

# **Training and Supporting Carers**

## **The National Evaluation of the**

### ***Caring with Confidence* Programme**

Edited by Sue Yeandle and Andrea Wigfield

## **CIRCLE**

Centre for International Research on Care,  
Labour and Equalities

**University of Leeds**

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**Centre for International Research on Care, Labour and Equalities  
School of Sociology and Social Policy  
University of Leeds  
Leeds LS2 9JT**

Email: **CIRCLEadmin@leeds.ac.uk**

Telephone: **+44 (0)113 343 5003**

Website: **[www.sociology.leeds.ac.uk/circle/](http://www.sociology.leeds.ac.uk/circle/)**

The report can be downloaded from:

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# Contents

|                                 |     |
|---------------------------------|-----|
| Tables, Figures and Boxes ..... | v   |
| Glossary of Terms .....         | vii |
| Acknowledgements .....          | ix  |
| Executive Summary .....         | x   |

## Chapter 1

### A New Programme of Training for Carers: *Caring with Confidence*

Hilary Arksey, Andrea Wigfield and Sue Yeandle

|     |   |   |
|-----|---|---|
| 1.1 | Introduction .....  | 1 |
| 1.2 | Policy context.....   | 1 |
| 1.3 | Other training initiatives for carers .....                 | 3 |
| 1.4 | The <i>Caring with Confidence</i> programme .....           | 4 |
| 1.5 | Evaluating the <i>Caring with Confidence</i> programme..... | 7 |
| 1.6 | Structure of the report.....                                | 7 |

## Chapter 2

### Evaluation Design and Methods

Andrea Wigfield and Sue Yeandle

|     |   |    |
|-----|---|----|
| 2.1 | The evaluation methodology .....            | 8  |
| 2.2 | Key elements of the evaluation design ..... | 9  |
| 2.3 | Study implementation .....                  | 15 |

## Chapter 3

### Management and Design of the *Caring with Confidence* Programme

Hilary Arksey, Andrea Wigfield and Sue Yeandle

|     |  |    |
|-----|--|----|
| 3.1 | Introduction .....   | 17 |
| 3.2 | The commissioning process and contractual arrangements .....                   | 17 |
| 3.3 | Governance and project management.....   | 19 |
| 3.4 | Developing a model for <i>Caring with Confidence</i> delivery .....            | 21 |
| 3.5 | Conclusions: strengths and weaknesses of programme management and design ..... | 25 |

## Chapter 4

### The *Caring with Confidence* Programme: Implementation and Performance

Benedict Singleton, Andrea Wigfield and Sue Yeandle

|     |   |    |
|-----|---|----|
| 4.1 | Introduction .....  | 28 |
| 4.2 | Implementing <i>Caring with Confidence</i> through a provider network .....             | 28 |
| 4.3 | Supporting and monitoring provider performance .....                                    | 36 |
| 4.4 | Performance of providers in delivering <i>Caring with Confidence</i> .....              | 37 |
| 4.5 | Conclusions: strengths and weaknesses of programme implementation and performance ..... | 42 |

## Chapter 5

### Carers' Experiences of the *Caring with Confidence* Programme

Lisa Buckner and Sue Yeandle

|     |  |    |
|-----|--|----|
| 5.1 | Introduction .....   | 44 |
| 5.2 | Carers who took part in the programme .....                | 45 |
| 5.3 | Carer engagement with the programme .....                  | 49 |
| 5.4 | Carers' experiences of the programme.....                  | 55 |
| 5.5 | Outcomes for carers who participated in the programme..... | 61 |
| 5.6 | Conclusions: what carers gained from the programme .....   | 74 |

## Chapter 6

### Providers' Experiences of Programme Delivery

Gary Fry and Andrea Wigfield

|     |  |    |
|-----|--|----|
| 6.1 | Introduction .....   | 76 |
| 6.2 | Delivering the programme: experiences of case study providers .....                            | 77 |
| 6.3 | Practical issues in delivering the programme .....   | 79 |
| 6.4 | Organisational and managerial challenges experienced by providers .....                        | 81 |
| 6.5 | The relationship between <i>Caring with Confidence</i> and existing services and support ..... | 82 |
| 6.6 | <i>Caring with Confidence</i> and new approaches to delivering carer support.....              | 83 |
| 6.7 | <i>Caring with Confidence</i> and the future of training for carers .....                      | 85 |
| 6.8 | Conclusions: providers' experiences .....  | 87 |

## Chapter 7

### *Caring with Confidence*: Conclusions, Policy Implications and Recommendations

Andrea Wigfield and Sue Yeandle

|     |   |    |
|-----|---|----|
| 7.1 | Key evaluative findings and recommendations ..... | 89 |
|-----|---|----|

|                         |    |
|-------------------------|----|
| <b>References</b> ..... | 97 |
|-------------------------|----|

# Tables, Figures and Boxes

## Tables

|                  |  |    |
|------------------|--|----|
| <b>Table 2.1</b> | Participating Carers Survey: distribution and responses.....                           | 11 |
| <b>Table 2.2</b> | Characteristics of survey respondents .....  | 13 |
| <b>Table 3.1</b> | Budget for the CwC programme .....   | 18 |
| <b>Table 3.2</b> | The CwC training modules .....   | 23 |
| <b>Table 3.3</b> | Strengths and weaknesses of programme management and design .....                      | 26 |
| <b>Table 4.1</b> | Key stages in the procurement of CwC training providers .....                          | 30 |
| <b>Table 4.2</b> | Expressions of interest and procurement outcomes, by type of organisation .....        | 31 |
| <b>Table 4.3</b> | Funding models used in commissioning the CwC provider network.....                     | 32 |
| <b>Table 4.4</b> | Providers and registered carers, by English region.....                                | 34 |
| <b>Table 4.5</b> | Achievement of carer targets: places filled and level of engagement.....               | 38 |
| <b>Table 4.6</b> | Carer places delivered by quarter: all CwC providers .....                             | 38 |
| <b>Table 4.7</b> | Carers reached through face-to-face provision, by target group.....                    | 39 |
| <b>Table 4.8</b> | Average cost per carer place, by time period .....                                     | 41 |
| <b>Table 4.9</b> | Strengths and weaknesses of programme implementation and performance .....             | 43 |
| <b>Table 5.1</b> | Carers participating in CwC face-to-face, by gender and ethnicity .....                | 46 |
| <b>Table 5.2</b> | Carers participating in CwC face-to-face, by caring circumstances .....                | 47 |
| <b>Table 5.3</b> | Carers participating in CwC face-to-face, by characteristics of those cared for .....  | 48 |
| <b>Table 5.4</b> | Carers with no previous experience of carer training, by selected characteristics..... | 49 |
| <b>Table 5.5</b> | CwC participants, by age, gender and mode of delivery.....                             | 51 |
| <b>Table 5.6</b> | CwC participants, by target group, selected characteristics and mode of delivery ..... | 52 |
| <b>Table 5.7</b> | CwC participants: characteristics and number of face-to-face modules attended .....    | 53 |
| <b>Table 5.8</b> | CwC participants, by caring circumstances and number of modules attended.....          | 54 |
| <b>Table 5.9</b> | CwC modules, by number of carers who attended .....                                    | 55 |
| <b>Table 6.1</b> | Case study providers: selected monitoring data .....                                   | 78 |

## Figures

|                   |   |    |
|-------------------|---|----|
| <b>Figure 2.1</b> | All carers in England (18+) by age.....       | 12 |
| <b>Figure 2.2</b> | Carers registered for CwC by age.....         | 12 |
| <b>Figure 2.3</b> | Survey respondents by age: PCS1 .....         | 12 |
| <b>Figure 2.4</b> | Survey respondents by age: PCS2 .....         | 12 |
| <b>Figure 2.5</b> | Survey respondents by age: PCS3 .....         | 12 |
| <b>Figure 3.1</b> | The CwC programme: governance structure ..... | 19 |

|                    |   |    |
|--------------------|---|----|
| <b>Figure 4.1</b>  | Geographical distribution of carers registered for CwC .....  | 35 |
| <b>Figure 5.1</b>  | Registered carers: age profile .....  | 45 |
| <b>Figure 5.2</b>  | National carer data: age profile .....  | 45 |
| <b>Figure 5.3</b>  | Sources of information about CwC: participating carers .....  | 50 |
| <b>Figure 5.4</b>  | Generic CwC sessions: carer feedback .....  | 56 |
| <b>Figure 5.5</b>  | Tailored CwC sessions: carer feedback .....   | 57 |
| <b>Figure 5.6</b>  | Carers' views about the programme: on completion .....  | 57 |
| <b>Figure 5.7</b>  | Carers' views about the programme: six months after completion.....   | 58 |
| <b>Figure 5.8</b>  | Carers' experiences of the programme: on completion.....  | 58 |
| <b>Figure 5.9</b>  | Unexpected effects of participation: six months after completion .....  | 60 |
| <b>Figure 5.10</b> | CwC self-study modules: carer feedback .....  | 61 |
| <b>Figure 5.11</b> | Impact of the programme on care given: carers' perceptions on completion.....   | 62 |
| <b>Figure 5.12</b> | Impact of the programme on care given: carers' perceptions six months<br>after completion.....                                      | 63 |
| <b>Figure 5.13</b> | Impact of the programme on those cared for: carers' perceptions on completion .....   | 65 |
| <b>Figure 5.14</b> | Impact of the programme on those cared for: carers' perceptions six months<br>after completion.....                                 | 66 |
| <b>Figure 5.15</b> | Impact of the programme on carers' own lives: perceptions on completion.....  | 67 |
| <b>Figure 5.16</b> | Impact of the programme on carers' own lives: perceptions six months<br>after completion.....                                       | 67 |
| <b>Figure 5.17</b> | Impact of the programme on selected aspects of their caring circumstances:<br>carers' perceptions on completion .....               | 68 |
| <b>Figure 5.18</b> | Impact of the programme on selected aspects of their caring circumstances:<br>carers' perceptions six months after completion ..... | 69 |
| <b>Figure 5.19</b> | Impact of the programme on their own health and well-being: carers'<br>perceptions on completion .....                              | 72 |
| <b>Figure 5.20</b> | Impact of the programme on their own health and well-being: carers'<br>perceptions six months after completion.....                 | 73 |
| <b>Boxes</b>       |   |    |
| <b>Box 1.1</b>     | Objectives of the CwC programme .....   | 4  |
| <b>Box 1.2</b>     | Development and delivery of the CwC programme: key principles .....   | 5  |
| <b>Box 2.1</b>     | Objectives of the national evaluation of the CwC programme .....  | 9  |
| <b>Box 3.1</b>     | Roles and responsibilities of the CwC National Team.....  | 20 |
| <b>Box 6.1</b>     | Developing new, additional or ongoing support for carers .....  | 84 |
| <b>Box 6.2</b>     | Examples of how CwC helped providers promote carers' issues .....   | 84 |
| <b>Box 6.3</b>     | Example of a provider continuing to develop CwC.....  | 87 |

# Glossary of Terms

|  |  |
|--|--|
| <b>Consortium partners</b>   | The carers' organisations which formed a partnership to deliver the CwC programme with the lead partner, EPP.  |
| <b>Caring with Confidence (CwC)</b>  | Programme of training and support for carers funded by the Department of Health.   |
| <b>Distance learning</b>   | Self-study or online learning opportunities that allowed carers to learn in their own time without a requirement to attend face-to-face modules.   |
| <b>Expert Patients Programme (EPP)</b>   | The CwC consortium's lead partner, contracted to the Department of Health to design, manage and deliver the CwC programme.   |
| <b>Facilitators</b>  | Individuals who satisfactorily completed a CwC-approved Facilitator Development Programme.   |
| <b>Facilitator Development Programme (FDP)</b>   | A three-day in-house training programme, aimed at equipping individuals to facilitate CwC modules with groups of carers.   |
| <b>Fully-funded providers</b>  | Fully-funded providers which received funding to deliver CwC to carers covering the following costs: initial set-up, on-going delivery; some marketing; facilitator training; carers' travelling expenses; and carers' alternative care costs. |
| <b>National Team</b>   | The team recruited and employed by EPP to manage and deliver CwC on a day-to-day basis.  |
| <b>Part-funded providers</b>   | Part-funded providers which received reimbursement of facilitator training costs (only) to deliver CwC to carers.  |
| <b>Pay-as-you-go (PAYG) providers</b>  | Providers funded to deliver CwC to carers under a tariff model based on an agreed cost per unit / carer place, set in negotiation with individual providers.   |
| <b>Project Board</b>   | The governing body of CwC, which included representatives of all consortium partners.  |
| <b>Provider network</b>  | The network of local providers delivering CwC.   |
| <b>Provider Liaison Managers (PLMs)</b><br>later referred to as<br>Provider Development<br>Managers (PDMs) | Staff employed by the National Team to develop and manage relationships between the National Team and providers. The role became more developmental over time, hence the change in title.  |
| <b>Reference Group</b>   | A group (with members from relevant organisations) set up to offer advice and support to the CwC programme.  |

|                           |   |
|---------------------------|---|
| <b>Scope of Works</b>     | The document which outlined the Department of Health's requirements for the CwC programme and formed part of the contractual agreement between the EPP-led consortium and the DH. |
| <b>Tailored modules</b>   | Training modules designed for carers with similar needs, e.g. carers of people nearing the end of life.   |
| <b>Target groups</b>      | Three groups, designated by the Department of Health, identified as priority groups to receive CwC training.  |
| <b>Unfunded providers</b> | Provider organisations which did not receive funding to deliver CwC, and had to pay the costs of facilitator training, but were approved to deliver the programme.                |



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# Executive Summary

## Background

The *Caring with Confidence* (CwC) programme aimed to provide support to 37,000 carers in England. It was the largest programme of training for carers ever planned in the UK, with a total budget of £15.2m over three years. It was designed to provide training and support to carers, thereby giving them greater choice and control in different aspects of their lives.

Management of the CwC programme was commissioned from a consortium of partners comprising four carers' organisations, led by the Expert Patients Programme (EPP), with delivery implemented through a network of local training providers.

CwC operated for two and a half years of its intended three-year lifespan and delivered support to carers between August 2008 and September 2010. It was terminated ahead of schedule when it failed to meet targets for carers participating and because of DH concerns about the costs of delivering the programme.

The programme was well received by most carers who accessed it. Feedback from those who took part was extremely positive, with carers reporting beneficial impacts on their health and well-being, better access to social care support and improvements affecting those they cared for.

## Evaluation and methods

The evaluation comprised a three-year study carried out at the University of Leeds between June 2008 and May 2011. The study team was asked to: provide an account of the National Team in setting up, implementing and sustaining CwC; report on the success or otherwise of CwC in delivering its objectives; assess the impact of CwC on carers taking part in the programme; and assemble evidence on the impact of CwC on the organisations contracted to deliver it.

A mixed-methods approach was used, comprising: observational work; key informant interviews; documentary analysis; a three-phase survey of participating carers; case studies of providers delivering the programme; and analysis of management information.

The programme was evaluated against a series of objectives which were devised collectively by the DH, the National Team and the evaluation team, covering: management and governance of the programme; programme design; establishing a network of local providers; recruitment, marketing and publicity; milestones, outputs and costs; supporting carers; and impact on provider organisations.

## Management and governance of the CwC programme

The governance structure enabled the programme to be guided by a Project Board and Reference Group, both of which had the potential to offer a wide range of expertise and knowledge. Some lack of clarity about roles and responsibilities meant the governance structure and the consortium leading the programme was less cohesive and effective than was desirable. Although the DH held regular review meetings to manage the contract there were some ambiguities and uncertainties about key deliverables within the contractual documentation and delays and difficulties in resolving these matters at times compromised the effectiveness of programme implementation.

## Programme design

A prescriptive and centrally planned approach to the programme design was taken, focussing on high quality, standardised training, drawing on relevant expertise. This comprised a flexible, modular

training programme delivered by trained facilitators, using approved training materials only. Carers could access the programme through three different modes: face-to-face; online; or through 'self-study'. A set of 'generic' modules, considered suitable for all carers (aged 18+) was offered as well as additional 'tailored' modules for carers in specific circumstances or with particular types of caring responsibility.

### **Establishing a network of local training providers**

A rigorous initial provider procurement process led to the recruitment of 32 fully or part-funded local training providers which offered CwC to carers throughout England. Many, but not all, of the providers had existing experience of providing training to carers. A second wave of provider procurement, based on a different tariff model of funding - on a cost per unit / carer place - was later developed in response to DH concerns about low carer recruitment figures, leading to the recruitment of an additional 14 providers. In total 46<sup>1</sup> providers were commissioned to deliver CwC. The latter system of funding appeared to result in a lower cost per carer place.

### **Monitoring and supporting delivery**

A Management Information (MI) system, subcontracted to an external agency, was developed to monitor the performance of providers and the programme as a whole. The MI system was less effective than planned: there were inconsistencies in the way data on carers were collected; some providers were unwilling or unable to comply with the data inputting required; and some carers (and providers) did not provide the data requested, leading to substantial information gaps. This made it difficult for individual providers, the National Team and the evaluation team to monitor and evaluate individual provider and collective programme performance.

### **Recruitment, marketing and publicity**

CwC was launched nationally, resulting in positive initial publicity. Local marketing was supported through the provision (to local providers) of standardised marketing templates and other guidance. A wide range of marketing strategies was used by providers and some ran good marketing campaigns. However, restrictions on the marketing budget made it difficult to run a high-profile, on-going, national marketing campaign. Some provider organisations had limited experience of marketing and carer recruitment and needed additional support.

### **Milestones, outputs and costs**

Ambitious targets were set relating to carer numbers, which individual providers and the programme overall had difficulty meeting: 27,000 were to be fully trained face-to-face, but only 5,427 were trained in this way: 108,000 carer places were to be provided but only 40,292 were filled; an additional 10,000 carers were to be trained through self-study or online but only 1,318 accessed CwC through these mechanisms. There was no specific target cost per carer trained or number of modules attended but low carer numbers led to a relatively high cost per filled carer place. Initially high delivery costs became more manageable for some providers once they had established the programme, and the later tariff model had the potential to deliver CwC more cost effectively than the 'fully-funded' provision.

### **Supporting carers**

Although target number of carers were not met, the programme succeeded in registering almost 14,000 carers, 10,238 of whom attended at least one CwC module, with many of these (59%) being fully trained. These carers were reasonably representative of the wider population of carers, and some success was achieved in meeting targets for some particularly hard-to-reach groups.

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<sup>1</sup> Forty-six providers were engaged to deliver CwC but six were either terminated, never allocated funding or never registered any carers. Forty contracted providers delivered CwC to registered carers entered on the MI database.

Most participating carers had very positive experiences of CwC, which included:

- Benefits such as: learning new skills; meeting other carers in a supportive environment; greater knowledge of how to access support; improved health and well-being; help to enact their caring role more effectively; and more confidence.
- Some carers used the financial guidance and information they received to identify benefits they had not previously claimed or gain additional support / services.
- Substantial minorities of carers took up new social, leisure or health activities, and (in some cases) commenced a new training course or found paid work.
- Well after their participation in the programme was complete, many carers reported benefits affecting their caring role.

### The impact on CwC providers

Through CwC, providers offered a new form of support to carers which enabled them to: extend / enhance their range of services; develop / deepen their commitment to carers; build new partnerships; raise local awareness of carer issues; gain practical experience of carer support (intelligence about: suitable venues; workable delivery arrangements; strategies for recruiting carers; establishing referral pathways; and offering carers alternative care support). Some providers attempted to sustain CwC beyond the programme's termination date.

Many providers noted that CwC offered a new form of support to carers which was previously lacking, and emphasised the importance of finding new ways of delivering support to carers of the quality achieved by CwC in the future. The availability of the CwC programme resources and module content provides an important legacy on which future carer support can be built.

### Recommendations

Eight recommendations arising out of the CwC programme evaluation were identified for future training and support programmes for carers. In summary form, these are:

**Recommendation 1:** Governance systems should be transparent, with unambiguous targets, outputs and outcomes specified in contractual documentation.

**Recommendation 2:** Programmes should be flexible in terms of local delivery and responsiveness to specific carer needs.

**Recommendation 3:** Output-related funding models should be considered.

**Recommendation 4:** Effective MI systems should be put in place.

**Recommendation 5:** Innovative marketing and recruitment techniques are needed.

**Recommendation 6:** Milestones, targets and costs need to be ambitious but achievable.

**Recommendation 7:** Innovative ways of supporting carers are needed, drawing on partnerships with independent sector providers and those who support, engage with or employ carers. The plans indicated in the Coalition Government's 'Next Steps' document (HMG, 2010), provide opportunities to address this.

