inappropriate or excessive caring. Over the next three years, Government is already committed to investing £3m in Extended Family Pathfinders enabling 6 local areas to model and trial new more preventative forms of support around families with young carers. These new investments will ensure more areas are supported to shift their systems towards more active prevention providing more centres of expertise on which all other LAs can draw. Becker (2004) and broader evidence from Government's "Hidden Harm" report, the new drugs strategy and other sources all point to the particular vulnerability of youngsters within families affected by substance misuse and mental health problems. Targeting further training and awareness raising on adult mental health and substance misuse teams likely to yield particular benefits in terms of increased protections for young carers.

Who bears costs Central government

Benefits outweigh costs? Gauging precise cost-benefits is difficult – these investments are designed to support systems change. In the short term direct benefits to young carers will accrue only in the pilot areas but the investments will form the basis of national change, the benefits of which are likely to be substantial.

ANNEX A

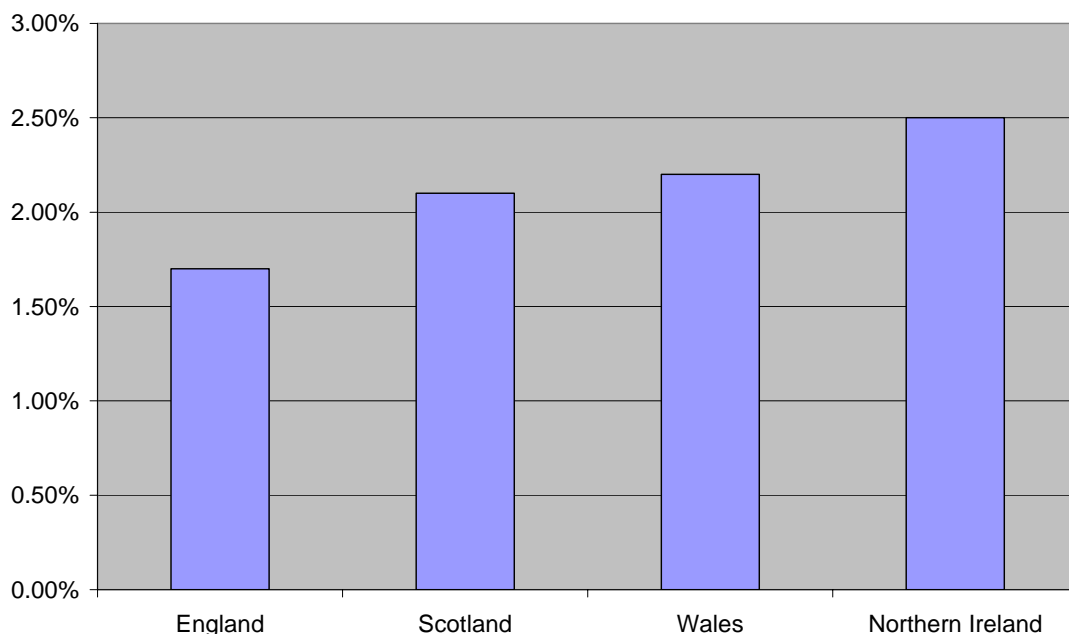
Young Carers-what do we know?

1. How many young carers are there?

- 139,000 in England
- 175,000 child carers in the UK

(Based on 2001 Census question “Do you look after, or give any help or support to family members, friends, neighbours or others because of: Long-term physical or mental ill-health or disability, or Problems related to old age?”)

Proportion of all children providing informal care



However, approximately 6% of children living in families with illness or disability provide informal care.

Problems with Census data on number of children providing informal care

- May not capture children caring for relatives with substance misuse problems, who are victims of domestic violence or who are suffering from HIV/Aids.
- May include children caring for non-family members (e.g. volunteering) which would not count as caring as usually understood.
- Differences in reporting/interpretation of the question may also lead to an under- or over-estimate of the numbers.

Other Research on Number of Children Providing Informal Care

The census estimates are supported by National Society for the Prevention of Cruelty to Children (NSPCC) data from a nationally representative sample of 3000 young people aged 18–24. This survey found that 4% of all young people in this age group had regularly cared for an ill or disabled relative during their own childhood (Aldridge and Becker, 2003:16–20; Cawson, 2002; Cawson et al., 2000).