**Recommendation 8:** Practical issues to consider when offering support to carers should include: identifying suitable venues; establishing workable delivery arrangements; developing strategies for recruitment and referral pathways; and identifying the most appropriate ways to offer alternative care support.

# Chapter 1

## A New Programme of Training for Carers: *Caring with Confidence*

Hilary Arksey, Andrea Wigfield and Sue Yeandle

### 1.1 Introduction

The *Caring with Confidence* (CwC) programme was a new measure introduced as part of the *New Deal for Carers* initiative, first proposed in the Department of Health White Paper *Our Health, Our Care, Our Say* (DH, 2006). The programme was funded by the Department of Health (DH), which allocated a budget of £15.2m over three years for this purpose. It aimed to provide training and support to carers, with the objective of giving them greater choice and control in important areas of their lives such as health, access to social care support and the ability to manage paid work or other activities alongside their caring role. It was anticipated that carers would benefit through improved health and well-being, greater levels of independence, and more time outside caring, which in turn would be of value to those they care for.

In spring 2008 the DH Policy Research Programme commissioned CIRCLE (*Centre for International Research on Care, Labour and Equalities*) at the University of Leeds to undertake a three-year evaluation of the CwC programme. The evaluation study was developed and undertaken in collaboration with SPRU (the *Social Policy Research Unit*) at the University of York until October 2010 when it became the sole responsibility of CIRCLE<sup>1</sup>. The study design and methods are outlined in Chapter 2.

The main purpose of this report is to explore the extent to which the objectives of the CwC programme were met, drawing on all data made available to the evaluation team or collected by the team as part of the evaluation study. This opening chapter briefly outlines the policy context in which the programme was commissioned, indicating that some training provision for carers already existed before CwC was developed. It sets out the main features of the programme as it was designed and delivered between November 2007 and September 2010, and specifies the high level objectives set out by the DH when it commissioned the programme. The chapter outlines the DH's requirements about carer beneficiaries and the training experience they would have during the planned period of programme delivery. It notes the DH's expectation that, through the experience gained in delivering CwC in a large, well-resourced programme over a three-year period, sustainable ways of delivering future training and support to carers across England (without the need for continuing central government funding) would be identified. The chapter also describes the approach taken by the research team in designing and delivering the evaluation study, which included both formative and summative elements. It concludes with a description of the structure of the report.

### 1.2 Policy context

Official recognition of the needs carers have for support and training in their caring roles was first indicated in *Caring About Carers*, the first national strategy for carers (HMG, 1999). Publication of this strategic commitment followed extensive lobbying for improved information and better financial and practical support for carers in preceding decades. This lobbying was led by voluntary organisations

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<sup>1</sup> The SPRU researcher involved took early retirement in September 2010 but continued to contribute to the evaluation study on a freelance basis.

representing carers with some support from those representing the interests of older people and people with disabilities. Their advocacy, and politicians' responses to it, resulted in the 1990s and 2000s in a range of policy and legislative changes designed to assist people to provide unpaid care to older, sick and disabled relatives and friends (Cook, 2007).

The *New Deal for Carers* was a package of additional support and services for carers introduced in a £33m programme announced in February 2007. Aimed at 'making carers' lives easier', it was led by the DH (working with other government departments and major carers' organisations) to create a long-term framework to come into force in 2008-09. The main commitments announced in 2007 were: £2.8m annually for a new carers' information service and telephone helpline; £25m for emergency respite care, through resources made available to local authorities; and £4.7m annually (initially for three years) for an 'expert carers' programme, to be 'up and running' by the end of 2008 (DH, 2007). The *New Deal for Carers* also included a commitment to revise the *National Strategy for Carers*, outlining a ten-year vision for carers. It was published in July 2008 (HMG, 2008).

The 2008 carers' strategy set out both a short-term agenda and long-term vision for the future support of carers, underpinned by £255m of additional funding. Among its key commitments was the 'programme of training' which had already been signalled in the New Deal the previous year, intended to strengthen carers in their caring role and empower them in their dealings with care professionals (HMG, 2008: 12). This new programme was to be developed in partnership with carers' organisations, building on relevant experience, including the development of the DH 'Expert Patient Programme' (Kennedy et al, 2006) and existing provision for carers available through voluntary organisations and local authorities. This new programme of training, initially referred to as the 'Expert Carers Programme', but subsequently named '*Caring with Confidence*', was rolled out through a network of training providers from August 2008 onwards. It ran as a DH-commissioned programme of support for carers in England until September 2010, when (following a DH review of performance, outcomes and costs) it ceased operation, final notice having been given of the Government's decision to terminate the CwC delivery contract at the end of June 2010.

When the programme was first conceptualised in 2006-7, it was intended as a contribution to meeting government's strategic aim of ensuring that, by 2018, carers would be 'respected' as 'expert care partners' who would have access to integrated and personalised services to help support them in their caring role (HMG, 2008). The DH hoped that carers themselves - and their advocates in the voluntary sector - would have a significant voice in shaping the new programme of support. It was to be a completely new programme which would build on existing initiatives operating at the local level through voluntary and local authority activities, including some funded since 2000 through the DH 'carers' grant' (Fry et al, 2009).

Most policy developments affecting carers in the 2000s enjoyed all-party support at both the national and local levels of government and, following the May 2010 General Election, the Coalition Government issued a statement on carer support in November 2010, setting out its plans to support carers through technology, health and social services and to assist those combining caring with paid work. Its emphasis was on supporting those providing care to identify themselves as carers, involving them in care planning, and enabling them to fulfill their educational and employment potential. Its commitments included personalised support designed to help them keep mentally and physically well, and it acknowledged an ongoing demand for suitable learning and training for carers, particularly that which assists them in carrying out their role effectively and safely (HMG, 2010).



### 1.3 Other training initiatives for carers

When the CwC programme was commissioned, there were already several national training initiatives for carers in existence delivering support to carers in England. These included *Learning for Living*, a programme run by City & Guilds, which had been developed in 2002-5 as part of the EU-funded 'Action for Carers and Employment' project led by Carers UK (Yeandle and Starr, 2007) and *Looking After Me*, a course developed within the DH-funded Expert Patient Programme which had been running since 2004. *Learning for Living* was operating as an on-line learning resource through which carers could obtain a Certificate in Personal Development and Learning for Unpaid Carers, a qualification accredited at level two within the National Qualifications Framework<sup>2</sup>; *Looking After Me* was designed for adults looking after someone living with a long-term health condition or disability and was run by the Expert Patients Programme (EPP). It aimed to promote self-help and the sharing of experience and expertise among carers (Hare and Newbronner, 2005).

There were also programmes of support for carers in Scotland which were already running (or being set up at the same time as the CwC programme), and some operating at the local level in England, mainly small projects operating through local carers' organisations such as those linked to the Princess Royal Trust for Carers (PRTC). In Scotland, carer support programmes included one run by the Alzheimers' Society for carers of dementia sufferers, a programme for black and minority ethnic (BME) carers and carers in rural communities (Carers Scotland, 2009) and a small pilot programme, also called 'Caring with Confidence' which (despite sharing the same name) was a completely separate programme funded by the Scottish Government in partnership with voluntary sector agencies in 2007-09 (Glasgow Caledonian University, 2009).

As its plans for developing a programme of support for carers began to take shape in 2006, the DH funded a small 'mapping exercise' to explore what training provision for carers was already available in England (commissioned via the PRTC). This showed that there were at least 176 organisations providing such training in England in spring 2006. Among these, 25% were carers' organisations, 24% were local authorities, 21% were NHS bodies, and 17% were other local charities. There was also some provision available through national carers' organisations and other charities (Clarke and Riley, 2006). The exercise found that the quality, relevance and geographical spread of this provision was 'unclear', and that further research was needed.

Apart from this there was limited documentation available about carer training when CwC was first commissioned at the end of 2007. The DH wished those responsible for designing and setting up CwC to undertake a mapping exercise of existing schemes and projects, and this was specified in the *Scope of Works* (a document outlining the requirements of the CwC programme) as a task to be completed by the end of April 2008 (see below and Chapter 3). Subsequently some aspects of the evidence base about the effectiveness of interventions for carers have improved. A systematic review of UK interventions and services for carers recently reported positive findings about carer education and training programmes, finding that (despite some evidence that skills may not be maintained over time) most studies reported consistently positive outcomes for carers in terms of developing new knowledge and skills and building confidence in existing knowledge and skills (Victor, 2009). A separate meta-review of international evidence on interventions supporting carers concluded that the strongest evidence of effectiveness (of any sort) related to education, training and information for carers. Such interventions, especially if 'active and targeted' rather than 'passive and generic', were found to increase carers' knowledge and abilities as carers (Parker et al, 2010: 67). Anticipating that investing in the development of a large programme of training for carers would be beneficial for carers and those they care for seems to have been a reasonable expectation in view of these research findings. As shown in Chapter 5 of this report,

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<sup>2</sup> <http://www.learning-for-living.co.uk/>.

carers themselves indicated, in a range of ways, that they valued and felt they had benefitted from the support they gained through taking part in *Caring with Confidence*.

### Box 1.1 Objectives of the CwC programme

To offer a range of learning opportunities to enable carers to gain the knowledge, skills and expertise they need to:

- Work in partnership with the person they care for, and with social care and health professionals.
- Safeguard their well-being and health, and that of the person they care for.
- Undertake the practical tasks associated with their caring role as safely and effectively as possible.
- Access and make appropriate use of services and benefits available to support them, and the person they care for.
- Manage the emotional impact of their caring role.
- Be better equipped to create and maintain new life roles as a carer and beyond.
- Advocate effectively - on their own behalf, on behalf of the person they care for, or others – at practical and policy levels.
- Form supportive and effective networks with other carers, to enable them to improve – at practical and policy levels - their own situation, that of the person they care for, other carers and cared for people.
- Move from a position of dependence to self-direction as citizens.

Source: Department of Health, Scope of Works, para 2.1 (2007, unpublished).

## 1.4 The *Caring with Confidence* programme

Following a 'limited' tender process, the DH commissioned the CwC programme in November 2007 from a consortium led by the Expert Patients Programme (EPP), a community interest company (CIC), which was already delivering the DH-funded *Expert Patient Programme*. In addition to EPP (acting as lead delivery partner) the consortium comprised four voluntary organisations (*Carers UK*; *Princess Royal Trust for Carers (PRTC)*; *Crossroads*; and *Partners (Family Leadership) UK CIC*). It was tasked with developing, delivering and managing a sustainable programme of support for carers, to be delivered across England via a variety of providers, including some from both the voluntary and public sectors. All members of the consortium remained involved with the CwC programme until its closure in autumn 2010 apart from *Partners (Family Leadership) UK CIC*, which withdrew from the consortium in autumn 2008. A diagram of the governance structure of CwC is provided in Chapter 3 (Figure 3.1).



**Box 1. 2 Development and delivery of the CWC programme: key principles**

- Actively involve carers in the development of its content and delivery.
- Empower and enable carers to develop their situation, skills and capacity on an on-going basis by individual and collective means.
- Draw on established and best practice.
- Build upon current ECP<sup>1</sup>-type provision.
- Reflect the changing needs of carers' roles, i.e. as their role begins, when the condition of the cared for person changes, or as the carer's role ends.
- Be accessible module-by-module, as appropriate on the caring journey.
- Be tailored to be accessible and relevant to all carers.
- Contain both generic training, and (as appropriate) training tailored to the particular needs of the cared for and / or carer.
- Take into account the individual learning styles and needs of carers.
- Offer a wide range of learning opportunities, in appropriate formats and locations.
- Include, where desired, access to accreditation that carers may transfer into future employment or life-long learning.
- Be of high quality, and quality-assured.
- Ensure that carers are recognised and valued for the role and contribution they make to their families and the community.
- Reduce social isolation.
- Be delivered by local organisations.
- Recognise that many carers are trying to combine caring with other responsibilities, such as childcare and work, and therefore provide training at times which accord with carers' lifestyles.
- Support carers to maintain or gain employment.
- Be free to carers. The programme would cover all costs carers incur in receiving training, including (but not limited to) transport, alternative caring arrangements, support staff (i.e. personal assistants/interpreters).
- Provide value for money.

Source: Department of Health, Scope of Works, para 3.1 (2007, unpublished).

<sup>1</sup> Expert Carer Programme.

Work on CwC began in January 2008, with governance of the programme via a *Project Board* made up of representatives of the consortium partners. This met regularly throughout the CwC programme (see Chapter 3, section 3.3). A *National Team* comprised of EPP employees was given responsibility for managing the programme and overseeing its delivery, and a *Reference Group* was established to offer guidance. This comprised representatives of the DH, key members of the National Team and representatives of a number of carers' organisations and organisations representing older, sick and disabled people and was chaired by the *Standing Commission on Carers* (SCC). The *Reference Group* met twice, in May and December 2008, but was not well attended and (following consultation between the DH, National Team and SCC) was disbanded in summer 2009, as recorded in minutes of the Project Board meeting held in September 2009.

The DH *Scope of Works* (which formed the basis of the initial contractual agreement) indicated that the CwC programme's remit was to provide training and support for carers aged 18 years and older in England<sup>3</sup> with an emphasis on specified 'target groups': carers who provide care for 50 or more hours per week; carers of minority ethnic heritage; carers of those of minority ethnic heritage; carers of those nearing the end of life; carers who are lesbian, gay, bi-sexual, or transgender (LGBT); and carers of those who are LGBT (described in Chapter 3). Initially it was expected that 50% of carers trained would belong to at least one of the target groups, although this target was revised (in October 2008) and replaced with three target groups each to comprise an equal proportion of carers<sup>4</sup>.

When the programme was set up, the DH expected CwC to deliver face-to-face training to 27,000 carers by 31 March 2011, alongside self-study and online provision to an additional 10,000 carers, making it the largest programme of training for carers ever planned in the UK. Later, the DH clarified this aim to encompass the expectation that CwC would, in meeting these objectives, deliver at least 108,000 'carer places' (based on the aspiration that each carer participating in CwC face-to-face would attend an average of four CwC modules). CwC was expected to offer participating carers new opportunities to gain knowledge, skills and expertise to look after themselves, and those they care for, in a safe, efficient and effective manner, and to access the information and support they need. Box 1.1 summarises the programme's key objectives.

One of the principal aims of CwC was to ensure that carers who participated in the programme would be better placed to exercise greater choice and control in important areas of their lives, for instance in relation to health care, social care support and paid work. It was thought that in the longer term this had the potential to facilitate increased well-being, choice and independence among carers, as well as to benefit those they cared for, enabling both carers and those they supported to participate in society according to their own wishes. The principles underpinning the development and delivery of the programme are outlined in Box 1.2.

The CwC Project Board met on at least 24 occasions, and more than 20 DH review meetings were held between the National Team and the DH to review progress on a regular basis and address issues. In June 2010, following a range of discussions about carer uptake of CwC and value for money, the DH decided to terminate the programme on 28 September 2010, six months before the initial three year funding period ended. At the end of September 2010, a total of 10,238 carers had attended one or more CwC modules, in a programme delivered through a network of 46<sup>5</sup> providers across England. During this time CwC delivered modules in 4,845 face-to-face sessions, delivering 40,292 carer places. The programme registered a total of 12,621 carers, 81% of whom attended at least one CwC session, with a further 1,318 carers participating in the programme through self-study or online.

<sup>3</sup> Health and social care are policy areas devolved to national governments in the UK, so the CwC programme, developed by the DH re its responsibilities in England, affected carers in England only.

<sup>4</sup> Target Group Three comprised any carer aged 18+ not in either Target Group One or Two, and thus in effect comprised any other carer.

<sup>5</sup> Forty-six providers were engaged to deliver CwC but six were either terminated, never allocated funding or never registered any carers. Forty contracted providers delivered CwC to registered carers entered on the MI database.

## 1.5 Evaluating the *Caring with Confidence* programme

The evaluation design for the programme was selected to: provide an account of the National Team's work in setting up, implementing and sustaining the programme; report on how far programme objectives were met; assess its impact on carers taking part; and consider its impact on organisations delivering the programme and on pre-existing support for carers. By agreement with DH, the study comprised eight key elements:

- Observations of meetings, events and programme delivery.
- A phased series of semi-structured interviews with 'key informants'.
- Extensive documentary analysis.
- A three-stage longitudinal survey of participating carers.
- Multi-method case studies of selected CwC providers, with site visits.
- Focus groups with carers who had taken part in CwC.
- A two-stage electronic survey of all CwC providers (with the option of a telephone interview, if preferred).
- Statistical analysis of the CwC management information data.

The evaluation comprised both summative and formative approaches, and in consequence some study findings, and recommendations based upon interim observations and analysis, were fed into the CwC programme during its lifetime. These included assisting the National Team and the Project Board to specify detailed interim and ultimate programme objectives (Appendix A<sup>6</sup>) against which the CwC programme would be evaluated.

## 1.6 Structure of the report

The report is organised as follows:

- Chapter 2 describes the evaluation methodology, its implementation and the adjustments made during the study to accommodate programme changes.
- Chapter 3 reviews and assesses evidence about the design and management of the CwC programme, reflecting on evidence relating to how it was commissioned and contracted, its governance and management arrangements and the model selected for delivery of CwC training to carers.
- Chapter 4 provides evidence about the implementation and performance of the National Team and the providers it contracted to deliver CwC, including an assessment of the difficulties they encountered in recruiting adequate numbers of carers to meet programme targets, and issues in delivering CwC at an acceptable cost.
- Chapter 5 provides detailed information about the characteristics of the carers who took part in the CwC programme, and considers both how they engaged with it and what their perceptions and experiences of the programme were. It also presents evidence of identifiable outcomes for carers.
- Chapter 6 draws on evidence from the CwC provider network. It considers practical matters in local implementation of the CwC programme; providers' organisational and managerial capacity; the impact of CwC on providers' existing programmes of work and organisational cultures; and what can be learned from this about the delivery of carer training in the future.
- Chapter 7 presents the conclusions and recommendations based on the evidence collected in the study.

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<sup>6</sup> The appendices to this report are available (in electronic format) from [www.sociology.leeds.ac.uk/circle/](http://www.sociology.leeds.ac.uk/circle/).

## Chapter 2

# Evaluation Design and Methods

Andrea Wigfield and Sue Yeandle

### 2.1 The evaluation methodology

A detailed methodology for the evaluation of the *Caring with Confidence* (CwC) programme was outlined in the research team's original proposal for the work, submitted to the DH towards the end of 2007. At that stage (prior to the commencement of both the CwC programme and the evaluation study), the overarching aims of the research design were to evaluate three aspects of the programme being commissioned by the DH: the role and activities of the National Team; the nature, scope and quality of the training delivered to carers; and the benefits of the programme for carers, those they care for, and others in the health and social care system.

The evaluation team began work on 1 June 2008, by which time the CwC programme had been running for five months. The team took immediate steps to familiarise itself with the National Team's activities and approach, holding a series of meetings with the DH Policy Research Programme (PRP), the DH policy manager responsible for management of the CwC contract, and members of the National Team. A detailed implementation plan for the study was then drawn up (and agreed with the DH PRP) and this (modified appropriately as the delivery of the programme itself evolved) guided the arrangements for the evaluation study and methods throughout.

The evaluation methodology comprised a mixed methods approach combining both qualitative and quantitative elements, together with observation and documentary analysis. It involved the collection of primary research data as well as the analysis of secondary data, and included a case study element to provide greater understanding of the local operation of the programme. Focus groups with carers were also included to elicit their views about the programme. The research plan was designed to meet four key evaluation objectives agreed in 2008 with the DH (Box 2.1).

The evaluation design chosen to achieve these objectives had six key elements, outlined in further detail in subsequent sections of this chapter: observational work; key informant interviews; documentary analysis; a three-phase Participating Carers Survey (PCS); case studies of providers delivering the programme; and analysis of management information. Preparatory activities, and other phased activities to ensure the evaluation could be undertaken and modified as the CwC programme evolved, included: negotiating ethical approvals; agreeing information transfer arrangements; and developing and testing research instruments. There was regular dialogue between the evaluation team and the DH PRP. At key points in 2008 and in 2010, methodological adjustments were agreed as aspects of the CwC programme changed<sup>1</sup>. The evaluation team provided the DH PRP with formal interim reports in June 2009, June 2010 and March 2011.

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<sup>1</sup> On the advice of the evaluation commissioning panel, the study did not include a comparative sample of carers who were not taking part in the CwC programme. Adjustments to the study design were made in late 2008, when a detailed understanding of CwC programme objectives was confirmed, and again in spring / summer 2010 when the DH was negotiating with the CwC NT about the early termination of the programme (fieldwork was temporarily halted at the request of the DH) and following the decision to end the programme early. The latter led to some difficulties for the study team in collecting local management information about programme delivery costs. Formal amendments to the evaluation contract were made in connection with the programme termination in autumn 2010.

**Box 2.1 Objectives of the national evaluation of the CwC programme**

- A. Provide an objective, evidence-based account of the National Team in setting up, implementing and sustaining CwC.
- B. Report on the success or otherwise of CwC in delivering on the agreed programme objectives, including meeting targets for participants and participant characteristics.
- C. Assess the impact of CwC on carers taking part in the programme, with particular reference to their health, access to services, information and support, and general well-being / social inclusion.
- D. Assemble an evidence base on the impact CwC has on the organisations contracted to deliver the programme at local level, noting any impacts on pre-existing support for carers.

## 2.2 Key elements of the evaluation design

The six key elements of the evaluation design are described in this section (with most research instruments available in the report appendices).

### Observational work

Observational work was integral to the multi-method approach used in the evaluation. It included attending and observing selected events and activities (including Project Board meetings, Reference Group meetings, events organised by the National Team to support the provider network and CwC module sessions being delivered to carers). The evaluation team considered this aspect of its work important as it helped contextualise decisions made and clarify processes, giving the evaluation team some first-hand experience of how issues were debated and addressed, and supplementing its analysis of formal documentation. It was used in achieving evaluation objectives A and D (described in Box 2.1).

### Key informant interviews

Interviews with 'key informants' (those with access to specialised information or closely involved in developing the CwC programme) were originally planned at three points: winter 2008-09; winter 2009-10; and winter 2010-11. These interviews sought to address the first key objective of the evaluation (Objective A described in Box 2.1). When the announcement of the early termination of the CwC programme was made in June 2010, and it became clear provision would cease at the end of September 2010, the third phase interviews were brought forward. In total, 35 key informant interviews were conducted over the three years, each using a topic guide and in most cases tape-recorded (with permission) for subsequent analysis. Interviewees included members of the CwC Project Board, National Team and Reference Group, and key personnel responsible for the programme at DH, as well as selected staff responsible for the sub-contracted Management Information (MI) system and the CwC facilitator training. Most key informant interviews were conducted face-to-face, although a few were completed by telephone, for logistical reasons or to accommodate interviewees' other commitments. For an example of the topic guides used in this part of the evaluation, see Appendix B.

### Documentary analysis

The purpose of the documentary analysis was to clarify the evaluation team's understanding of formal agreements and arrangements during the development and delivery of CwC and to ensure that the evaluation team had the opportunity to understand the formal basis of decision-making within the programme and could review reports and documents relating to the National Team's progress and



performance. A wide range of material was assembled across the three years of the evaluation, including: documents relating to the contractual arrangements between DH and the CwC Project Board and National Team; reports on progress; papers relating to the contractual obligations agreed between the National Team and providers, including procurement processes; selected documents developed to guide the work of the provider network; examples of CwC publicity materials; examples of module documentation; and reports which the National Team commissioned from external suppliers (to map provision, consider issues such as programme accreditation, etc.). When reviewing documentation, the evaluation team used an analysis template to map and record key issues and link them to other aspects of the evaluation.

### The participating carers survey

A three-phase survey of carers participating in the CwC programme (the PCS) was developed to explore the characteristics, perceptions and circumstances of carers who sought support via the programme. Its aim was not only to assess the impact of the CwC programme on those carers who took part (on their health, access to services, well-being, ability to pursue a 'life of their own', and to be appropriately sustained and supported in their caring role), but also to guide future targeting of resources towards carers.

With 27,000 carers expected to go through the CwC programme in the main sites in 2009-11, and a further 10,000 expected to engage with the online and / or self-study versions of the programme, the programme provided an opportunity to collect data from a sample of carers large enough to permit statistical analysis of sub-groups within the sample. In view of the timing of the evaluation contract (2 June 2008 to 1 June 2011), the significantly revised timing of CwC programme delivery in the main sites in 2008-09 and the decision in autumn 2008 to abandon 'phased delivery' of CwC in favour of a spring 2009 roll-out across 25 provider sites<sup>2</sup>, it was decided (in consultation with the DH PRP) to survey all carers who joined the programme during an appropriate time period. This arrangement also offered a way of reducing the research burden on CwC providers, as the initial questionnaire, PCS1, could be delivered through a 'survey pack', distributed to all carers when they first engaged with the programme. All carers were originally expected to join the programme via its gateway module *Finding your way* before choosing which other modules to access from the flexible range of optional CwC modules). Following discussion with the National Team and liaison with CwC providers, the survey was implemented in three phases, as follows:

- PCS1, administered via the *Finding your way* module as carers joined the programme.
- PCS2, sent to carers (at their home addresses) approximately 12 weeks later.
- PCS3, sent to carers (at their home addresses) approximately five to six months later (i.e. approximately eight to nine months after first joining the CwC programme).

Copies of the three questionnaires developed for the study (all of which were piloted with carers prior to implementation) are available in Appendix B. The PCS1 questionnaire collected data on carer characteristics, including labour market circumstances, health and well-being (using a standardised instrument, the WHO-5 Well-being index<sup>3</sup>), caring situation and views on caring. The PCS2 questionnaire collected data on carer health and well-being, changes to their circumstances and caring situation and their perceptions of how their own life (and that of the person they cared for) had been affected by their participation in CwC. It also collected carers' views about, and experiences of, participating in the programme. The PCS3 questionnaire again collected data about carer health and well-being and

<sup>2</sup> The planned number for the phase one recruitment of face-to-face fully-funded providers was 25. In the event, 26 providers were recruited at this stage.

<sup>3</sup> This was chosen in preference to a standardised 'carer burden' scale, as in piloting the survey carers responded adversely to the standardised instrument originally selected, which they found to be inappropriately negative.

caring circumstances. It aimed to establish whether carers felt participating in the programme had had any lasting effects on them or on those they cared for, and included a question about their financial situation.

The PCS1 questionnaire was administered to all carers joining the programme in face-to-face delivery sites from the start of delivery until delivery ended or until the end of August 2010). This allowed those joining the programme at the latter date to be followed up in November 2010 (PCS2) and March 2011 (PCS3). Those carers who returned their PCS1 questionnaire to the evaluation team (prepaid envelopes were supplied) and who also gave permission for further research contact and provided a contact address, were sent PCS2 (and, if they agreed, PCS3) at their home addresses. All questionnaires received by April 2011 were scanned and the data were then captured into SPSS for cleaning and analysis. Distribution and achieved responses for the different stages of the survey are shown in Table 2.1.

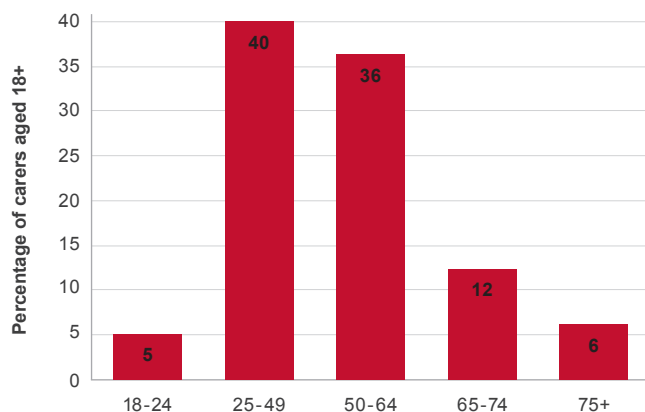
**Table 2.1 Participating Carers Survey: distribution and responses**

|   | PCS1               | PCS2  | PCS3            |
|---|--------------------|-------|-----------------|
| Questionnaires distributed (estimated)    | 6,210 <sup>1</sup> | 1,136 | 700             |
| Questionnaires returned                   | 1,278              | 741   | 499             |
| Response rate (%)                         | 21 <sup>1</sup>    | 62    | 71              |
| Carers who agreed to follow-up survey     | 1,136              | 700   | .. <sup>2</sup> |
| Carers who agreed to follow up survey (%) | 89                 | 94    | .. <sup>2</sup> |

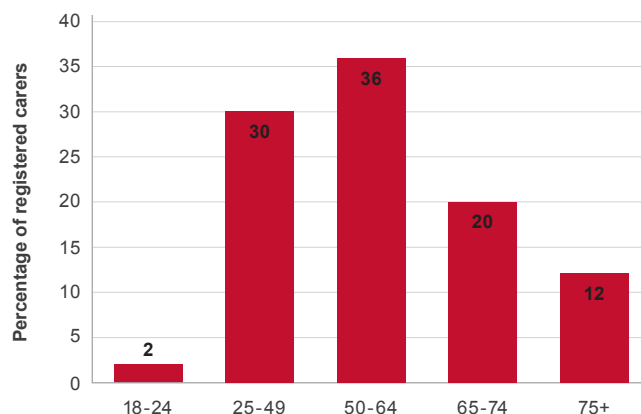
<sup>1</sup> Estimates. Figures are based on the assumption that all carers who attended at least one module with a funded face-to-face provider (during the survey period) received a questionnaire. Providers were asked to record and return a list of the carers who were given a questionnaire, but some did not comply with this request; it is impossible to know what proportion of distributed questionnaires were actually given to carers.

<sup>2</sup> As the last planned contact, the PCS3 questionnaire did not ask carers if they were willing to be followed up.

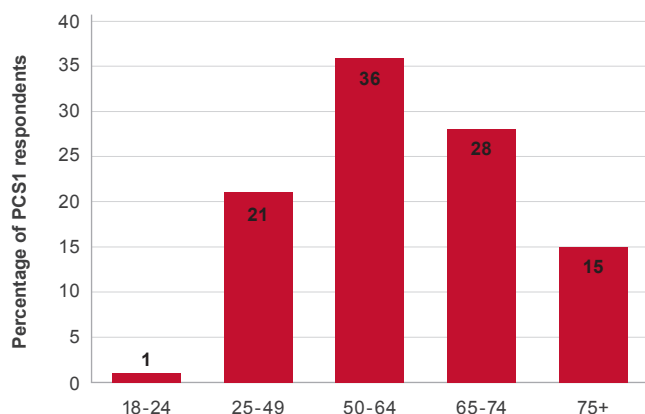
The age profiles of carers in England (derived from the 2001 Census), carers registered with the CwC programme and carers who responded to the three different stages of the carers' survey are shown in Figures 2.1 to 2.5. A high percentage of carers registering for the programme were aged 50 or older (68%, compared with 55% in England as a whole). Carers who responded to the three different waves of the PCS were remarkably similar in their age profile. However, PCS respondents in all three waves were rather older than all carers registered for CwC. Three-quarters were aged 50 or older, compared with two thirds of all carers registered for CwC.

**Figure 2.1 All Carers in England (18+) by age**

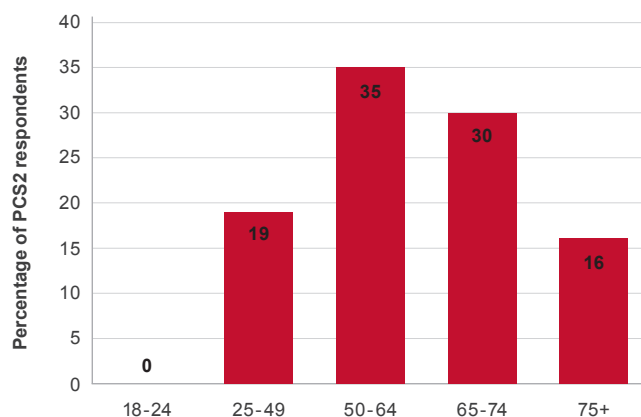
Source: 2001 Census, Crown Copyright (2003).

**Figure 2.2 Carers registered for CwC by age**

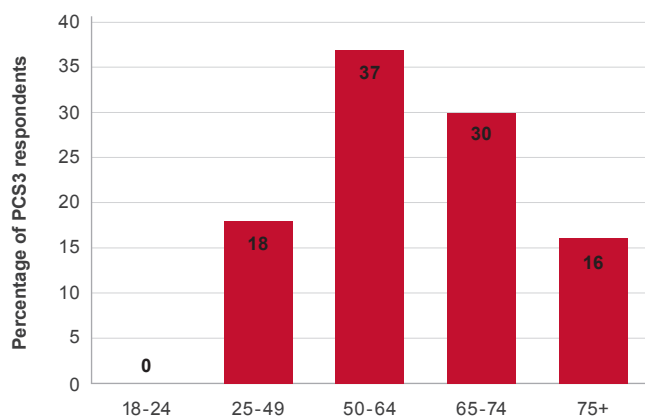
Source: CwC Carer Registration Forms and Additional Information Forms.

**Figure 2.3 Survey respondents by age: PCS1**

Source: CIRCLE, University of Leeds, CwC PCS1.

**Figure 2.4 Survey respondents by age: PCS2**

Source: CIRCLE, University of Leeds, CwC PCS2.

**Figure 2.5 Survey respondents by age: PCS3**

Source: CIRCLE, University of Leeds, CwC PCS3.



The detailed characteristics of carers who responded to the different phases of the survey, together with comparable data for all carers participating in CwC, are shown in Table 2.2. This shows that, when compared with all carers participating in CwC, carers responding to the PCS survey were less likely to be from BME groups and more likely to be caring for 35 or more hours per week.

## Case studies

The case studies were designed to collect evidence about the local operation of the *Caring with Confidence* programme and how the provider network contributed to the achievement of programme objectives. Results from the case studies were mainly used in assessing evaluation objectives C and D. The aim of the case studies was to find out about any challenges the provider sites might face in meeting the objectives of the programme and in delivering the *Caring with Confidence* modules to carers, and, where appropriate, to explore how they had overcome these. Providers were also asked about their perspectives on management issues, on the partnerships involved in delivering the programme, and about how carers locally were benefiting from it.

**Table 2.2 Characteristics of survey respondents**

%

|  |                           | PCS1  | PCS2 | PCS3 | CwC carers <sup>1</sup> |
|--|---------------------------|-------|------|------|-------------------------|
| <b>Carer characteristics</b>                     | <i>no. of respondents</i> | 1,278 | 741  | 499  | 6,077                   |
| Gender <sup>2</sup>                              | Men                       | 22    | 23   | 23   | 21                      |
|  | Women                     | 78    | 77   | 77   | 79                      |
| BME groups <sup>3</sup>                          |                           | 7     | 6    | 3    | 11                      |
| Lesbian, Gay, Bisexual, Transgender <sup>4</sup> |                           | 2     | 3    | 3    | 3                       |
| In receipt of Carers Allowance <sup>5</sup>      |                           | 32    | 30   | 28   | 31                      |
| Cares for 35+ hours per week <sup>6</sup>        |                           | 82    | 82   | 80   | 76                      |
| <b>Characteristics of person cared for</b>       | <i>no. of respondents</i> | 1,058 | 618  | 413  | 6,077                   |
| BME heritage                                     |                           | 5     | 4    | 3    | 14                      |
| Lesbian, gay, bisexual, transgender              |                           | 1     | 1    | 1    | 2                       |
| A disabled child with complex needs              |                           | 11    | 10   | 10   | 11                      |
| A disabled adult with complex needs              |                           | 25    | 25   | 26   | 25                      |
| A person living with mental ill-health           |                           | 21    | 19   | 20   | 21                      |
| A person with dementia                           |                           | 27    | 31   | 32   | 23                      |
| A person with long-term conditions               |                           | 59    | 61   | 61   | 54                      |
| A person nearing the end of life                 |                           | 9     | 10   | 9    | 7                       |

Notes:

<sup>1</sup> All CwC carers for whom AIF data available.

<sup>2</sup> Number of responses: PCS1=1,242; PCS2=704; PCS3=479.

<sup>3</sup> Number of responses: PCS1=1,044; PCS2=611; PCS3=407.

<sup>4</sup> Number of responses: PCS1=882; PCS2=520; PCS3=348.

<sup>5</sup> Responses: PCS1=1,016; PCS2=599; PCS3=401.

<sup>6</sup> Responses: PCS1=990; PCS2=578; PCS3=386.

Nine case study organisations were selected on the basis of: (i) their geographical location; (ii) their carer target group(s); and (iii) the type of organisation responsible for the programme delivery, with a view to gaining a rounded understanding of how the programme worked in different contexts. The case studies were initially implemented by sending each provider selected a 'pre-visit familiarisation questionnaire' to be completed before the first visit with the project manager, other staff and carers. This approach was chosen to capture the organisation's achievements in delivering the programme, and to explore its effects on both carers and providers. Over a period of up to 18 months, evaluation study researchers made 12 visits to 6 case study organisations. One case study had to be abandoned when the provider's contract was terminated early in 2010 by the National Team. Case studies of the online, self-study and NEdL (nearing the end of life) providers were implemented using an adapted methodology, as these providers did not operate in a discrete local area.

The first case study visit (the familiarisation visit) was used to explore, with six local fully-funded (face-to-face) providers: why the organisation chose to become a *Caring with Confidence* training provider; what had been its experiences of bidding to become a provider; what previous experience they had of working with carers and delivering training; and how *Caring with Confidence* related to their existing service provision. Issues such as local management and the relationship with the CwC National Team were also discussed. In this case study visit providers were asked about their understanding of their reporting responsibilities, and of their aims and targets for participating carers. Interviews were conducted with: a senior manager at the provider organisation; at least one project worker; and at least one module facilitator. The visit was also used as an opportunity to collect local documentation developed for carers, including local publicity about the programme, and where possible to observe a CwC module training session with carers.

The second visit (approximately six months after the familiarisation visit) explored how easy or difficult it was for the provider to achieve its targets, both in terms of recruiting carers and in ensuring they engaged appropriately with the programme. The methods they had tried, and what had worked well and not so well, were discussed. Management and partnership issues were also investigated in this visit, to find out about any changes, locally or nationally, affecting local delivery of the programme. This visit also involved interviewing a senior manager at the provider organisation, a project worker, and a module facilitator; in all cases the visit was also used to observe a training session with carers.

A third visit, following a similar pattern to the second, was originally planned, but the arrangements for these were affected by the early termination of the CwC programme. Instead, to capture as much information as possible from providers about the programme's local operation before the end of September 2010, a range of additional research activities were undertaken, including focus group discussions with carers (nine focus groups<sup>4</sup> were run involving 73 carers) and an electronic questionnaire, which was designed and distributed to providers (apart from those included in the evaluation as case studies), with 14 responses received.

A selection of the case study research instruments used in the study is included in Appendix B; these were developed by the research team and tested prior to implementation.

### Analysis of management information

As part of the arrangements put in place by the National Team when negotiating contracts with providers, data from each carer (from the CwC Carer Registration Forms and from the CwC Additional Information

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<sup>4</sup> Four of these focus groups were with carers engaged in CwC by providers which were not case studies.

Forms) were entered on the CwC MI system. This was developed, under contract to the National Team, by Kent House. Information about modules selected and attended, together with reasons for any non-attendance and for leaving the programme early, were logged on this database by providers. Information was also collected about providers and facilitators.

The evaluation team negotiated access to this information with the National Team and Kent House, enabling data to be downloaded remotely and carer data to be linked (where possible) to the file of PCS responses. The data were also capable of being analysed independently to measure the characteristics of carers registering for the programme and assess how far carers in the target categories were being recruited to the programme. The analysis of the CwC MI fed into evaluation objectives B and D. The documents on which the MI data base relied were:

- The Carer Registration Form (CRF), which asked for contact details and the date of birth of all carers registering with the programme (see Appendix C).
- The Additional Information Form (AIF), which asked about carer characteristics and the caring role (gender, ethnicity, sexuality, Carers Allowance, hours of caring, characteristics of the person cared for and their condition). This was distributed at registration to be returned when carers attended their first session. Part way through the programme, the CwC National Team decided to make some adjustments to this form (and therefore two forms are presented in Appendix C).
- Module feedback forms, which were distributed to all carers at the end of each module to capture their views of each session they attended (Appendix C).
- Carer learning plans, which included information about the modules carers had booked and attended.
- Session information, on each module arranged and delivered by providers.

To reduce respondent burden, the PCS1 questionnaire was designed so that it did not ask the same questions as the CRF and AIF. The evaluation team put arrangements in place to link the CRF and AIF data with the PCS responses, but this could only be done where CRF and AIF data were both collected from carers and recorded by providers on the MI database. Providers' generally poor compliance with this limited the data available to the evaluation team, affecting evaluation objectives B and C.

## 2.3 Study implementation

The evaluation team was in regular contact with the DH PRP to discuss developments and ensure its approach was consistent with DH requirements. Some early difficulties in obtaining access to key documents were resolved in summer 2008. The team liaised with the DH PRP over research instruments and associated documentation at each stage and when amendments were made to the evaluation strategy and plan. When significant changes were made to programme delivery, the evaluation director participated in meetings and conference calls with the DH PRP and DH policy lead to clarify interpretation of the CwC contract (including programme targets and timescales and their significance for the evaluation). This process culminated in preparation, by the evaluation team, of a document outlining the programme objectives (subsequently endorsed with minor amendments by the Project Board, see Appendix A), as part of the evaluation team's strategy for the overall evaluation.