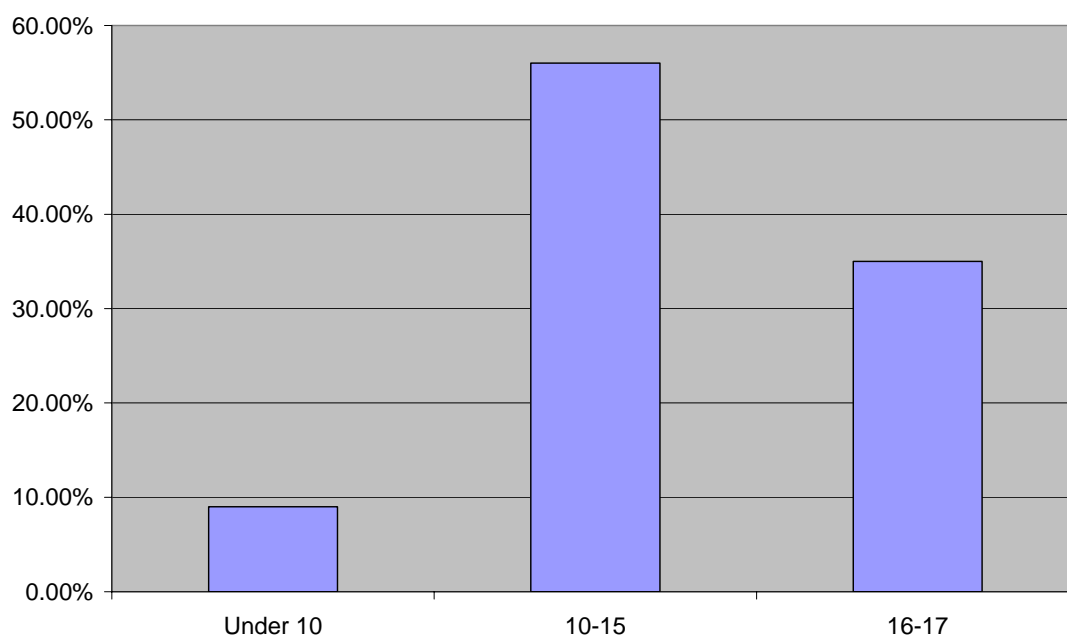
Data from Australia and the USA, though subject to differences in survey methodology and age bands also support a figure of 2-4% of children acting as caregivers (Becker Global Social Policy article 2007 p. 8).

Of 378 children and young people who were randomly selected for interview by Warren (2004), 34 (9% of the total sample) identified themselves as looking after or giving special help to someone at home who was ill, had a disability or other special needs. This suggests that in a UK population of approximately 11.66 million dependant children (ONS, 2004), up to 1.05 million may provide care that remains hidden. This finding has more recently been replicated by the Princess Royal Trust for Carers (PRTC, 2004). In an unpublished study of the experiences and views of a representative sample of over 1300 children and young people aged 7-19, the Princess Royal Trust for Carers found that around 12% of these young people showed signs of performing caring tasks within the home (PRTC, 2004). However, the categories used by Warren and the Royal Trust ('giving special help', 'showing signs of performing caring tasks in the home') are very wide and probably represent a considerable overestimate of the number of children giving substantial and regular care.

Earlier studies, in the 1990s, suggested much lower numbers of young carers than the census. A study in Sandwell suggested a figure of 10,000 young carers nationally. Research based on data from three Regional Health Authority-funded projects suggested a range of between 15,000 and 40,000 [Mahon and Higgins, 1995]. Parker and Olson [SSI Workshop paper 1995] claim that among 440,000 families which contain disabled parents and dependent children, only some 54,000 contain adults with substantial care needs. They also suggest a large proportion of young people in such families are not primary carers and have a limited caring role.

ONS figures (Walker, 1996) only included children who were providing 'substantial or regular care'. This produced an estimate of 19,000-51,000 young carers.