### Research ethics, confidentiality and related issues

Formal policies guided the framework for the evaluation activities, including the DH Research Governance Framework for Health and Social Care. The evaluation team observed agreed procedures in undertaking the study, relevant to: research ethics and professional integrity in fieldwork; health

and safety; data protection, storage and encryption of electronic data; protocols governing participant confidentiality and consent; and protocols for responding to issues raised by research participants.

### **Data analysis**

The observational data collected in the study were recorded in the form of research notes, using recording templates where appropriate and subjected to thematic analysis as part of the overall evaluation evidence base. It was linked with data collected for the documentary analysis where such material was available.

Analysis of the survey data (from the PCS) was conducted using SPSS with tests of statistical significance applied as appropriate. Data quality was assured through conventional data cleaning and checking techniques.

Research interviews, qualitative aspects of the case study material and focus group data were variously tape-recorded, captured in detailed research notes or recorded on specially designed templates. The emergent qualitative database was then subjected to thematic analysis, in a series of steps involving all relevant members of the research team.

### **Limitations of the study**

Most elements of the planned evaluation study were implemented as intended, although modifications were made to accommodate: changes to programme delivery at the national level, including the early termination of the programme; changes or new information about local delivery arrangements for the programme (which, for example, guided the selection of case studies for the evaluation); and the complexities of the MI arrangements, which arose mainly from providers' difficulties in (or reluctance to) collect data from carers and input it to the central database.

There were difficulties also in implementing a planned survey of those cared for by carers participating in the programme. Although a research instrument was designed, tested and implemented for this, the limitations on distributing this instrument (which could only be done via participating carers, and in cases where both the evaluation team and the carer felt it appropriate to do so) were considerable. Insufficient data were collected from those cared for to merit statistical analysis.

The inability of providers to supply MI data on around half of all programme participants (discussed in more detail in Chapter 5) inevitably affected the reliability of the data on carer target groups. Steps were taken to assess how far respondents to the PCS were similar to or different from all carers registered for the programme (as discussed above). These enabled the evaluation team to be reasonably confident that the PCS data are drawn from carers who shared many characteristics with other programme participants.

## Chapter 3

# Management and Design of the *Caring with Confidence* Programme

Hilary Arksey, Andrea Wigfield and Sue Yeandle

### 3.1 Introduction

The principal objective of the *Caring with Confidence* (CwC) programme was to ‘*establish a sustainable programme of support for carers in England*’. This required a well designed national programme, with an effective management structure and a focus on achieving cost-effective programme delivery. This chapter provides an evidence-based account of the process by which the CwC programme was managed and designed. It evaluates:

- The commissioning process and contractual arrangements, exploring the tender process, the contract management, and the timescales (section 3.2).
- The governance structure and project management, examining roles and responsibilities and issues of clarity and transparency (section 3.3).
- The model developed for delivering the programme, looking at a range of issues such as the modular design, requirements and quality standards for facilitators and training materials, target carer groups and marketing and publicity (section 3.4).

The chapter concludes by outlining some key strengths and weaknesses of the way the programme was designed and managed (section 3.5).

### 3.2 The commissioning process and contractual arrangements

As mentioned in Chapter 1, commissioning and contracting arrangements for the CwC programme began in 2006, when five organisations, Carers UK, the Princess Royal Trust for Carers (PRTC), Crossroads, Partners (Family Leadership) UK CIC and the Expert Patients Programme CIC (EPP) were invited by the DH to outline their ideas for the optimum components of an ‘Expert Carer’ programme. These five organisations submitted their suggestions and met with senior DH officials and the Minister for Social Care in summer 2007, after which a joint bid was submitted for consideration, with EPP leading the consortium. The DH then put in place a ‘limited tender’ process before letting the contract. This involved issuing a ‘Scope of Works’ outlining the DH’s specification for the programme and establishing a ‘competitive dialogue’ between the DH and the consortium organisations. Towards the end of 2007 the consortium submitted its ‘Offer of Works’ to the DH, aiming to meet the requirements of the DH specification for a total cost of £15.2m, as specified in the Scope of Works. The consortium’s offer included face-to-face training provision for 27,000 carers, with a further 5,000 carers to be trained through self-study or online (later revised to 10,000).

The terms of the contract were agreed in December 2007 and January 2008, with the Scope of Works and Collaboration Agreement between EPP and the consortium partners guiding the contractual obligations of the consortium and the performance management of the programme. The Scope of Works specified that the programme should ‘*build upon existing provision, ensuring that the service received by carers is of high quality, appropriate to the needs of all carers and is available countrywide on an equitable basis*’ (DH, Scope of Works:5). It also specified that the face-to-face training would operate to full capacity by 31 December 2008 (with the ‘tailored’ courses for the target groups available

at full capacity by 1 April 2009) and that the programme should *‘be free to carers, with all costs carers incur in receiving training, including (but not limited to) transport, alternative caring arrangements, support staff (i.e. personal assistants / interpreters) being covered by the programme’* (DH, Scope of Works:3).

The overall programme budget was set at £15.2m inclusive of VAT<sup>1</sup> for the period 1 January 2008 until 31 March 2011, with an option to extend until 31 March 2014. The breakdown of the initial programme budget produced in December 2007, as part of the offer put forward by the EPP-led consortium, was later updated in August 2008 to reflect the actual spread of costs that were incurred during the first six months of the programme.

**Table 3.1 Budget for the CwC programme**

£

|                             | Original Budget<br>December 2007 | Revised Budget<br>August 2008 | Variance    |
|-----------------------------|----------------------------------|-------------------------------|-------------|
| Management                  | 4,487, 000                       | 4,240,000                     | 247,000     |
| Distance Learning           | 156, 000                         | 236,000                       | (80,000)    |
| Training Provision          | 8,293,000                        | 9,565,000                     | (1,272,000) |
| Contingent Provider Support | -                                | 806,000                       | (806,000)   |
| VAT                         | 2,263,000                        | 353,000                       | 1,910,000   |
| <b>Total</b>                | <b>15,200,000</b>                | <b>15,200,000</b>             | <b>0</b>    |

Source: CwC National Team, unpublished document.

The original and revised breakdown of the programme budget (Table 3.1) shows that the amount available for programme management was reduced slightly during this early period, while that available for training and provider support was raised, with a new item, ‘contingent provider support’, introduced. The budget for VAT was significantly reduced and reallocated, accommodating these changes.

The Scope of Works specified the key aspects of the programme in some detail. Its key components were that:

- The overall objective was to offer a range of learning opportunities to enable carers to gain the knowledge, skills and expertise they needed. A set of key objectives and principles underpinning the delivery of the CwC Programme was provided (as explained in Chapter 1 in Boxes 1.1 and 1.2).
- The programme content was to include: training for the caring role; empowerment and improvement; training for outside the caring role; training to sustain themselves; and financial matters.

<sup>1</sup> Whether VAT was applicable to CwC activities was debated throughout the programme. In the initial budget, VAT liabilities were calculated to be £2,263,000. However the National Team, on seeking legal advice, found that the project was likely to be outside the scope of VAT. As such, output VAT of £2.26m would not need to be accounted for, while input VAT (charged on services provided by the National Team) became an additional expense of £353,000. The net impact of this was that the total funds available for the CwC project increased by £1.9m, reflected in an updated budget. This interpretation was never confirmed by HMRC, however, despite the Project Director’s regular attempts to clarify the matter in 2009 and 2010. It remained unresolved when the CwC programme was terminated.

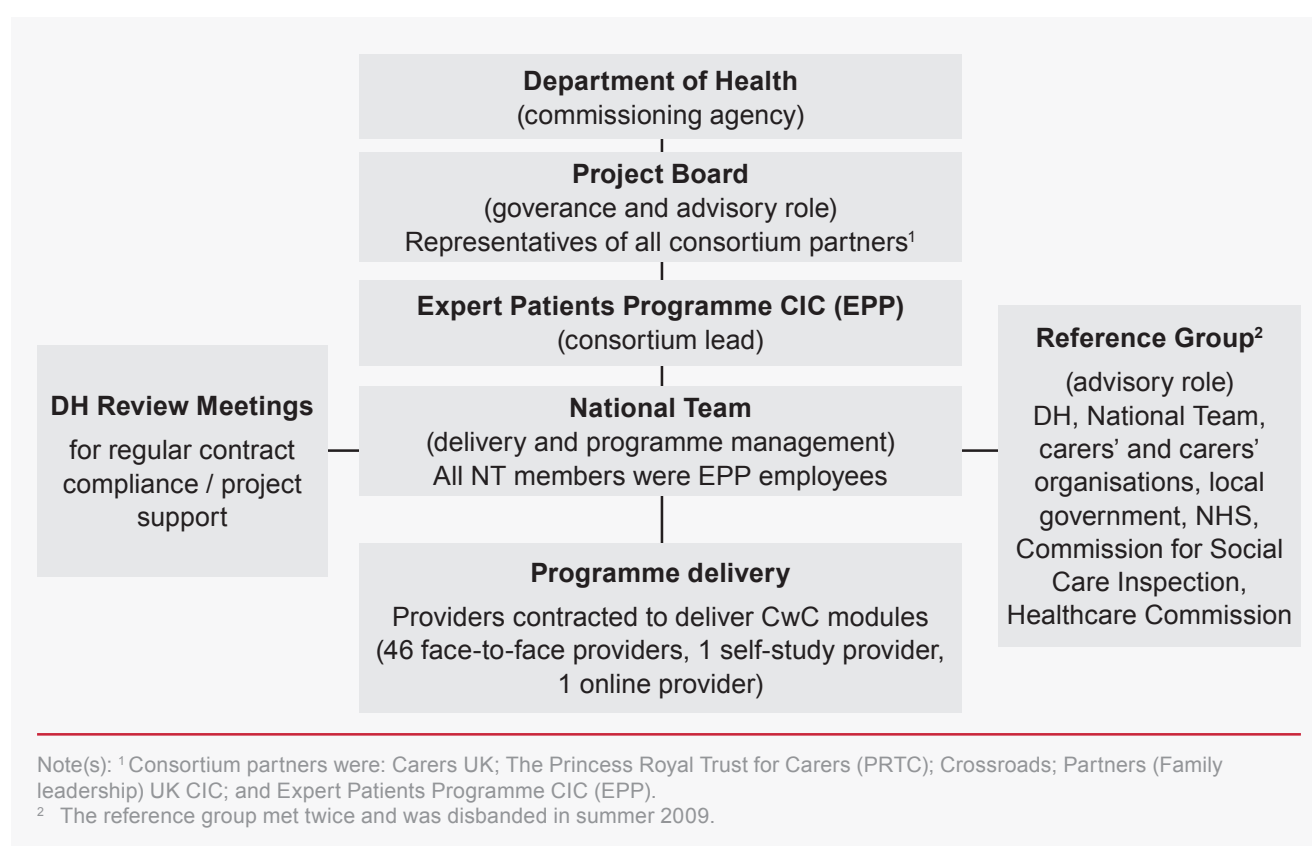


- Trainees were to be carers aged 18 and above, with specific target groups, including carers: who provided care for 35 or more hours per week<sup>3</sup>; of minority ethnic heritage; of those of minority ethnic heritage; of those nearing the end of life; who are lesbian, gay, bi-sexual, or transgender (LGBT); of those who are lesbian, gay, bi-sexual or transgender (LGBT) (Appendix A)<sup>4</sup>.
- Delivery was to build upon existing provision (where there was any), ensuring a high quality, equitable service, led and developed by a National Team which would provide the infrastructure to enable the delivery of the service to carers, and provide support and funding to providers of training to carers, but which would not itself provide face-to-face training to carers.
- Training was to be face-to-face (on a group or one-to-one basis), or by distance learning, specifically *'A carer who has all their training on a face-to-face basis would typically receive their training in six to eight meetings, held weekly and lasting two and a half hours. Training provided in other styles, will seek to provide a similar level of learning opportunity'*.
- A timetable of key tasks, with dates indicating when these were to be achieved was provided.

### 3.3 Governance and project management

The principles of the governance structure of the CwC programme were initially set out in the Scope of Works and a system was put in place reflecting this (depicted in Figure 3.1).

**Figure 3.1 The CwC programme: governance structure**



<sup>3</sup> At the end of August 2009, this was changed to 20 hours per week. It was not possible to incorporate this change into data analysis.

<sup>4</sup> The Scope of Works did not explain the reasons for selecting these very specific target groups, or include any targeting rationale.

The *Project Board* had overall strategic responsibility for the programme, was chaired by an EPP Board representative, and comprised representatives of each of the consortium partners. The terms of reference for the Project Board were agreed in a Collaboration Agreement between EPP and the consortium partners, and were reviewed in August 2008. The purpose of the Project Board meetings was to: monitor delivery of the CwC contract; take strategic decisions on issues relating to the delivery of the contract; and review and approve the contract reporting documentation prepared for the DH.

Throughout, Project Board meetings were held either monthly or (towards the end) bi-monthly, usually in London. All Project Board meetings were attended by senior members of the National Team, who reported progress and activity for the previous month(s). The meetings were minuted and papers for each Project Board were prepared by the National Team and circulated to members in advance.

The National Team was established to lead and develop the programme, to provide the infrastructure to enable the delivery of the service to carers, and to provide support and funding to the training providers. All members of the National Team were employed by EPP. As set out in the Scope of Works, the National Team had a number of key roles and responsibilities, including those shown in Box 3.1.

### **Box 3.1 Roles and responsibilities of the CwC National Team**

- Develop a title for the programme.
- Form a reference group to inform the programme's implementation.
- Map all existing similar activity and the need for it, and set national standards.
- Ensure that distance learning is provided, quality assured and performance managed.
- Develop existing and new providers to ensure breadth of provision.
- Manage quality assurance, performance management and accreditation of providers.
- Develop a resource pack (in physical or electronic form) to be provided to all carers attending training, providing high quality and accessible information relating to the carer's or cared for person's needs.
- Evaluate the potential for accreditation.
- Contribute to knowledge management through mapping, accreditation, quality assurance and performance management.
- Provide a branding and marketing strategy, the latter to be developed in conjunction with training providers.
- Ensure that processes are in place to handle any and all complaints and criticisms made by participants in the programme.

As would be expected, the size and structure of the National Team and the roles of individual staff within it evolved as the programme developed. The National Team was based in the EPP's offices near Leeds and was responsible for sub-contracting a network of providers to deliver CwC. Following early concerns expressed by the DH about the ability of the National Team to meet certain of its contractual obligations, a 'recovery plan' was submitted by EPP to the DH in August 2008. This clarified the composition of both the Project Board and the National Team, including their roles and responsibilities. Arising from this, several new posts were filled in winter 2008/09, including a Project Director, two Partner Liaison



Managers, a Quality Assurance Manager, and administrators. The Project Director's responsibilities included project delivery and performance, strategic and operational planning and managing EPP's relationships with the DH.

A diagram depicting the organisational structure of the National Team when fully established is provided in Appendix D.

*DH review meetings* were held on a monthly basis between the DH and the National Team and were the principal mechanism by which the DH managed the overall contract for the delivery of the programme. These were usually held at the National Team's offices, to enable the DH to monitor delivery of the CwC contract and to inform DH of decisions about strategic issues that impacted on the delivery of the contract. They were attended by the Director of the National Team (from his appointment in October 2008 onwards), the Chair of the Project Board and the DH Project Manager, and were supplemented with telephone contact between meetings<sup>5</sup>.

A *Reference Group*, whose membership of 'relevant organisations' was specified in the Scope of Works, was set up to provide a forum of interested parties to offer advice and support to the programme<sup>6</sup>, chaired by the Chair of the *Standing Commission on Carers*. The Reference Group was designed to inform the implementation and ongoing development of the programme, especially in relation to: mapping and understanding need; product development; provider development; marketing; dissemination of knowledge gained; and assisting dissemination of information about the programme to carers and key stakeholders. The DH and the Project Board anticipated that the Reference Group would provide a forum to support the development of the programme and help raise awareness (through its members' networks and organisations) of the opportunities it offered to carers. Its initial meetings were not well attended, however, and as explained in Chapter 1, it was disbanded in summer 2009.

### 3.4 Developing a model for *Caring with Confidence* delivery

The National Team began work on its delivery model for CwC immediately its contract with DH began, implementing an approach which had been specified in some detail in the consortium's bid to deliver the work. In accordance with the Scope of Works, the consortium bid and the contractual agreement between the DH and EPP (as lead partner), the delivery model for CwC was shaped by: market research; a 'mapping exercise' exploring existing carer training provision; the programme specification (as set out in the Scope of Works); and the National Team's access to existing experience (particularly that in the Expert Patients Programme but also drawing on the expertise of the carers' organisations within the consortium).

At the start of 2008, the National Team commissioned initial market research from an independent market research consultancy, Waves, which presented its findings to the National Team in April 2008. Based on this research and following the National Team's own 'mapping' investigation into the geographical distribution of existing carer training in England, it was initially envisaged that CwC would be delivered in key 'hot spots' to ensure a sufficient critical mass of delivery at a local level. The identified 'hot spots' were used as one of the National Team's criteria for selecting the provider network. Organisations were selected to develop the CwC programme delivery in as many different geographical areas as possible, whilst at the same time avoiding duplication of existing carer training provision (see Chapter 4, section 4.2 for further details).

<sup>5</sup> The Evaluation Team did not attend the DH review meetings but had access to review meeting papers and minutes.

<sup>6</sup> These were defined as: DH (and / or its delegates); carers; carers' organisations; ECP providers; local government and NHS representatives; Commission for Social Care Inspection (CSCI); Healthcare Commission; and those conducting the research programme.

## Module development

The CwC programme was developed in three delivery formats, as set out in the Scope of Works: face-to-face group delivery; self-study using distance learning workbooks; and online. The face-to-face modules were designed as three-hour sessions, each to be delivered by two trained and accredited facilitators. Participation was free, carers could claim reasonable expenses for travel and alternative care for the person cared for, and they could 'mix and match' modules and formats, to suit their individual needs and caring circumstances. In developing the CwC modules, the National Team drew on a range of pre-existing expertise, recruiting a range of 'experts' to design and develop the modules and training materials, 'road-testing' them with more than 70 carers in June 2008, and subsequently revising them to reflect feedback. A 'Module Standard' for CwC, setting out processes and standards for CwC delivery and training materials, was also established.

The initial CwC offer to carers comprised seven 'generic' modules, developed centrally, which were aimed at a general audience of carers. All CwC providers and facilitators were expected to deliver the programme using these modules. Later (from October 2008) further materials were developed for a set of 'End of Life' modules and for specific carer groups ('tailored' modules), in line with the target groups established in the Scope of Works. The full range of modules developed during the lifetime of the programme is shown in Table 3.2.

## Facilitators

To ensure standardised and quality training delivery, a three-day (compulsory) Facilitator Development Programme (FDP) was established, delivered by FDP qualified 'coaches'. This was initially a residential-only programme, although in summer 2009 this rule was relaxed<sup>7</sup>. To ensure that they achieved the required standard of delivery, following successful completion of the FDP each facilitator's delivery of at least six modules was monitored. Those who became fully qualified CwC facilitators through this process were awarded a CwC 'Passport to Practice'. To allow providers to begin offering CwC modules to carers soon after signing contractual agreements, 50 facilitators were trained in advance. These were then assigned to providers (on a regional basis) as provider contracts went 'live'. This arrangement addressed early concerns about meeting delivery deadlines. The National Team felt that preparing a pool of facilitators in advance would enable providers to begin delivery quickly, helping to recover early delays.

By the end of June 2010, more than 400 facilitators had been trained on the FDP and 116 had achieved a Passport to Practice. Evidence from the case studies suggested that the FDP was well regarded by programme providers and had the potential to build sustainable networks of peer support. Facilitators themselves provided very positive feedback, rating the FDP programme '9.6' out of 10. Members of the National Team later noted, however, that the FDP had been both time consuming and relatively expensive (its estimated cost was £600 to £1,000 per facilitator trained), not least because most FDP training sessions were delivered to far fewer participants (typically eight or nine) than the intended number, 16. Initially the intention was that two trained facilitators would be used to deliver each CwC module, as specified in the 2008 quality standard for CwC programme providers (Appendix D), and some providers used two trained facilitators throughout the programme. During 2010 some others experimented with delivering the programme with only one facilitator, primarily as a cost saving measure. To provide a degree of sustainability after the CwC contract ended, the National Team produced a delivery guide for the FDP and made efforts to train as many facilitators as possible immediately prior to the programme termination date.

<sup>7</sup> One provider tested out a non-residential approach in 2009 which was found to produce no deterioration in standards achieved.

**Table 3.2 The CwC training modules<sup>1</sup>**

| 'Generic' modules        | 'End of life' modules                     | 'Tailored' modules   |
|--------------------------|---|--|
| Finding your way         | Finding your way near end of life         | Caring for a disabled child  |
| Caring day-by-day        | Caring day-by-day near end of life        | Caring for someone living with mental ill health                   |
| Caring and me            | Caring and me near end of life            | Caring for an adult with complex needs                             |
| Caring and communicating | Caring and communicating near end of life | Caring for someone living with dementia                            |
| Caring and resources     | Caring and resources near end of life     | Lesbian, gay, bisexual and transgender carers and cared for people |
| Caring and coping        | Coping after caring                       |  |
| Caring and life          | Life after caring                         |  |

Note: <sup>1</sup> The modules listed were archived and made available for download from the NHS Choices website in 2010: <http://www.nhs.uk/CarersDirect/carers-learning-online/Pages/resources-for-training-providers.aspx>

### Quality assurance

The Scope of Works emphasised the need for a high quality and quality-assured programme that met national standards and the National Team put a lot of effort and resources into achieving this. A quality standard for programme providers was developed in December 2008. This specified the criteria that providers were required to meet in terms of quality, principles and standards. Providers were to carry out a self-assessment, scoring themselves against a series of quality measures using a standard template. The completed forms were then to be submitted to the National Team and a proportion of providers were to have site assessment visits<sup>8</sup>.

A Module Standard was also developed, as previously mentioned. This outlined the process and standards that the training material was to comply with. A programme review group was established to assess each new module, comprising specialists in the particular target carer groups, as well as carers themselves, over 70 of whom 'road-tested' the modules, which were later revised in light of their feedback. At an early stage, the National Team (advised by the Project Board) sub-contracted Harrogate and Craven Carers Centre to quality assure the CwC training materials.

The Scope of Works specified that the National Team should evaluate the potential for accreditation of the programme by the end of December 2008. However, due to time pressures, issues relating to accreditation were deferred until the end of 2009, by agreement with DH. An independent organisation<sup>9</sup> was commissioned to carry out research to assess the potential of accreditation for the programme, and a report, '*Caring with Confidence – the path to accreditation*' was produced in April 2009 (Equal Access Consultancy, 2010).

<sup>8</sup> Available documentation did not confirm whether or not these plans were implemented.

<sup>9</sup> The contract for this work was initially let to an external agency which subsequently withdrew from the contract, necessitating the appointment of a replacement organisation (Equal Access Consultancy) which authored the report produced.

The report on accreditation recommended that the National Team should concentrate on delivering its current programme, but undertake further work on accreditation as the CwC programme's implementation progressed, with the possibility of adopting formal external accreditation arrangements from 2010. It advised that accreditation of CwC, if implemented, would have both benefits and drawbacks, encouraging some carers to participate but acting as a possible disincentive to others, and called for further research into the requirements and needs of carers. Following the submission of the report, the National Team continued its investigations into the potential for accreditation, but by the end of the programme the issue was still under consideration and no system of accreditation had been implemented.

As required in the contractual agreements, module standardisation, quality assurance and accreditation were all addressed by the National Team. While the accreditation issue was never resolved, module standardisation and quality assurance were taken very seriously, probably contributing to the high module feedback ratings participating carers gave (see Chapter 5).

Offering standardised and quality assured modules clearly helped the programme achieve a uniform level of good quality materials and module sessions. Standardisation inevitably meant that some degree of flexibility was compromised, however. Comments made by some interviewees suggested that inflexibilities in module design and delivery arrangements meant that the training provided was not always as tailored as it could have been to the needs of some groups of carers.

### **Marketing and publicity**

In line with its obligations within the Scope of Works, the National Team developed a marketing strategy in November 2008 (later updated in April 2009). The strategy aimed to: raise awareness of CwC in England (among carers, health and social care professionals, carers and other voluntary sector organisations); facilitate the recruitment of carers, especially those in the target carer groups; and position the CwC programme as a leading provider of learning resources to support carers.

A national campaign was developed to officially launch the programme in May 2009. This attracted national media attention, through radio interviews (national and local), articles in the press and online reports. Various complementary public relations and marketing activities were also undertaken, including: the production of a promotional DVD; search engine optimisation; and social marketing (carried out by Amaze, an independent consultancy).

Marketing templates and model publicity documents (including leaflets and posters) were also developed to enable providers to establish provider-specific local marketing plans and materials. All fully-funded providers were expected to produce an annual, costed marketing and communications plan for National Team approval, detailing what materials they required and how they intended to implement their plan<sup>10</sup>.

The suitability of the marketing strategy chosen is hard to assess. Some interviewees thought the national marketing campaign was under resourced and that the marketing templates were inadequate, particularly for those local voluntary sector providers which had limited marketing expertise. If accurate, this may have contributed to the recruitment difficulties that many providers faced (see Chapter 4).

Details of the establishment of the provider network and the roll-out of the programme are provided in Chapter 4.

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<sup>10</sup> Although some of these plans were submitted, evidence from some key informant interviews suggested that their quality was generally poor and that provider compliance with this requirement was rather patchy.

### 3.5 Conclusions: strengths and weaknesses of programme management and design

The DH decision to terminate the CwC programme ahead of schedule indicates that some problems were encountered in the delivery of this new programme of training for carers. To conclude this chapter, the three points at which DH concerns became apparent and were explicitly addressed with the National Team and Project Board are briefly summarised. An overall evaluative assessment of the programme's management and design, highlighting its strengths and weaknesses, is then presented. The evaluation evidence about the implementation of the CwC programme through its provider network is outlined and discussed in Chapter 4.

Between the initial establishment of governance arrangements for the CwC programme (Section 3.3) and its early termination in 2010, the DH initiated contract review procedures on several occasions. In each case this arose from its concerns about delivery and progress towards programme targets.

In summer 2008, the DH reviewed the contract because of its concerns about the National Team's slower than expected progress in establishing a provider network. This resulted in: new arrangements for chairing the Project Board; the appointment of a Project Director to manage the National Team; a review of key contract deliverables and associated timetables; and a decision to abandon a planned 'phased' procurement process, replacing it with a single large-scale procurement exercise.

The contract came under further close scrutiny in spring 2010, when cost per carer place and the National Team's capacity to deliver target numbers (matters which had been under regular review in DH monthly review meetings for some time and which were being addressed through a 'contingency plan' presented at the review meeting in July 2009) were key issues. In March 2010 the EPP was given initial notice of the DH's intention to terminate the programme early, although it was subsequently allowed to explore adjusted funding arrangements with new providers and other cost saving measures between April and June 2010.

Final notice of the DH's intention to terminate the contract (six months ahead of the original contract end date) was given to the National Team on 28 June 2010, and the National Team then gave its providers three months' immediate notice of contract termination, as it was required to do. All contracts for delivery of CwC consequently ceased on 28 September 2010. After that date, some providers continued to deliver the programme using other sources of funding (see Chapter 6). The total spend on the programme by its end date in September 2010 was £10,117,669.

In the context of an innovative programme with a relatively short lead-in time, tight timescales and ambitious outputs, the programme was very successful in developing a high quality standardised programme of support to carers which was delivered through quality assured modules by well trained facilitators. However priority does not seem to have been given at an early enough stage to establishing the provider network or to ensuring that roles and responsibilities in the governance and programme management structure were absolutely clear and understood. Inadequate marketing and a rather costly and time-consuming Facilitator Development Programme also contributed to difficulties in meeting deadlines and achieving target carer numbers, for the duration of the programme. The programme was an ambitious and entirely new venture and cost estimates, targets and timescales were all, necessarily, based on the best estimates of the DH and the consortium at the bidding stage. This needs to be borne in mind in evaluating the way the programme was managed and designed.

The key strengths and weakness of the different aspects of programme management and design are set out in Table 3.3. The evaluation team's overall assessment, set out in Chapter 7 and in Appendix A, places these in the necessary wider context. The effectiveness of programme management and the quality of the design of the programme need also to be considered alongside the provider procurement and delivery arrangements, discussed in Chapter 4, and the outcomes of the programme for carers who participated in it, considered in Chapter 5.



**Table 3.3 Strengths and weaknesses of programme management and design**

| Key Issues  | Strengths  | Weaknesses   |
|---|--|--|
| Contract established through a 'limited tender' process | <ul style="list-style-type: none"> <li>Used a collaborative approach, involving national carers' organisations, which drew on existing expertise.</li> <li>The partnership approach added value.</li> </ul>        | <ul style="list-style-type: none"> <li>Opportunities to draw on the expertise of other training organisations to enable them to contribute to a delivery consortium may have been missed.</li> <li>Some consortium partners were not entirely comfortable with the composition of the consortium.</li> <li>Consortium partners' original expectations of what their roles and responsibilities would be were not fully met.</li> </ul> |
| Contractual documentation                               | <ul style="list-style-type: none"> <li>Provided a detailed description of the programme objectives and principles.</li> </ul>  | <ul style="list-style-type: none"> <li>Some partners felt there were ambiguities and uncertainties about key deliverables and / or outputs.</li> <li>Contractual obligations were open to different interpretations by consortium partners.</li> <li>Some aspects of the programme may have been over-specified in advance of adequate exploration (e.g. target groups of carers).</li> </ul>  |
| Contract management                                     | <ul style="list-style-type: none"> <li>DH review meetings were held regularly, with detailed documentation supplied by the National Team to guide decision-making.</li> </ul>                                      | <ul style="list-style-type: none"> <li>Tensions arising from delivery difficulties and differences of interpretation were not always well managed.</li> </ul>  |
| Lead-in time and timescales                             | <ul style="list-style-type: none"> <li>Ambitious targets were set, facilitating a quick start up to allow time for delivery, with potential to maximise programme outputs.</li> </ul>                              | <ul style="list-style-type: none"> <li>The delivery schedule was overly optimistic.</li> <li>The National Team was slow to recruit key staff in 2008.</li> <li>Insufficient priority was given to early planning of the provider network.</li> <li>Provider procurement quickly fell behind schedule.</li> <li>Once behind schedule, 'fire fighting' was needed to achieve key milestones.</li> </ul>                                  |
| Governance structure                                    | <ul style="list-style-type: none"> <li>The approach to project governance was inclusive and comprehensive.</li> <li>Provided a wide range of expertise and knowledge to inform and guide the programme.</li> </ul> | <ul style="list-style-type: none"> <li>There was a lack of clarity about some roles and responsibilities, particularly relating to the Project Board and Reference Group.</li> <li>The wide range of involvement led to some 'lack of ownership', and perceived 'disempowerment' by some consortium partners.</li> </ul>   |

**Table 3.3 Strengths and weaknesses of programme management and design (continued)**

| Key Issues   | Strengths   | Weaknesses  |
|--|---|---|
| Delivery of the programme via facilitators and approved training materials | <ul style="list-style-type: none"> <li>• Drew on experts to design the programme.</li> <li>• High quality, standardised training provision and materials were produced, supported by a well-regarded Facilitator Development Programme.</li> <li>• Sustainable peer support networks were developed.</li> </ul> | <ul style="list-style-type: none"> <li>• Modules had limited flexibility, with scope for local adaptation weaker than necessary.</li> <li>• Implementation of the Facilitator Development Programme was time-consuming and resource-intensive.</li> </ul>   |
| Modular training design  | <ul style="list-style-type: none"> <li>• Enabled flexible delivery, which was inclusive of carers' needs and empowering for carers.</li> </ul>  | <ul style="list-style-type: none"> <li>• Some of the specialist, 'tailored' modules only became available some time after the main roll-out of the programme.</li> </ul>  |
| Target carer groups  | <ul style="list-style-type: none"> <li>• Targeted 'harder to reach' carers who were not supported through pre-existing provision.</li> <li>• Encouraged innovation in carer recruitment.</li> </ul>   | <ul style="list-style-type: none"> <li>• Challenges in recruitment were experienced by many providers.</li> <li>• Provision did not always meet needs of specified target groups, partly as a result of delays in providing tailored training materials.</li> <li>• No age or gender targets were identified; the target groups selected were probably over-complex.</li> </ul> |
| Marketing and publicity  | <ul style="list-style-type: none"> <li>• A successful national launch gained good publicity.</li> <li>• Provider-specific local marketing was encouraged and supported (via standardised templates for local adaptation).</li> </ul>  | <ul style="list-style-type: none"> <li>• Some providers had limited marketing experience and needed more support than anticipated.</li> <li>• The National Team found it difficult to achieve ongoing high-profile national marketing.</li> </ul>   |

## Chapter 4

# The *Caring with Confidence* Programme: Implementation and Performance

Benedict Singleton, Andrea Wigfield and Sue Yeandle

### 4.1 Introduction

Once the *Caring with Confidence* (CwC) programme had been designed, as outlined in the previous chapter, it was 'rolled out' by the National Team through a procurement process which involved recruiting a network of local providers. This chapter examines the extent to which the CwC programme was implemented successfully through the provider network and delivered the programme targets within agreed timeframes and budgets. It evaluates:

- How the provider network was established, exploring the procurement phases, the types of providers recruited, and how they worked together (section 4.2).
- The support and monitoring processes put in place, including how adequate they were and the extent to which they enabled performance data to be monitored (section 4.3).
- The extent to which the providers: met the programme outputs and targets (including carer numbers and appropriate levels of carer engagement); kept within allocated budgets; and handled financial and marketing issues appropriately (section 4.4).

The chapter concludes by outlining some key strengths and weaknesses of the programme implementation process and summarising levels of provider performance.

### 4.2 Implementing *Caring with Confidence* through a provider network

As described in Chapter 3, in the early months the National Team focused its main efforts on the design of the programme and the development of training materials. In summer 2008, aware of its obligation to commence delivery to carers by 31 August 2008, it began detailed planning of its intended provider network, identifying two local carers' centres (organisations with a background in supporting carers, located in the North East and in the Midlands) as 'test sites'. These sites were set up to a very tight time scale and operated as test sites between August and December 2008, and January and March 2009. The two test site providers experimented with different approaches to carer recruitment and delivery, noting some difficulties in recruiting carer participants, but attributing this primarily to insufficient time and resources for marketing, as well as to bad weather in early 2009.

The National Team's report of the test sites activity (an internal document prepared in March 2009) showed that between late August 2008 and mid March 2009 these two sites recruited a total of 162 carers and delivered 77 module sessions. They filled 53% of the places at the sessions they ran. Carers attended an average of four sessions each and a total of 655 carer places were filled. The average number of carers attending each module was 8.5. The test site providers also monitored drop-out and non-attendance and reported that 75% of carers who were recruited to the programme attended at least one module. When carers failed to attend a module for which they were registered, the usual reason given was sickness (of either the carer or the person cared for). The report on the test sites also noted that once carers had failed to attend a session, they did not usually re-engage.



In October 2008, guided by the DH review of the CwC contract the previous summer, the National Team commenced its main provider procurement exercise, completed in April 2009. This involved a number of different steps for the National Team and prospective bidders, outlined in Table 4.1. The National Team, with the Project Board and DH approval, approached the procurement of its provider network as follows:

- An open invitation was issued to any organisations in the voluntary, private and public sectors to make a formal Expression of Interest (EOI). The EOIs were then assessed. Only those organisations which met specified criteria were subsequently invited to complete a Pre Qualification Questionnaire (PQQ).
- To assist prospective providers in the PQQ process, organisations were invited to attend 'Bidders Information Days', where the programme's objectives, delivery expectations and design were explained to delegates, and their questions answered.
- Submitted PQQs were assessed by a panel of evaluators. Those which met the threshold criteria were subsequently invited to submit a formal tender.
- To assist prospective providers in the ITT process, all organisations whose completed PQQs met the relevant threshold criteria were invited to attend i) Dialogue Days; and ii) CwC 'taster' sessions.
- The tenders which the organisations subsequently submitted were assessed by a panel of evaluators, which scored tenders on specified aspects of their submissions, using a formal, standardised procedure.
- A full report on the panel's assessments was presented to the Project Board. This made recommendations about which providers should be progressed to pre-contractual negotiations and awarded funding. The Project Board ratified these proposals.
- The pre-contract negotiations which subsequently took place included a number of specific 'due diligence' tests applied by the National Team to ensure that contracted providers had the capacity and organisational attributes necessary to meet their contractual obligations.

The entire procurement process was designed to ensure that contracts were let only to organisations which were 'fit bodies' suitable, by virtue of their experience, knowledge and expertise, to deliver the CwC programme. The evidence available indicates that this process was carried out robustly and conscientiously, despite the time pressures on the National Team.

The assessment panel of individual evaluators which the National Team established to evaluate the 63 full tender submissions comprised: a member of the National Team; two individuals nominated by members of the Project Board (drawn from the staff of the Princess Royal Trust for Carers (PRTC) and Crossroads Caring for Carers); and an external consultant (recently retired, who had been employed by the EPP and had been involved in the early development of the CwC proposal and project).

A classification of the different types of organisations which expressed an interest in providing CwC (indicating also those that were ultimately successful in the procurement process) is shown in Table 4.2. The National Team's selection approach was determined by preliminary research into optimum selection models and involved selecting and deselecting proposed providers from the final list based on the quality of the submission; the proposed cost of delivery; the intended geographical location of delivery; and the applicant organisation's access to target groups.

**Table 4.1 Key stages in the procurement of CwC training providers**

| Stage  | Purpose  | Number of organisations responding / attending                               |
|--|--|--|
| Expressions of Interest (EOI) invited<br>( <i>open submission</i> )                        | To identify organisations interested in becoming CwC providers.  | 381 EOIs submitted.  |
| Bidders Information Days<br>( <i>open to any organisation</i> )                            | To provide information about CwC and the PQQ stage of the application process for interested organisations.                            | 123 attendees (at two events in Manchester and London).                      |
| Pre-Qualification Questionnaire (PQQ)<br>( <i>open to all those who submitted an EOI</i> ) | To assess whether interested organisations were suitable to go forward to the ITT stage.   | 128 PQQs submitted.<br>76 organisations approved to go through to ITT stage. |
| Dialogue Days<br>( <i>invited organisations</i> )  | To brief prospective bidders on the CwC programme scope, funding arrangements, facilitator approach and general requirements.          | 55 organisations attended five sessions.                                     |
| CwC 'taster' sessions<br>( <i>invited organisations</i> )                                  | For potential providers to get a better understanding of the programme prior to submitting a full tender.                              | 31 potential providers attended, in two sessions.                            |
| Invitation To Tender (ITT)<br>( <i>invited organisations</i> )                             | To assess the marketing competency, delivery plans, access to target groups, and proposed cost of delivery of the potential providers. | 63 tenders submitted.  |
| Formal assessment of ITTs  | To ensure a fair and appropriate provider selection process.   |  |
| Procurement report presented to Project Board  | To present evidence-based proposals re the providers selected and seek Project Board ratification of these.                            |  |
| Contracts offered  | To 32 organisations (26 for 'fully-funded' provision).   |  |
| Contracts let  | After completion of due diligence process.   |  |

Source: CwC National Team's provider procurement report (internal document, 2009).

**Table 4.2 Expressions of interest and procurement outcomes, by type of organisation**

*numbers*

| Organisation Type   | Organisations which submitted an EOI | Fully- funded sites selected following EOI, PQQ and ITT | Part / unfunded sites selected following EOI, PQQ and ITT |
|---|--------------------------------------|---|---|
| <b>Voluntary and community organisations</b>                |                                      |   |   |
| Black & Minority Ethnic (BME)                               | 2                                    | 1   | 0   |
| Carers' organisations                                       | 119                                  | 16  | 3   |
| Other charities   | 5                                    | 1   | 1   |
| 'Condition-specific' organisations                          | 98                                   | 1   | 1   |
| Lesbian, gay, bisexual and transgender (LGBT) organisations | 1                                    | 1   | 0   |
| <b>Private bodies</b>                                       |                                      |   |   |
| Private training organisations                              | 69                                   | 0   | 0   |
| <b>Public bodies</b>  |                                      |   |   |
| Academic institutions                                       | 11                                   | 0   | 0   |
| Local authorities   | 48                                   | 3   | 0   |
| NHS Primary Care Trusts (PCTs)                              | 18                                   | 3   | 1   |
| Other training organisations                                | 3                                    | 0   | 0   |
| <b>Other organisations not classified above</b>             | 7                                    | 0   | 0   |
| <b>TOTAL</b>  | <b>381</b>                           | <b>26</b>   | <b>6</b>  |

Source: CwC National Team's provider procurement report (internal document, 2009).