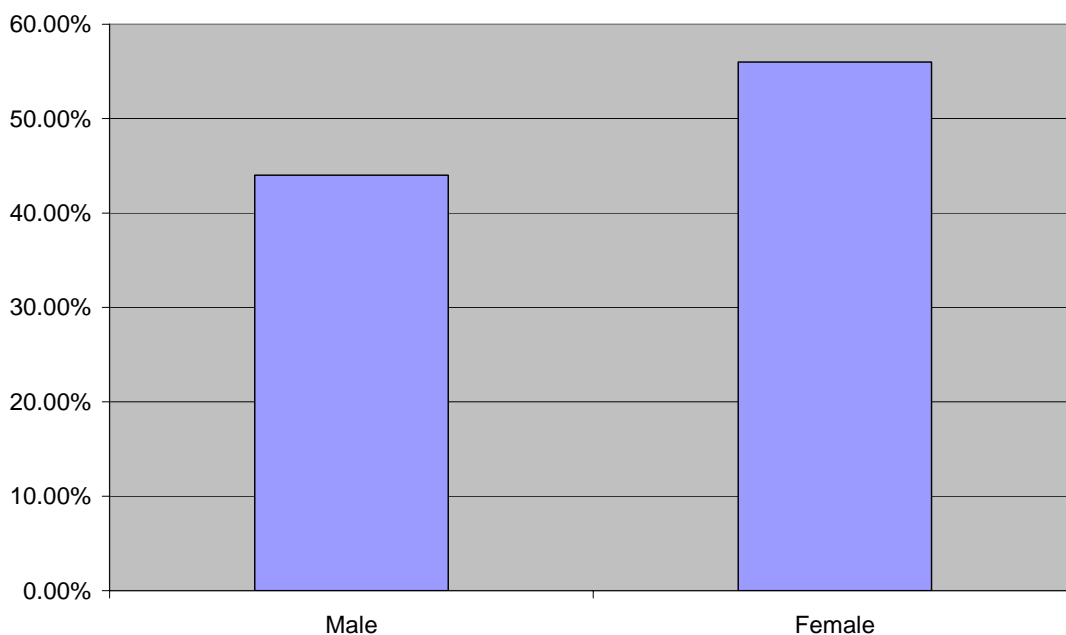
2. What age and demographic groups do young carers come from?



Source: Census 2001

Becker (2004) in a study of 6000 young carers in contact with support projects found 29% aged 5-10, 57% 11-15 and 14% 16-18 which they hypothesise reflects the fact that 'as young carers get older they use projects less'.

Gender of children involved in caring



Source: Becker (2004)

84% were white and 3% African Caribbean (the largest minority ethnic group). 56% were living in lone parent families.

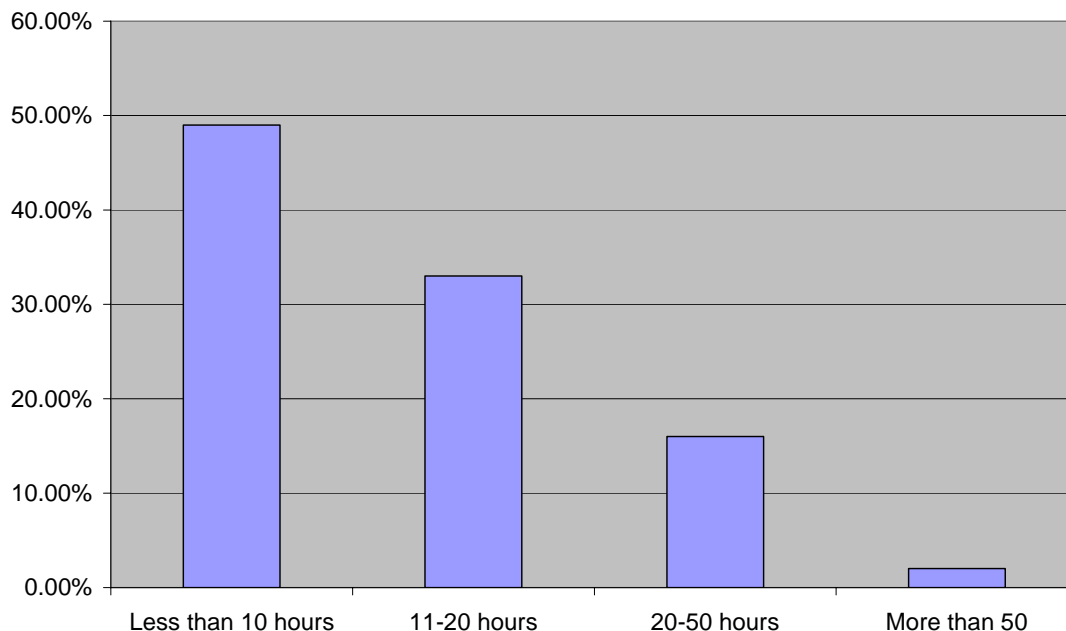
Only 4% of adults with care needs are in employment. Even where there was another adult in the household, only 54% of them were in employment. Young carers are therefore often in families living in relative poverty.

Other Research

Warren (2004) found that, of known young carers, three-quarters lived in lone parent families and two-thirds lived in households where no adult was employed. Of 'hidden' young carers just over half (59%) described their ethnic origins and background as black/black British, Asian/Asian British or dual heritage, the largest minority group being Asian/Asian British (44%). Warren hypothesises that young carers in some minority ethnic groups are less likely to be known to be young carers.

3. How many hours of care do young carers provide?

% of young carers by hours of care provided



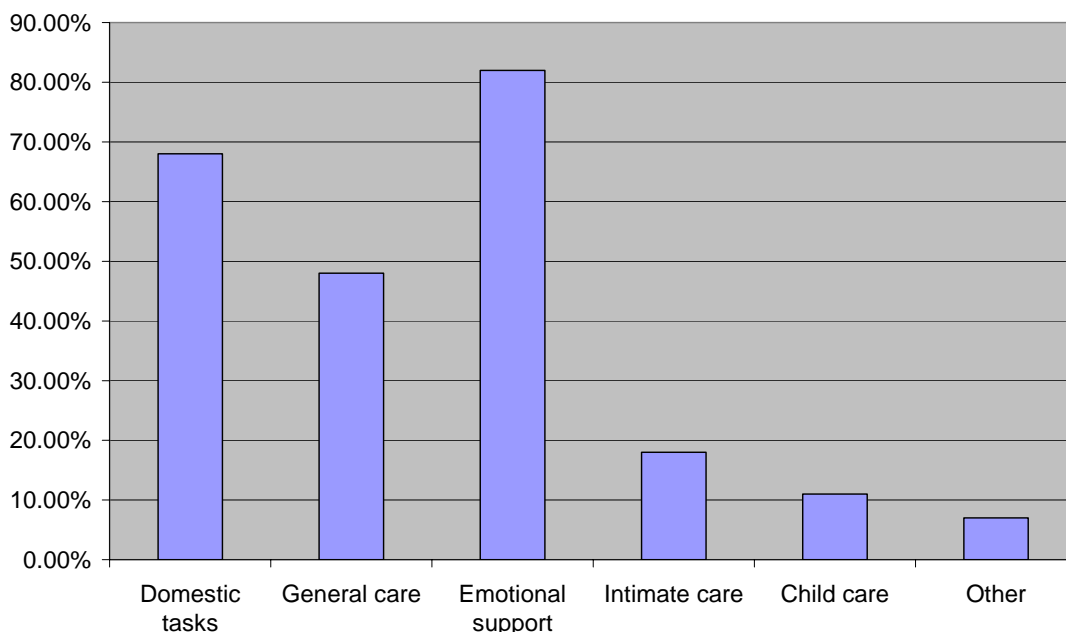
Source: Becker (2004)

The work of Becker (2004) shows a considerably higher proportion caring for 20 or more hours than suggested by the 2001 census but a smaller proportion caring for more than 50 hours. This may be as a result of young carers with very long hours not being in touch with carers projects though it is unclear whether this reflects lack of time to attend or if being in touch with projects reduces hours spent caring. Significant is that the largest number of young people providing care for more than 50 hours are 16 and 17, the age group with least contact with projects.

36% of young carers had been caring for 2 years or less, 44% for 3-5 years, 18% for 6-10 years and 3% for over 10 years. However, initiation into caring may have been a gradual process with children initially 'helping out' before adopting what we would understand as a caring role.