The spring 2009 procurement exercise described above led to the commissioning of 32 providers: 26 fully-funded, including one specialist 'end-of-life' provider; and six 'partly' or 'unfunded' providers (see Table 4.3 for details of the funding models used). At least one of the organisations selected was based in each of the nine English regions (including the two test providers, both of which applied and were successful in the formal exercise). Key features of the different funding models adopted, including the later 'PAYG tariff' model, in use from 2010, are shown in Table 4.2. The National Team's procurement report included explicit reference to the geographical distribution of the provision to be developed.

**Table 4.3 Funding models used in commissioning the CwC provider network**

| Funding Model | Key features   | Procurement phase | Providers commissioned number |
|---------------|--|-------------------|-------------------------------|
| Fully-funded  | Enabled providers to receive funding to cover costs of: initial set-up, on-going delivery, some marketing, facilitator training, and carers' travelling expenses / alternative care. | Phase 1           | 26                            |
| Part-funded   | Enabled providers to be reimbursed for facilitator training.   | Phase 1           | 2                             |
| Unfunded      | Providers received no funding, and paid the costs of facilitator training themselves.  | Phase 1           | 4                             |
| PAYG          | Providers were funded under a 'tariff PAYG model' based on cost per unit / carer place. Precise details were negotiated with individual organisations.                               | Phase 2           | 14                            |

Some providers selected were commissioned, from the outset, to focus primarily on particular carer target groups. The Lesbian and Gay Foundation in Manchester, for example, was requested to focus on LGBT carers and carers of LGBT people. Others were to focus on BME carers and carers of BME people<sup>1</sup>.

Once the selection decisions were ratified by the Project Board in March 2009, the National Team engaged promptly in post-tender negotiations and completed due diligence procedures with the selected organisations. Formal contracts were signed by the majority of providers in April and May 2009 with an expectation that they would commence delivery of CwC soon afterwards, although there were some delays affecting organisations where difficulties were encountered in completing due diligence procedures. By June 2009, seven fully-funded providers had still not signed contracts. The National Team's activities in developing and supporting these CwC providers to establish and deliver the programme in their localities are described in section 4.3.

Later, a second wave of provider procurement took place, beginning with discussions with a number of organisations in September 2009. This was set up as part of the National Team's contingency planning exercise to address the need to extend the range and reach of the provider network and to increase carer recruitment. The National Team decided not to run another 'costly and time consuming'<sup>2</sup> provider procurement exercise at this point and instead approached organisations that could be potential providers. Negotiations took place with several organisations considered capable of filling gaps in service delivery, leading to the recruitment of 14 additional organisations shortly before the termination of the DH-funded CwC programme took effect in September 2010. In total, 46<sup>3</sup> providers were recruited across the two procurement phases. Appendix E provides summary information about both the first and second waves of providers recruited, indicating key dates and targets.

<sup>1</sup> One of the specialist BME providers ceased operating in autumn 2009, following the National Team's investigation into reporting irregularities.

<sup>2</sup> Phrasing in original documentation, Project Board minutes.

<sup>3</sup> Forty-six providers were engaged to deliver CwC, but six were either terminated, never allocated funding or never registered any carers. Forty contracted providers delivered CwC to registered carers entered on the MI database.

The second wave of providers was recruited using a different funding model, based on 'costs per carer place', described by the National Team as a 'Pay As You Go Model' (PAYG). Under this system, providers were paid £85 per carer place<sup>4</sup> (inclusive of carer travel and alternative care costs). The detailed PAYG 'tariff model' arrangement was that 10% of the expected fee (based on each provider's targets for carer recruitment) was paid to providers 'up front', with the (90%) balance payable after target numbers of carers had been engaged (each provider could determine its own target number of carers, in negotiation with the National Team). If planned carer target numbers were not met, a 'claw back' system was employed. Providers had to repay a proportion of the initial payment. If, for example, a provider fell short of target carer numbers by 15%, 15% of the 10% advance payment was repayable. This model was selected as it allowed the programme to *'engage a variety of different organisations regardless of their size and ensures a flexible approach based on the numbers of carers that they are confident in reaching'*.<sup>5</sup>

As before, the National Team did not seek to recruit particular types of providers, but selected applicant providers on their predicted 'costs per carer place' and through 'continued' mapping, consistent with its attempts to improve geographical coverage. The different funding models used for providers in the two waves of procurement described above are outlined in Table 4.3.

The second wave of procurement was successful in increasing provider numbers and widening the scope and reach of the provider network. Several of the new providers achieved success in reaching large numbers of carers within quite short time-frames, with one delivering the second highest number of sessions achieved by any provider across the whole network. However many of the second wave providers had very limited time to implement their planned provision before they received notice of programme termination in June 2010.

Whilst the initial model of provider selection was designed to ensure that organisations (or bidding consortia) would be capable of working independently to deliver the CwC programme to carers in specified geographical areas, there was also some contact between providers within the network, something which was encouraged and supported in various ways by the National Team. This had both positive and negative outcomes. Some of the providers selected as evaluation case study sites mentioned co-operating effectively with other providers, while others expressed reservations, for example noting that they were in effect 'competing' with one another to recruit the same carers. The issues raised suggest that maximising opportunities for collaboration between providers may need to be considered more carefully and addressed more specifically in future programmes.

In the provider case study interviews, some staff voiced concerns about 'competition' and 'lack of collaboration' among the provider network. Some claimed matters became worse when the second wave of providers was recruited. Issues raised (not necessarily representative of the perspective of others in the network) included:

- New providers were being introduced in areas covered by (fully-funded) providers already experiencing difficulty in recruiting sufficient numbers of carers.
- Multiple provision of the CwC programme in a locality would be 'confusing' for carers.
- Existing providers were given inadequate information about the new providers and what they were offering.

<sup>4</sup> This figure was determined by the National Team on the basis of its review of provider cost forecasts in the later stages of programme delivery.

<sup>5</sup> As explained in the CwC 'Activity Report' for July to October 2009 (an internal CwC document presented at the DH CwC review meeting on 01/12/09).

- The way the second phase recruitment was undertaken was unfair and ‘closed’; one manager felt bringing new providers in on a different funding system was inequitable.
- Recruitment to specialist sessions was negatively affected. One manager reported that referrals of carers to its specialist Nearing End of Life (NEoL) CwC provision ceased when a new provider began delivering in the same locality.

Despite these concerns and difficulties, evaluation of the programme’s development indicates that it did partially meet its objectives of establishing a network of providers and ensuring national reach. The geographical distribution of carers who registered for *Caring with Confidence* over the lifetime of the programme is shown in Figure 4.1. This shows the number of carers (see key to figure) registered with face-to-face and self-study CwC providers located in England’s 152 Primary Care Trust areas, with the highest concentrations of registered carers indicated by the darkest shaded areas<sup>6</sup>. Although CwC reached carers in many areas of England (for example in North Yorkshire and the West Midlands), in other areas (such as Cornwall and Northumberland) very few carers registered. The providers and registered carers in each of the English regions is shown in Table 4.4, confirming that some CwC provision was established in all nine regions, although registered carers were not evenly distributed between the regions.

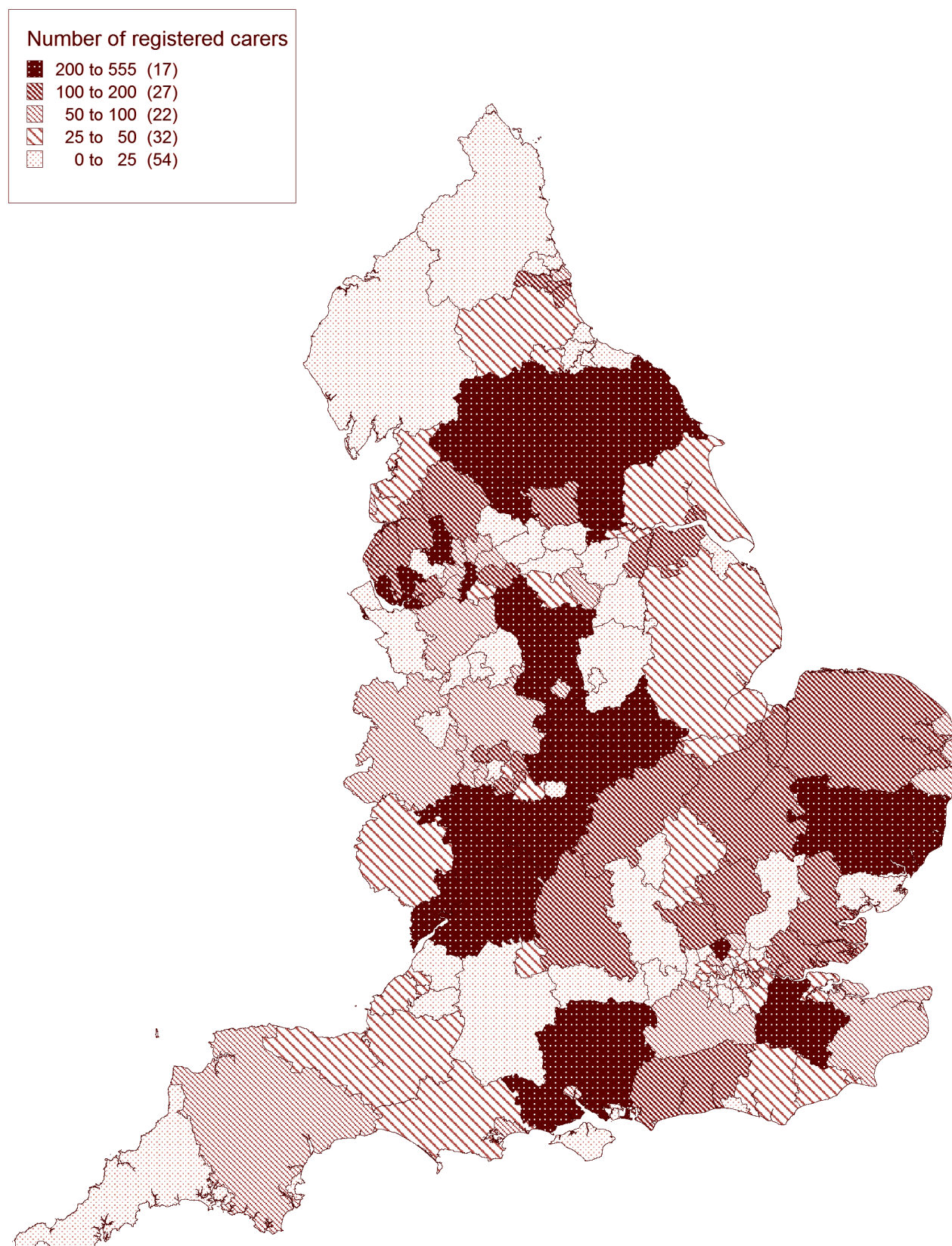
**Table 4.4 Providers and registered carers, by English region**

| Region                      | Number of providers based in region<br>(all provider types) | Carers registered |     |
|-----------------------------|---|-------------------|-----|
|                             |   | No.               | %   |
| East Midlands               | 3 providers   | 1,412             | 11  |
| East of England             | 5 providers   | 1,608             | 13  |
| Greater London              | 5 providers   | 1,235             | 8   |
| North East                  | 1 provider  | 514               | 4   |
| North West                  | 6 providers   | 1,730             | 14  |
| South East                  | 3 providers   | 821               | 7   |
| South West                  | 4 providers   | 515               | 4   |
| West Midlands               | 4 providers   | 1,427             | 11  |
| Yorkshire and the Humber    | 3 providers   | 899               | 7   |
| Other (not region-specific) | 6 providers   | 2,399             | 19  |
| Total                       | 40 providers  | 12,621            | 100 |

Source: CwC MI database.

<sup>6</sup> No data were available to the evaluation team for those registered for the ‘online’ version of CwC.



**Figure 4.1 Geographical distribution of carers registered for CwC<sup>1</sup>**

Source: CwC MI database. Boundary data supplied by NHS Information Centre © Crown copyright. All rights reserved 100020290 2010.

<sup>1</sup> For technical reasons, it was not possible to assign a small number (5%) of registered carers to a PCT area.



Some delays were experienced in recruiting the provider network, and the procurement process undertaken in 2009-2010 took longer to complete than had been anticipated. The procurement process should probably have been given greater priority in the first half of 2008, when it seems this topic was discussed relatively little in Project Board and DH Review Meetings.

Almost two-thirds of all providers recruited in the first main procurement exercise were carers' organisations, and all but six of the initial face-to-face providers were in the voluntary and community sector. The National Team's inability to recruit more widely in other sectors may have contributed to some of the delivery and management problems experienced (see further discussion in section 4.4). Increasing the number and type of providers through the second recruitment process widened the programme's reach, but the early loss of time (the programme was originally expected to be fully operational by 31 December 2008), meant the programme struggled throughout its period of operation to meet its targets. There is some evidence that not all providers within the network worked well together, and (especially after the second wave of procurement) some seem to have felt there was a degree of inappropriate competition.

### 4.3 Supporting and monitoring provider performance

Once the initial main procurement process was fully under way, the National Team developed a comprehensive support structure for all providers, and (to assist in monitoring their performance and that of the programme as a whole) it subcontracted an external agency, Kent House, to develop the CwC management information (MI) system<sup>8</sup>. Providers were each required to record on this database specific details about the modules and sessions they ran and the carers they recruited and supported.

To support providers in undertaking these activities, two *Provider Development Managers* (originally designated 'Provider Liaison Managers') were employed by the National Team to help providers establish and implement the programme<sup>9</sup>. The role of these staff included developing and managing delivery relationships and negotiating contracts with providers. As a further source of support for local providers, the National Team also developed guides, frameworks, marketing toolkits and templates (for invoices and budget spreadsheets) to assist them in their administrative and accounting tasks.

Three '*Provider Network Days*' were also held, one in November 2009 and two in June 2010 (in different locations). The primary purpose of these was to disseminate information and provide an opportunity for providers to discuss and clarify issues with the National Team. The November session introduced the 'contingency plan' for the programme (see Chapter 3) and the June sessions were used to discuss the introduction of the PAYG tariff system (see section 4.2).

The CwC MI system was also designed to record provider performance, including: details of the carers enrolled and participating in the programme; the modules they attended; the modules arranged and delivered by each provider; and information about facilitators. Information about carers was collected using two forms: a 'Carer Registration Form (CRF)', which asked for carers' names, contact details and date of birth; and an 'Additional Information Form' (AIF), which was designed to collect further characteristics about each carer who joined the programme (Appendix C). The AIF data included information relating to whether or not a carer was in one of CwC's target groups. The National Team anticipated that the MI system would be adequate to provide the information it needed to monitor provider performance. However many providers failed to enter their CRF and AIF data adequately, and consequently there were significant gaps in monitoring data<sup>10</sup>.

<sup>8</sup> The MI on the test sites provision was collected and collated by the National Team.

<sup>9</sup> Later, two additional Provider Development Managers were appointed.

<sup>10</sup> Examination of data entered prior to carers starting their first module shows that, of the 13,939 carers registered, 9% had either no age recorded or had recorded an age that was improbable (that is, less than 18 or above 100). This arose partly because there was no consistent method for recording missing data.

Data entered by providers from the AIF were particularly patchy. In total, only 59% of carers who attended at least one module ever had AIF information entered on the database, despite repeated chasing by members of the National Team. This proportion varied significantly by provider, from 2% to almost 94%, for providers that had been running modules for several months. How far this problem was due to carers not completing the forms or to providers not entering the data remains unknown. Key informant interviewees felt that although some providers fully understood the importance of providing up-to-date MI data, others were unable or unwilling to comply with it as required. In the case studies, some providers claimed that the MI database was complicated to use and inefficient, and some said there was some resistance by carers to completing the AIF form. Some thought its length and the perceived 'intrusive' nature of some of the questions were problematic<sup>11</sup>. These issues had an impact on the quality of the data available for the evaluation, and limited the ability of both the providers and the National Team to monitor performance and supply evidence relating to the achievement of overall target numbers and specific target groups (see also Chapter 5).

There were differing perspectives on whether the level of support available to providers was appropriate and sufficient. There is some evidence (in key informant interview data) that the National Team provided valued support for providers and operated in an accessible, responsive and helpful manner. Some provider case study interviewees (in the first round of interviews) mentioned the strength of the National Team's support for providers and the good working relationships they had with Provider Development Managers. However, during the second round of case study visits, some staff at provider sites mentioned communication with, and support from, the National Team as an area for potential improvement.

Thus although a monitoring and support system was put in place, the large gaps in the data collected limited its value as a management tool. Some providers found it burdensome and many did not fully understand the importance of the procedure. These difficulties with the monitoring system therefore limited the National Team's ability to identify and respond to challenges in a timely manner and, as such, probably contributed to the programme's early termination.

## 4.4 Performance of providers in delivering *Caring with Confidence*

The extent to which the providers delivered the key outputs of the programme on time and to budget are important aspects to examine in an evaluation of the programme. As explained in Chapter 3, the overall target during the lifetime of the contract was that at least 27,000 carers would receive face-to-face training, with a further 10,000 being supported via remote access (initially 5,000) and a minimum of 108,000 carer places provided.

After considerable debate, successful participation in the programme was defined, by agreement, as a carer participating in four modules (in any combination of delivery modes). Key performance indicators are assessed below including: carer numbers and retention rates; costs and budgets; marketing and recruitment; and project management.

### Carer numbers and retention

The target numbers of face-to-face carer places and participating carers and the numbers actually delivered are shown in Table 4.5.

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<sup>11</sup> The evaluation team advised the DH and National Team in 2008 that the question about sexuality might cause some problems, and that it would have been preferable to use a single form, to be completed by carers when their training needs were assessed prior to joining the programme.

**Table 4.5 Achievement of carer targets: places filled and level of engagement**

|                                       | Target number of carers | Achieved carer numbers |
|---------------------------------------|-------------------------|------------------------|
| Carer places (face-to-face provision) | 108,000                 | 40,292                 |
| Carers attending 4+ sessions          | 27,000                  | 5,427                  |

Source: CwC MI database.

In total, 40,292 face-to-face carer places were delivered, a significantly lower figure than the target of 108,000 carer places. Even taking the early termination of the programme (with its foreshortened timescales) into account, this was a disappointing final level of performance, which can be attributed to a combination of factors: ambitious targets; delays in provider procurement (and thus in starting to deliver the programme to carers); and providers' difficulties in recruiting carers.

Providers inevitably needed time to set up the programme and recruit carers, and over the lifetime of the programme the collective level of carer recruitment improved<sup>12</sup>. Provision of carer places increased during each quarter of the programme (Table 4.6), from just 670 carer places provided in quarter one to 13,169 provided in the final quarter. Had the quarter six figures been sustained, the programme would have been delivering over 52,000 carer places per year, in effect reaching the level required to meet its target. It is impossible to know if this level of performance would have been sustained had the programme run its full course.

**Table 4.6 Carer places delivered by quarter, all CwC providers**

|                        | April-June 2009 | July-September 2009 | October-December 2009 | January-March 2010 | April-June 2010 | July-September 2010 |
|------------------------|-----------------|---------------------|-----------------------|--------------------|-----------------|---------------------|
| Carer places delivered | 670             | 2,872               | 4,464                 | 7,616              | 8,717           | 13,159              |

Source: CwC Provider monitoring spreadsheet.

Over the course of the programme, 12,621 individual carers were registered for face-to-face modules. This was less than half the number expected to successfully participate in the programme (by attending four or more modules) (Table 4.7). In all, only 43% of those registered (5,427 carers) attended four or more face-to-face sessions, approximately one fifth of the target number for the programme overall (Table 4.5). While providers did not supply full data on why carers failed to attend sessions for which they had booked, MI data available for over 4,000 cases where carers booked a place but failed to attend showed that in 51% of these the carer was 'too busy' to attend. In 33% of cases carers were ill or could not attend because of deterioration in their own health or that of the person they cared for. About 12% said they did not wish to continue with CwC, or that the programme was either not as they had expected or wanted or was not meeting their needs. A very small percentage (less than 2%) found the venue insufficiently accessible and 3% did not attend because the person they cared for had died.

<sup>12</sup> Case study data suggest that although a significant attempt was made to access carers not in touch with services via 'taster sessions', supermarket promotions, advertisements in GP practices, etc., most carers who participated in CwC were people already in touch with support services of some kind or with carers' organisations (see Chapter 5 and Figure 5.3).

**Table 4.7 Carers reached through face-to-face provision by target group**

|                           | All carers<br>registered<br>number | Target Group<br>1<br>% | Target Group<br>2<br>% | Target Group<br>1 or 2 <sup>1</sup><br>% | Target Group<br>3<br>% |
|---------------------------|------------------------------------|------------------------|------------------------|--|------------------------|
| Test sites                | 1,268                              | 59                     | 67                     | 70                                       | 30                     |
| First round<br>providers  | 7,386                              | 41                     | 49                     | 50                                       | 50                     |
| Second round<br>providers | 3,510                              | 26                     | 29                     | 30                                       | 70                     |
| Non-funded<br>providers   | 396                                | 52                     | 67                     | 68                                       | 32                     |
| All providers             | <b>12,621</b>                      | <b>39</b>              | <b>45</b>              | <b>47</b>                                | <b>53</b>              |
| Target                    | <b>27,000</b>                      | <b>33</b>              | <b>33</b>              | <b>67</b>                                | <b>33</b>              |

Source: CwC MI AIF.

Note: <sup>1</sup> Carers could be in both Target Group 1 and Target Group 2.

A fairly positive picture emerges when assessing the extent to which carers from the specific target groups were recruited for the face-to-face sessions (Table 4.7). This shows that while the overall number of carers recruited was lower than planned, the programme was successful in reaching carers from the target groups, achieving 39% of carers from Target Group One and 45% from Target Group Two against the initial targets of 33% from each of these groups. However, carers could fall in both Target Group One and Target Group Two, resulting in 'double counting' of carers in the target groups. When the proportion of carers in either Target Group One or Two is compared with the target of 67%, only the test sites and non-funded providers achieved this. The lack of data to evidence whether or not many carers were in a specific target group (arising from inadequate submission of AIF data) makes it extremely difficult to assess how far the targeting strategy employed in the programme was successful.

The performance of individual CwC providers against the commitments they made in their tender submissions, by Target Group, is indicated in Appendix E. This shows that the provider network was largely successful in recruiting carers from many of the target groups, for example BME carers, carers caring for 35 plus hours per week or in receipt of Carer's Allowance, carers of people who are disabled with complex needs and who have a long term illness or condition. However, providers had difficulties recruiting LGBT carers, carers of people who are LGBT and carers of people who have dementia. Individual provider recruitment varied greatly (see Appendix E for the target and delivered places by individual provider).

The following points summarise key aspects of provider performance, more details of which are shown in Appendix E:

- There were a few 'higher performing' providers, but many underperforming ones. At one stage, 40% of all programme delivery was being achieved by just five providers.

- Variable provider performance was evident in all aspects of carer recruitment and programme delivery. Among the first round of face-to-face providers, one achieved 75% of its target number of carer places, while another achieved just 4%. One provider achieved 63% of participating carers successfully engaging in the programme, whereas one of the poorer performers achieved only 13%.
- Recruitment of carers within the specific target groups also varied by provider, with four fifths of the carers recruited by one provider being in Target Group One or Two, the comparable figure for some other providers being just over a quarter.

As noted earlier, the National Team and Project Board were also expected to meet targets for delivery of the CwC programme through the self-study and online versions of CwC. In December 2008 the original initial target for carers to access CwC through self-study or online was increased from 5,000 to 10,000, following discussion between the National Team and the DH. The self-study option was trialled in 2008 and became available to carers, with the National Extension College commissioned to deliver this element of the programme, in April 2009.

Three organisations bid to design and maintain the website for the online provision, and after assessment of these bids Intelligo was selected in January 2009 to operate this element of the programme. The website became available (with limited content) in April 2009, and fully operational in June 2009.

The numbers of carers accessing the programme through self-study and online were much lower than expected. By 20 September 2010, shortly before the termination of the programme, only 733 carers had registered for self-study and only 585 for the online option, against a target of 10,000.

Thus the overall target for carers successfully participating in the programme - 27,000 carers face-to-face and 10,000 via remote access - was not achieved. Once delays in provider recruitment were identified, concerns about meeting targets were repeatedly raised in DH review meetings, with a 'contingency plan' to address this implemented in 2010.

### **Costs and budgets**

No targets for costs per carer place were included in the original programme specification. When providers submitted their bids (through the ITT process) they were required to estimate costs and these were part of the assessment process and post-tender negotiations for successful bidders. Initially, cost per carer place was very high (Table 4.8) and this too was a regular focus of the DH review meetings, discussions in the Project Board and amongst the National Team and provider network. It proved extremely difficult to reduce costs among the providers in the first phase of recruitment, partly because (as discussed in Chapter 6) of planned sessions needing to be cancelled, partly because sessions ran with fewer carers attending than anticipated (the target for participation in each session was 10-16 carers), and partly because of the relatively resource-intensive programme design.

The implementation of the National Team's contingency plan in 2010 (leading to the second procurement process in which a different, PAYG funding model, was used) did result in reduced costs per carer place, as shown in Table 4.8<sup>13</sup>. In other quarters, the PAYG providers consistently delivered the programme at a lower cost per carer place than their fully-funded counterparts.

Some providers were more successful than others in achieving a lower cost per carer place, for example, as they gained experience of delivering the programme three of the first wave providers succeeded in reducing their average cost per carer place to a figure lower than their bid submission target.

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<sup>13</sup> Apart from the first quarter in which the PAYG providers were delivering the programme, quarter three.



**Table 4.8 Average cost per carer place, by time period**

£s

| Provider type | Q1<br>2009 | Q2<br>2009 | Q3<br>2010 | Q4<br>2010 | Q5<br>2010 | July<br>2010 | Aug<br>2010 | Sept<br>2010 | All<br>Qrs |
|---------------|------------|------------|------------|------------|------------|--------------|-------------|--------------|------------|
| Fully-funded  | 580        | 189        | 95         | 81         | 118        | 262          | 230         | 118          | 147        |
| PAYG          | -          | -          | 285        | 55         | 75         | 30           | 88          | 73           | 85         |
| Total         | 580        | 188        | 93         | 75         | 105        | 162          | 147         | 88           | 133        |

Source: CwC provider monitoring spreadsheet.

Despite the higher than expected costs per carer place, and a range of interim adjustments, the difficulties many providers continued to face in recruiting carers resulted in an overall under-spend in the total CwC budget allocated to the providers (calculated by the National Team as £52,247 by the end of the programme in its final reporting of programme costs to the DH). All but six providers reported an under-spend in their (provider-level) budgets, in one case amounting to over £27,000. Five providers reported over-spends however, with figures for this ranging from the very modest to in one case over £170,000.

Ultimately, it was continuing high costs per carer place and the substantial shortfall in recruitment (rather than any concerns about programme quality or content) which led the DH to decide to terminate the contract earlier than initially envisaged.

### Marketing and recruitment

Providers used a wide variety of publicity and marketing strategies to advertise CwC and to attract carers to the programme including: local radio interviews; advertisements in the local press; producing leaflets and newsletters; contacting carers via existing databases; and taster sessions. A variety of approaches was adopted, but according to key informant interviewees, a number of individual providers experienced difficulty in developing a local marketing approach. Some felt that the CwC providers, as a group, lacked marketing experience and struggled to produce effective local approaches. The National Team felt it lacked the resources necessary to help those providers which needed support with marketing; and at least one provider reported that it had needed more support than it received from the National Team with this aspect of its work. The key informant and case study interviews also revealed that some providers did not focus their marketing and recruitment strategies on the 'harder-to-reach' carers very effectively, although by the end of the programme, some of the marketing efforts were yielding results.

Determining the success of the marketing approaches used is difficult, as providers used different combinations of methods and were not obliged to gather evidence about their effectiveness. The MI data show that participating carers mainly found out about the programme through referral by a carers' organisation (53%), with leaflets and posters the next most frequently cited source of information (12%) (see Chapter 5 for further details).

Those providers which were carers' organisations seemed to find it easier to market and promote CwC, as they had existing knowledge of carers and of the local services carers use. The case study evidence showed that providers took a variety of steps to recruit carers to the programme, including: sending letters to all carers on their existing database; targeting specific carer groups by accessing the places where these groups were likely to be (for example, schools attended by children with disabilities);

and using existing networks of voluntary sector organisations to signpost carers to the programme. A provider which did not have a background in supporting carers reported that its lack of knowledge of local referral pathways for carers limited its ability to target its marketing approach. With hindsight, this provider felt it had not recognised early enough that recruiting to CwC using word of mouth (via carers who had accessed the programme) might have been its best way of recruiting other carers.

## **4.5 Conclusions: strengths and weaknesses of programme implementation and performance**

A network of providers was recruited to deliver the CwC programme through two procurement phases, which together led to the recruitment of 46 providers, a much higher number than had initially been envisaged. Providers were offered support to monitor their own performance (through an externally subcontracted MI System) and implement the CwC programme (through the National Team's Provider Development Managers, provider development days and the standardised guides, frameworks and toolkits it made available). Some providers needed more support than was initially anticipated, however, and not all of them fully cooperated with the need to provide MI data on participating carers. Ambitious targets for carer engagement were established at the outset which providers had difficulties meeting, leading to an overall underperformance by providers in terms of the number of carer places filled and the numbers of participating carers recruited. As a result, costs per carer place were higher than expected. The fact that no provider came near to meeting its targets for carer numbers suggests these may have been overambitious from the outset.

The key strengths and weakness of the different aspects of the CwC programme implementation and performance are set out in Table 4.9. The evaluation team's overall assessment, set out in Chapter 7 and in Appendix A, places these in the necessary wider context. The implementation of the programme, performance of individual providers and performance of the overall programme need to be considered within the context of the programme management and design, which was discussed in Chapter 3, and the outcomes of the programme for the carers who participated in it, considered in Chapter 5.



**Table 4.9 Strengths and weaknesses of programme implementation and performance**

| Key Issues                               | Strengths  | Weaknesses   |
|--|--|--|
| Establishing a network of providers      | <ul style="list-style-type: none"> <li>• Rigorous first wave provider procurement process undertaken.</li> <li>• Flexible response to poor carer recruitment through a second procurement phase based on a performance-related payment system.</li> </ul>  | <ul style="list-style-type: none"> <li>• The National Team was slow to implement the provider procurement process.</li> <li>• Competitiveness and some lack of co-operation emerged between some providers, particularly between first and second wave providers.</li> <li>• Inconsistent funding models used for different providers caused some tensions.</li> </ul>           |
| Monitoring performance                   | <ul style="list-style-type: none"> <li>• The MI system was contracted to a specialist external agency.</li> </ul>  | <ul style="list-style-type: none"> <li>• Two different forms were developed to collect MI data on carers, leading to confusion.</li> <li>• Providers did not fully co-operate with the need to obtain MI data, leading to large gaps in information.</li> <li>• For a period, providers were unable to access their own monitoring data to inform their own planning.</li> </ul> |
| Provision of support to provider network | <ul style="list-style-type: none"> <li>• Provider Development Managers were available to support providers.</li> <li>• Provider development days were run to disseminate information.</li> <li>• Guides, frameworks and toolkits were produced.</li> </ul> | <ul style="list-style-type: none"> <li>• Some providers needed considerably more support than anticipated.</li> </ul>  |
| Carer numbers and retention              | <ul style="list-style-type: none"> <li>• Ambitious targets were set.</li> </ul>  | <ul style="list-style-type: none"> <li>• Overall underperformance by providers, in terms of targets met.</li> <li>• Numbers of carer places filled and of participating carers were well below target.</li> <li>• Targets for some carer groups were not met, or were difficult to assess.</li> </ul>  |
| Financial issues and budgets             | <ul style="list-style-type: none"> <li>• Financial issues and performance were regularly reviewed with DH in structured meetings.</li> </ul>   | <ul style="list-style-type: none"> <li>• Cost per carer place was higher than expected.</li> <li>• The VAT issue was never resolved.</li> </ul>  |
| Marketing and recruitment                | <ul style="list-style-type: none"> <li>• A wide range of marketing strategies was used.</li> <li>• Some providers ran successful marketing campaigns.</li> </ul>   | <ul style="list-style-type: none"> <li>• Some providers ran weak marketing campaigns and needed a lot of support.</li> <li>• A lack of innovative marketing strategies, appropriate to the client group was apparent (especially in non-carer organisations).</li> <li>• The impact of local marketing strategies was not monitored.</li> </ul>                                  |

## Chapter 5

# Carers' Experiences of the *Caring with Confidence* Programme

Lisa Buckner and Sue Yeandle

### 5.1 Introduction

This chapter is about the experiences of the carers who took part in the *Caring with Confidence* programme between September 2008 (when the first CwC modules were made available in two 'test' sites') and September 2010 when the programme terminated. During this time almost 14,000 carers registered for the programme. The characteristics of those who registered for CwC, their engagement with and experiences of the programme, and its outcomes for them are presented in the chapter, drawing on evidence in: (i) the CwC Management Information (MI) database (the information providers supplied about the carers registered for the programme); (ii) the data collected from programme participants as they completed each module they attended (via CwC Module Feedback Forms); and (iii) from the survey of carers participating in the programme (the Participating Carers Survey - PCS), undertaken as part of the national evaluation of the programme between 11th September 2009 and 15th March 2011. These data provide a rich, but incomplete, evidence base about carers' experiences of the programme and are complemented by additional qualitative data collected in focus groups with some carers after their participation<sup>1</sup>. The broad research questions addressed in each section of this chapter include:

- Who were the carers who took part in CwC, and how representative were they of all carers? (section 5.2)
- How did carers find out about and engage with CwC? What were their patterns of attendance and participation, and which groups of carers engaged most successfully with the provision offered? (section 5.3)
- How did carers participating in CwC experience the programme and what did they value or dislike about the way it was delivered? (section 5.4)
- What were the outcomes of CwC for those who took part, and which carers benefitted most and least from their involvement with it? (section 5.5)

This last question, addressing some of the key objectives of the programme, also allows a number of supplementary questions to be explored in the chapter:

- How far did the CwC programme succeed in reaching its target groups of carers?
- Did CwC provide carers with new skills and knowledge which enabled them to carry out their caring role more effectively?
- Did carers emerge from participation in CwC feeling more in control, more confident or better empowered in their everyday lives?
- How did engaging with CwC affect carers' lives outside caring? Did it help them to access leisure, employment, education or training or to participate more fully in the lives of their families and communities?
- Did CwC have any beneficial effects on carers' health and wellbeing, or that of those they care for?

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<sup>1</sup> Available data are discussed in Chapter 2, with some additional information in Appendix B.

## 5.2 Carers who took part in the programme

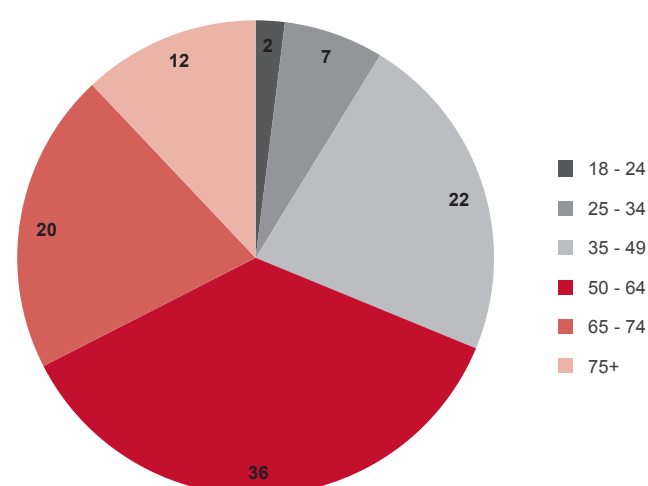
In total, 13,939 carers indicated their interest in taking part in the CwC programme by registering with one of the CwC programme providers. This included 733 carers who accessed the programme via self-study, 585 who participated online, and 12,621 carers who registered for face-to-face modules.

The experiences of those accessing the programme through the self-study and online modes are discussed in sections 5.3 and 5.4; in what follows here, the experiences and characteristics of the CwC participants who accessed CwC in the face-to-face study mode (the vast majority - 90%) are presented and discussed.

### Age of participants

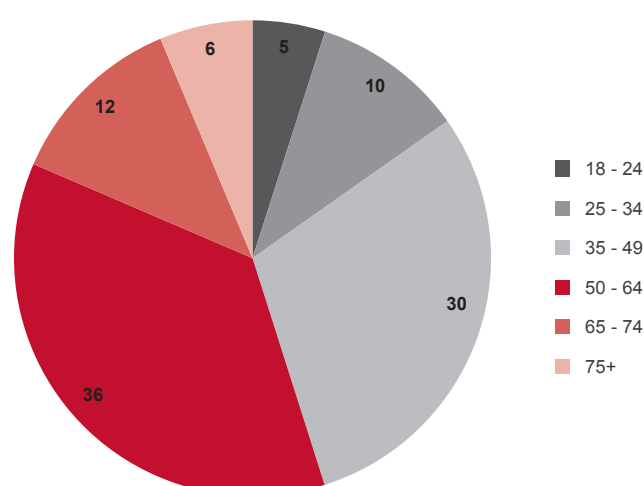
Carers who registered with the CwC programme were older than the general population of carers. Almost one third (32%) were aged 65 or older, compared with 18% of carers nationally, and only one in 5 (22%) were aged 35-49, compared with 30% for all carers in England (Figures 5.1 and 5.2)<sup>2</sup>.

**Figure 5.1 Registered carers<sup>1</sup>: age profile**



Source: CwC carer registration forms.  
Note: <sup>1</sup> Data available for 11,405 registered carers. This figure is the base for %s shown.

**Figure 5.2 National carer data: age profile\***



Source: 2001 Census Standard Tables, Crown Copyright (2003).  
Note: Data for all carers aged 18+, England.

### Additional characteristics of participating carers and programme targets

Data on the gender, ethnicity and caring circumstances of carers participating in the programme were collected by CwC providers as part of their contractual obligations, using the CwC 'Additional Information Form', which all participants were invited to complete, usually when they attended their first module<sup>3</sup>.

<sup>2</sup> Data about the age of carers registered for the programme for face-to-face modules, available for 90% of carers, are presented in Figure 5.1, with the age profile of carers in England (from the 2001 Census) shown in Figure 5.2 for comparison.

<sup>3</sup> When CwC was planned, all participants were expected to register for the programme and subsequently to attend at least one module. The NT chose to collect information about the characteristics of attendees using two forms: a Carer Registration Form, completed at initial registration (with the carer's postcode and date of birth) and an 'Additional Information Form' (AIF), used to collect data on characteristics relevant to the CwC 'target groups', including sexuality. These data were then entered on the central MI database by providers. By the end of the programme, providers had entered AIF data for 48% of carers registered for face-to-face provision (n=6,077). All data based on the AIF thus refers to this number / sub-set of carers and not to all those registered for or attending CwC modules. Characteristics are thus missing from the final MI data base for 52% of CwC registered carers.

**Table 5.1 Carers participating in CwC face-to-face, by gender and ethnicity** %

|   | Carers participating in CwC | Census 2001 data <sup>1</sup> |
|---|-----------------------------|-------------------------------|
| <b>Gender</b> <i>data available for 5,993 CwC participants</i>    |                             |                               |
| Men   | 21                          | 42                            |
| Women   | 79                          | 58                            |
| <b>Ethnicity</b> <i>data available for 5,919 CwC participants</i> |                             |                               |
| White British   | 79                          | 90                            |
| White Irish   | 1                           | 1                             |
| Other White ethnic groups   | 1                           | 2                             |
| Mixed ethnic groups   | 1                           | 1                             |
| Indian  | 8                           | 2                             |
| Pakistani   | 4                           | 1                             |
| Bangladeshi   | 1                           | 1                             |
| Other Asian ethnic groups   | 1                           | 0                             |
| Black Caribbean   | 1                           | 1                             |
| Black African   | 1                           | 1                             |
| Other Black ethnic groups   | 0                           | 0                             |
| Chinese   | 1                           | 0                             |
| All other ethnic groups   | 1                           | 0                             |

Sources: CwC MI AIF responses (data supplied by 6,077 carers); 2001 Census Standard and Commissioned Tables, Crown copyright (2003).

Note: <sup>1</sup> Census data are for England: for data on gender, carers aged 18+; for data on ethnicity, carers aged 16+.

Compared with all carers over the age of 18 in England, those registering for CwC were disproportionately female (79% compared with 58%); they also over-represented carers from the Indian, Pakistani and Chinese ethnic groups (Table 5.1). 'Carers from BME groups' were a target for the programme, so reaching these particular groups suggests effective steps were taken to achieve this goal. There was no CwC target relating to gender, however, and the rather disappointing outcome in terms of male carer participation probably in part reflects a lack of focus on reaching out to male carers at the programme commissioning stage.

The programme did succeed in providing training for some of the carers in most need of support and / or in the most demanding or intensive caring roles, as shown in Table 5.2. Over three-quarters of CwC carers were co-resident with the person they cared for (78%, compared with an estimated 47% for all carers in England). Two in five CwC carers (40%) had been in their caring role for a decade or more (compared with 27%), and 1 in 5 carers (22%) were caring for more than one person (compared with 17% nationally). In addition, close to a third of participating carers (31%) reported being in receipt of Carer's Allowance on joining CwC, effectively meeting the National Team's target for 'one third of carers' to be in this group.