4. What types of care are provided?

Proportion of carers carrying out different types of care



Source: Becker (2004)

Becker (2004) distinguishes different caring tasks into: domestic tasks (household chores); general care (nursing type tasks such as giving medication, changing dressings, assisting with mobility); emotional support (e.g. observing care recipients' emotional state, providing supervision or trying to cheer them up);

intimate care (washing, dressing and assisting with toilet requirements); child care (helping to care for younger siblings in addition to other caring tasks; and other (e.g. household and other administration, bill paying, translating, accompanying to hospital).

Intimate care is most commonly provided where the person with care needs has a physical health problem or disability. Emotional support is far more common where the person has mental health problems. Girls are more involved in providing domestic and intimate care, especially as they get older.

5. Who is being cared for and why?

Becker (2004) finds the majority of people with care needs are mothers; this is especially true in lone parent families where mothers account for 70% of people needing care. In two parent families 46% of people receiving care are siblings. 50% of the people with care needs had physical health problems and disabilities, 29% had mental health problems, 17% learning difficulties and 3% sensory impairment. Parents were more likely to have physical and mental health problems, siblings more likely to have learning difficulties. Only 4% of adults with care needs are in employment. Where there was another adult in the household, only 54% of them were in employment.

6. What external support is received?

There are now **over 350 dedicated projects across the UK in contact with around 25,000 young carers** (Becker, 2007).

Becker (2004) found 18% had social services assessments, mostly as 'children in need' under Section 17 of the Children Act (1989). There were no significant differences between those who had been assessed and those who had not in relation to gender, age or caring tasks. 25% of BME young carers had been assessed compared to 17% of white young carers. Overall, while 11% of young carers were assessed under the Children Act, 21% of BME young carers were. Conversely, 6% of white young carers were assessed under the 1995 Carers (Recognition and Services) Act compared to 3% of BME young carers. This might be explained by the fact two thirds of BME young carers were in lone parent families and 14% of young carers in lone parent families were assessed as 'children in need' compared to 8% from two parent families. 28% of those caring for a relative with substance misuse problems had been assessed-24% under the Children Act. Of this category of carers 68% were also in lone parent families. However, there were no significant differences between young carers from lone parent and two parent families other than that they were more likely to care for a parent rather than a sibling.

21% of the families of young carers received no additional services other than the young carers' contact with a project. Social services support was the most common external support service received, accounting for around a third of all services received. Social services departments were also the main source of referral to projects.

A recent survey of 83 young people aged 6-19, all of whom were supported by Barnardo's young carers' projects, revealed that on average each young carer had spent four years looking after a relative or parent before they received any support (Barnardo's, 2006).

7. What are the impacts on young carers?

Educational

The 2003 national survey found 22% of young carers age 5-15 were missing school or experiencing educational difficulties-27% in the crucial 11-15 period compared to 13% age 5-10. Of children who were caring for a relative with substance misuse problems (7% of the recorded total) 34% had missed school and 40% were experiencing educational difficulties. The definition of 'educational difficulty' used by the survey is very general and so these figures may be overestimates. The figures on missing school seem likely to be more robust.

Warren (2004) data shows that whilst young carers are more likely than non-caring children and young people to miss school because of their caring roles, a large majority of young carers, in fact, do not miss school. This confirms earlier and ongoing research findings by Dearden and Becker (1998, 2004). Similarly, whilst young carers are more likely to be late for school than children and young people who are not carers because of the help that they give at home, most young carers are, in fact, nevertheless punctual for school.

Social, Emotional and Physical Well-Being

High levels of caring can also result in isolation from the peer group and extended family, limited time for social and leisure activities, and can limit opportunities and make transitions into adulthood more problematic (c.f. Dearden and Becker, 2000). Other effects can include feeling stigmatised, unrecognised and not understood, guilty at conflict between own needs and caring role and physical effects later in life (e.g. arthritis from lifting). There is no evidence of long-term emotional or mental health problems as a result of caring (Kachorek & Shifren, 2003)

On the other hand, children often derive satisfaction from their caring role and from their responsibility and influence within the family; feel loved and needed; and gain maturity, insight, self-esteem and independence (Aldridge and Becker, 1993). Negative effects may be related to socio-economic disadvantage rather than the caring role per se (Young Carers-Something to Think About: Report of Four SSI workshops May-July 1995). The one thing young carers consistently say is that "it's the worry that gets you"-simply being responsible for someone at home may be an emotional burden regardless of intensity of direct caring tasks.

The research does, however, suggest that young carers are more likely than non-caring children and young people to report that other children make fun of them or bully them because of the help that they give at home. This bullying can be directly related to other children's knowledge of young carers' domestic and caring roles, their parents' illness or disability or the fact that young carers are perceived as being different and so may not be accepted by their peers. As Crabtree and Warner (1999) have stressed, young carers may have fewer social skills as a result of their minimal social life experience and may find it harder to make and sustain relationships.

Warren (2004) provides evidence of the impacts that different types and levels of caring have on children and young people's capacity to socialise and engage in leisure and recreational activities. Young carers are, for example, more likely than non-caring children to be prevented from participating in social and leisure activities by factors associated with their caring roles and familial circumstances, such as needing to help at home, looking after someone in the family, the financial costs of caring and problems with transport. When young carers do participate in leisure and recreational activities away from the home, these activities are more likely to be based at school than in other community groups, such as a youth club, a music group, the Brownies or Guides.

Impact on future aspirations

Warren (2004) reports that young carers are more likely to identify a need to work in order to financially support their studies. Moreover, the data show that while many young carers directly choose to continue to live at home when they leave school, as a group, they are more likely than non-caring children to experience ambivalence about where they will live in the future. As other research (see Dearden and Becker, 2000) suggests, leaving home is especially problematic for many young carers, particularly if they have to leave a parent who requires help and support. Continuing to live at home, therefore, may be the only course of action open to young carers in the absence of support from elsewhere. Warren (2004) shows that young carers are more likely than other children and young people who are not carers to identify a range of barriers that might prevent them from fulfilling their future ambitions. In order of priority these include a lack of money, a need to look after a family member and a lack of qualifications.

Benefit of proposals in reducing the negative impacts of caring

We know that the educational performance of many young carers suffers as a result of their caring role. A significant number miss days at school which is linked to lower attainment. The aspirations of others for continuing in post-compulsory education are negatively affected by their caring role. By enabling

schools and other universal services to better identify young carers and strengthening the quality and range of support available to them, the proposals should enable more young carers to be given the support they need to fulfil their educational potential. As shown in table 1, given the lifetime returns to A*-C GCSEs and to A-Levels, it would only require 71 more young carers to achieve the former or 57 more young carers to achieve the latter for the economic benefits of the proposals to outweigh the costs.

Table 1

	Lifetime returns estimate	Additional young carers achieving for benefits of policy to equal costs (£6.02 million)
GCSE A*-G	£130,500	46
GCSE A*-C	£85,000	71
A-Level	£105,500	57
HE degree	£160,000	38

Source: DCSF, 2007 (unpublished)

Even these numbers are likely to be overestimates. The extra number of young carers that gain A*-C GCSE grades are as a result also more likely to obtain A-Levels, and similarly many of the extra numbers that gain A-Levels will be more likely to obtain higher education degrees, the return to which, as table 1 shows, is even higher. Therefore the benefits of the proposal would exceed the costs with considerably fewer numbers of young carers than 70 or 56 gaining more A*-C GCSEs or A-Levels. It can be reasonably expected that, at the very least, the implementation of the proposals would result in a sufficient number of young carers improving their educational outcomes to outweigh the cost of the proposals.

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	Yes/No	Yes/No
Small Firms Impact Test	Yes/No	Yes/No
Legal Aid	Yes/No	Yes/No
Sustainable Development	Yes/No	Yes/No
Carbon Assessment	Yes/No	Yes/No
Other Environment	Yes/No	Yes/No
Health Impact Assessment	Yes/No	Yes/No
Race Equality	Yes/No	Yes/No
Disability Equality	Yes/No	Yes/No
Gender Equality	Yes/No	Yes/No
Human Rights	Yes/No	Yes/No
Rural Proofing	Yes/No	Yes/No

Annexes

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