**Table 5.2 Carers participating in CwC face-to-face, by caring circumstances %**

|   | Carers participating in CwC | 2009/10 Survey of Carers in Households |
|---|-----------------------------|--|
| <i>Total carers for whom CwC data available n=6,077</i>                 |                             |  |
| <b>Carer lives in same household as person cared for</b> <i>n=5,546</i> | 78                          | 47                                     |
| <b>Duration of caring role</b> <i>n=4,566</i>                           | 79                          | 58                                     |
| Less than 1 year  | 4                           | 10                                     |
| One year or more, but less than three years                             | 18                          | 21                                     |
| Three years or more, but less than five years                           | 14                          | 18                                     |
| Five years or more, but less than ten years                             | 24                          | 24                                     |
| 10 years or more  | 40                          | 27                                     |
| <b>Hours of care per week</b> <i>n=5,492</i>                            |                             |  |
| 1-19  | 13                          | 52                                     |
| 20-34   | 10                          | 18                                     |
| 35-49   | 11                          | 5                                      |
| 50+   | 65                          | 22                                     |
| <b>In receipt of Carer's Allowance</b> <i>n=5,556</i>                   | 31                          | 11                                     |
| <b>Caring for more than one person</b> <i>n=5,502</i>                   | 22                          | 17                                     |

Sources: CwC MI AIF responses; Survey of Carers in Households 2009/2010, NHSIC (2010).

LGBT (lesbian, gay, bi-sexual and transgender) carers were among the CwC target groups from the outset, and commissioning and procurement reflected this. Two providers were recruited with an expectation that the majority of the carers they recruited would be in this group, on the basis of their prior focus or record of engagement with the LGBT community (LGF Manchester, 75% LGBT target, and London Borough of Hounslow, 85% target). In addition, three other providers had a target to recruit between 10% and 15% of their CwC participants from the LGBT community. These targets were always ambitious and given uncertainty about the prevalence of these groups in the wider population (and absence of any carer statistics on them) may have been misconceived. The National Team attempted to collect data about participating carers' sexuality using the AIF, the question asked being reasonably well answered (by 79% of respondents). The majority of these (97%) recorded their sexuality as 'heterosexual', with the remaining 3% (120 LGBT carers) including 49 who identified as gay, 36 as lesbian, 27 as bisexual and eight as transgender. The participating carer group probably included other carers in these groups who either did not complete an AIF or did not answer the question.

**Table 5.3 Carers participating in CwC face-to-face, by characteristics of those cared for**

%

|  | Participating carers |
|--|----------------------|
| <i>Carers for whom data available n=6,077</i>                        |                      |
| <b>Care needs of the person cared for:</b>                           |                      |
| A disabled child with complex needs                                  | 11                   |
| A disabled adult with complex needs                                  | 25                   |
| A person living with mental ill-health                               | 21                   |
| A person with dementia   | 23                   |
| A person with a long-term condition                                  | 54                   |
| A person nearing the end of life                                     | 7                    |
| <b>Carer's relationship to the person cared for</b>                  |                      |
| Spouse / partner   | 46                   |
| Child under 18   | 13                   |
| Child 18 or over   | 15                   |
| Parent / parent-in-law   | 22                   |
| Other relative   | 6                    |
| Friend   | 2                    |
| <b>Personal characteristics of person cared for (target groups):</b> |                      |
| A person of Black or minority ethnic heritage                        | 14                   |
| A person who is lesbian, gay, bisexual or transgender                | 2                    |

Source: CwC MI AIF responses.

Other aspects of the caring circumstances of carers participating in CwC are presented in Table 5.3. This indicates the care needs of the person they cared for (more than one need could be recorded) and their relationship to that person; it also shows some data relevant to the targets set for CwC, which included the expectation that one third of carers would be caring for someone in specified categories ('Target Group Two: BME and LGBT carers and carers of those with specified needs and conditions', as described in Appendix D). No directly comparable data are available on these variables for the whole carer population in England, so Table 5.3 does not include this information. Nevertheless it is worth noting the evidence of the 2009/10 *Survey of Carers in Households* which showed that caring for a spouse or partner was much more common at older ages, with 58% of those aged 65+ caring for a spouse (compared with 23% of those aged 55-64 and 14% of those aged 35-44) (NHSIC 2010: 112). This suggests that the high proportion of CwC carers caring for a spouse or partner (46%) may be related to their (relatively older) age profile. Conversely, in the NHSIC national survey 40% of carers cared for a parent or parent-in-law, the largest category in that study, and 9% cared for a friend or neighbour<sup>4</sup>, whereas among carers participating in CwC these categories were considerably smaller (Table 5.3).

<sup>4</sup> The *Survey of Carers in Households* collected data about the 'main cared for person', whereas the CwC AIF asked carers about all those cared for, a difference to be borne in mind in interpreting these data.



Most CwC carers were caring for someone with a long-term condition (54%); one quarter were caring for a disabled adult with complex needs (25%); and similar percentages were caring for someone with dementia (23%) or mental ill-health (21%). Again no directly comparable national data exist. The NHSIC survey found 42% of those caring for 20+ hours per week looked after someone with a 'long-standing illness', 8% someone with dementia; and 15% someone with a mental health problem. These differences provide very broad indicators only, but would also be consistent with carers participating in CwC being older than the general population of carers.

### Previous experience of carer training

Among carers registered for face-to-face modules, the majority (72%) had no previous experience of attending any kind of training for carers (Table 5.4). This suggests CwC succeeded in its aim of reaching out to a wider group of carers than was being supported by other types of service.

**Table 5.4 Carers with no previous experience of carer training, by selected characteristics**

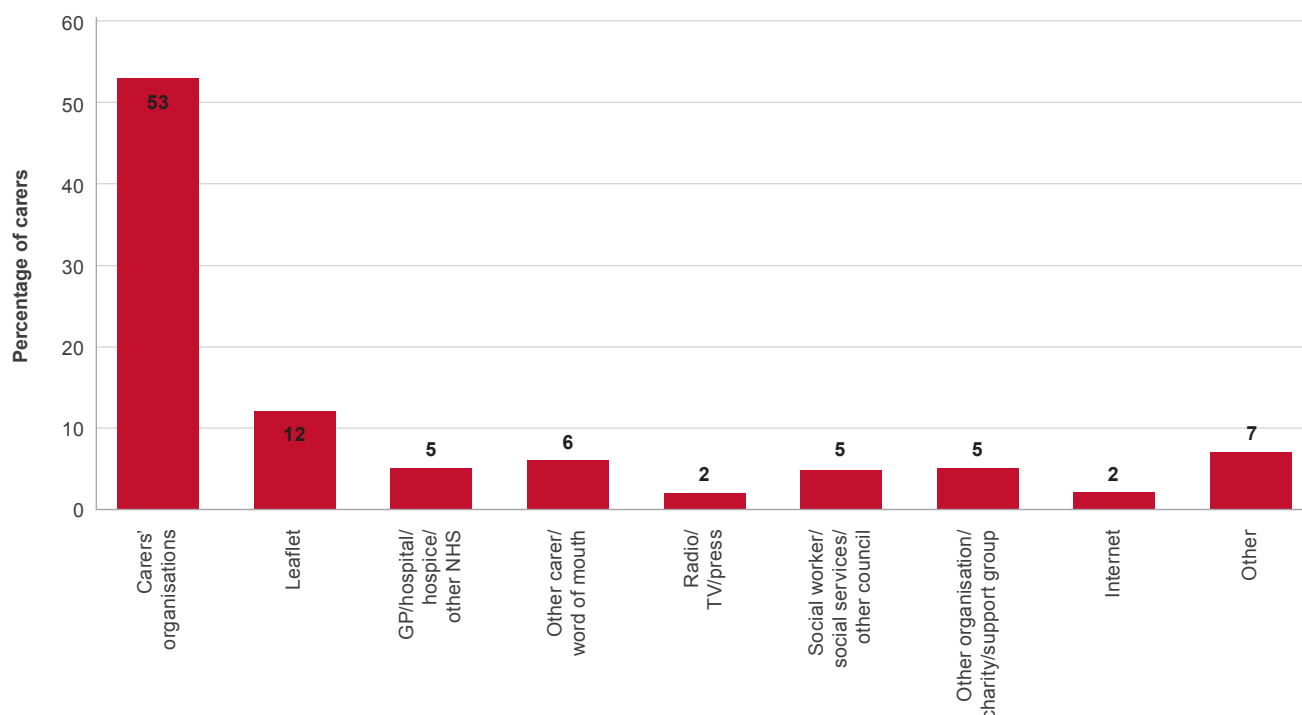
%

| Selected carer group                   | Carers with selected characteristics | All other participating carers |
|--|--------------------------------------|--------------------------------|
| New to caring (< 2 yrs)                | 81                                   | 69                             |
| Carers of those with mental ill-health | 61                                   | 74                             |
| Carers of people living with dementia  | 68                                   | 73                             |
| Carers in BME groups                   | 76                                   | 71                             |
| Carers in LGBT groups                  | 81                                   | 71                             |
| All CwC carers                         | ..                                   | 72                             |

Source: CwC MI AIF responses.

## 5.3 Carer engagement with the programme

Most carers who came into contact with the CwC programme found out about it through their links with voluntary sector agencies. Detailed information about this aspect of their recruitment to the CwC programme was collected using the AIF administered by providers, and (for those who answered the relevant question) is presented in Figure 5.3. Just over half the carers reported that they had found out about the programme through 'recommendation of a carers' organisation' (53%), by far the most common way carers became aware of it. One in eight (12%) had found out about CwC through a 'leaflet / poster', while others had become aware of it through 'another carer' (6%), health professionals (5%), social services (5%), 'other community organisations or charities' (5%) and through radio or internet publicity (each 2%). Although most carers who participated in the survey felt the programme was 'easy to find out about' (72%), the fact that recruitment was so difficult, especially for providers new to working with carers, indicates that this cannot have been true for other carers (particularly in the context of the good ratings participants gave the programme). The majority of participants (53%) found out about CwC through carers' organisations (Figure 5.3). The case study research showed that some providers in this category relied heavily on their existing contacts and mailing lists for carer recruitment.

**Figure 5.3 Sources of information about CwC: participating carers**

Source: CwC MI database (categories reclassified from those on AIF for clarity of presentation).

### Self-study and online options

As already indicated, most carers who engaged with the CwC programme did so by attending venues where CwC was delivered face-to-face via approved CwC modules. However, carers could also access the programme through specially approved self-study materials or online. The number choosing these options (1,318 carers) was far smaller than the planned figure (10,000). The age and gender of carers accessing the programme through the different modes available are shown in Table 5.5. Compared with those participating in CwC face-to-face, those choosing the self-study mode were more likely to be women and to be under age 65, but otherwise there were few differences between the groups.

Groups of carers more likely to register for self-study included LGBT carers, carers of people nearing the end of life, carers of disabled children, and carers in receipt of Carer's Allowance (Table 5.6). Overall (shown in Table 5.6, bottom rows), those who chose the online version of the programme were much more likely to be in Target Group One (TG1)<sup>5</sup>. Both the face-to-face and the self-study providers had less success in recruiting carers from TG1 and TG2, in both cases ending the programme with over half their participants in the 'any other carer' group<sup>6</sup>.

<sup>5</sup> The Target Groups for the CwC programme are explained in Appendix A.

<sup>6</sup> It is impossible to establish if carers for whom no AIF data exist differ statistically from other participants.

**Table 5.5 CwC participants, by age, gender and mode of delivery**

%

|                                    | Carers registered for  |              |              | ALL registered carers |
|------------------------------------|------------------------|--------------|--------------|-----------------------|
|                                    | Face-to- face sessions | Self-study   | Online       |                       |
| <i>Number of registered carers</i> | 12,621                 | 733          | 585          | 13,939                |
| <i>% of all registered carers</i>  | 90                     | 5            | 5            | 100                   |
| <b>Age<sup>1</sup></b>             | <i>n=11,405</i>        | <i>n=733</i> | <i>n=0</i>   | <i>n=12,138</i>       |
| 16-24                              | 2                      | 2            | *            | 2                     |
| 25-34                              | 7                      | 11           | *            | 7                     |
| 35-49                              | 22                     | 37           | *            | 23                    |
| 50-64                              | 36                     | 38           | *            | 36                    |
| 65-74                              | 20                     | 8            | *            | 20                    |
| 75+                                | 12                     | 3            | *            | 11                    |
| <b>Gender</b>                      | <i>n=5,993</i>         | <i>n=234</i> | <i>n=544</i> | <i>n=6,561</i>        |
| Men                                | 21                     | 18           | 21           | 21                    |
| Women                              | 79                     | 82           | 79           | 79                    |

Source: CwC MI AIF responses.

Note: <sup>1</sup> Age data include those registered for face-to-face / self-study only; not available for online registration.

### Intensity of carers' engagement with the CwC programme

In total, 10,238 registered carers attended at least one CwC face-to-face module, each on average (median) attending four modules, thereby meeting the agreed 'acceptable' level for carer engagement (see Chapter 3). Carers' characteristics, by number of modules attended, are shown in Table 5.7. Just over half of carers who attended at least one module (54%<sup>7</sup>) attended four or more modules, the target agreed for 'successful' participation<sup>8</sup>. Data available from the AIF forms show that, among participating carers, some groups were slightly more likely than others to attend four or more modules (Tables 5.7 and 5.8). These included: carers aged 65+; carers of disabled adults with complex conditions; and carers of people with a long-term condition (with results were statistically significant for these groups<sup>9</sup>). Carers of disabled children with complex needs were significantly less likely to attend 4+ modules than other carers, however.

<sup>7</sup> Only 54% of the 12,621 carers for whom MI data was entered by providers participated in 4+ modules. This differs from the % in Figure 5.11, which shows that 59% of the 6,077 carers for whom AIF data was available attended 4+ modules.

<sup>8</sup> Carers' propensity to report positive changes following participation in the CwC programme rose with number of modules attended, levelling off after attendance reached four modules, suggesting this was an appropriate measure.

<sup>9</sup> A result is said to be statistically significant if it is unlikely to have occurred by chance. The significance level most commonly used to show that a finding is 'good enough to be believed' is 5% (reported as  $p=0.05$  or any figure below 0.05). This means that there is a 5% or lower chance of the observed data occurring by chance (Young and Bolton, 2009).

**Table 5.6 CwC participants, by target group, selected characteristics and mode of delivery**

%

|   | Carers registered for |            |           | ALL registered carers |
|---|-----------------------|------------|-----------|-----------------------|
|   | Face-to-face sessions | Self-study | Online    |                       |
| <b>Target Group 1 - carers who are:<sup>1</sup></b> |                       |            |           |                       |
| from a BME group                                    | 20                    | 14         | 15        | 19                    |
| LGBT  | 3                     | 7          | 4         | 3                     |
| caring for 35+ hours a week                         | 76                    | 81         | 68        | 76                    |
| receiving Carer's Allowance                         | 31                    | 43         | 31        | 31                    |
| <b>Target Group 2 - carers of:<sup>2</sup></b>      |                       |            |           |                       |
| people from a BME group                             | 14                    | 10         | 6         | 13                    |
| people who are LGBT                                 | 2                     | 2          | 4         | 2                     |
| disabled children with complex needs                | 11                    | 20         | 14        | 12                    |
| disabled adults with complex needs                  | 25                    | 24         | 22        | 25                    |
| people living with mental ill-health                | 21                    | 21         | 20        | 21                    |
| people with dementia                                | 23                    | 26         | 21        | 23                    |
| people with long-term conditions                    | 54                    | 57         | 49        | 54                    |
| people nearing the end of life                      | 7                     | 14         | 9         | 8                     |
| <b>Carers<sup>3</sup></b>                           |                       |            |           |                       |
| <b>in Target Group One</b>                          | <b>38</b>             | <b>27</b>  | <b>64</b> | <b>39</b>             |
| <b>in Target Group Two<sup>4</sup></b>              | <b>8</b>              | <b>4</b>   | <b>23</b> | <b>8</b>              |
| <b>in Target Group Three (any other carer)</b>      | <b>54</b>             | <b>69</b>  | <b>13</b> | <b>53</b>             |

Source: CwC MI AIF responses.

Notes: <sup>1</sup> Figures for Target Group One variables are for the % of carers who responded to the specific question.<sup>2</sup> Data for Target 2 relate to 733 carers.<sup>3</sup> Data based on all carers registered with the programme. Carers who supplied insufficient information to be allocated to TG1 or TG2 were placed in TG3 (any other carer) by default.<sup>4</sup> Excluding any who were also in TG1.

Of carers participating in the programme, a quarter (25%) attended only one module. The groups of carers more likely to be in this category were: working age carers; LGBT carers; and carers of people from BME groups (also statistically significant results)<sup>10</sup>: carers of disabled adults with complex conditions, however, were slightly less likely than other carers to attend only one module.

Nearly one in five of those who registered for face-to-face CwC sessions (19%) did not attend a face-to-face module at any stage. Carers of working age were significantly more likely than older carers to register for the programme without ever attending a module.

Wide variations in carer engagement (measured by number of modules attended) were evident for different CwC providers (details of this variation are shown in Appendix E).

<sup>10</sup> Data on carers who attended only one module were more likely to be missing. MI records show that carers attending 2+ modules were significantly more likely to have AIF data entered than carers who attended only one module.

**Table 5.7 CwC participants: characteristics and number of face-to-face modules attended**

| Carer characteristics                | Number of modules carers attended |              |              |       |
|--------------------------------------|-----------------------------------|--------------|--------------|-------|
|                                      | One module only                   | Two or three | Four or more | ALL   |
| <i>Number</i>                        | 1,259                             | 1,234        | 3,584        | 6,077 |
| <b>% of all participating carers</b> | 21                                | 20           | 59           | 100   |
| <b>Age</b>                           |                                   |              |              |       |
| 16-49                                | 22                                | 22           | 56           | 100   |
| 50-64                                | 18                                | 21           | 61           | 100   |
| 65+                                  | 21                                | 19           | 60           | 100   |
| <b>Gender</b>                        |                                   |              |              |       |
| Men                                  | 22                                | 19           | 59           | 100   |
| Women                                | 20                                | 21           | 59           | 100   |
| <b>Ethnicity</b>                     |                                   |              |              |       |
| White British                        | 21                                | 20           | 59           | 100   |
| White Irish / Other White            | 25                                | 19           | 56           | 100   |
| Black and minority ethnic groups     | 18                                | 21           | 60           | 100   |
| <b>Sexuality</b>                     |                                   |              |              |       |
| Heterosexual                         | 20                                | 20           | 60           | 100   |
| Lesbian, Gay, Bisexual, Transgender  | 28                                | 18           | 54           | 100   |

Source: CwC MI AIF responses.

**Table 5.8 CwC participants, by caring circumstances and number of modules attended**

%

| Caring circumstances of carer                            | Number of modules carers attended |              |              |     |
|--|-----------------------------------|--------------|--------------|-----|
|  | One module only                   | Two or three | Four or more | ALL |
| <b>Carer lives in same household as person cared for</b> |                                   |              |              |     |
| Yes  | 20                                | 20           | 59           | 100 |
| No   | 22                                | 21           | 57           | 100 |
| <b>Length of time caring</b>                             |                                   |              |              |     |
| Less than 2 years  | 21                                | 19           | 60           | 100 |
| 2 years or more  | 21                                | 21           | 59           | 100 |
| <b>Hours of care per week</b>                            |                                   |              |              |     |
| 1-34 hours   | 22                                | 19           | 59           | 100 |
| 35+ hours  | 20                                | 21           | 59           | 100 |
| <b>Cares for more than one person</b>                    |                                   |              |              |     |
| Yes  | 21                                | 20           | 59           | 100 |
| No   | 19                                | 22           | 59           | 100 |
| <b>Cares for:</b>  |                                   |              |              |     |
| A disabled child with complex needs                      | 22                                | 25           | 53           | 100 |
| A disabled adult with complex needs                      | 18                                | 20           | 62           | 100 |
| A person of Black or minority ethnic heritage            | 17                                | 20           | 63           | 100 |
| A person living with mental ill-health                   | 20                                | 20           | 60           | 100 |
| A person with dementia                                   | 21                                | 20           | 59           | 100 |
| A person with a long-term condition                      | 20                                | 19           | 61           | 100 |
| A person nearing the end of life                         | 18                                | 24           | 58           | 100 |
| A person who is lesbian, gay, bisexual or transgender    | 26                                | 24           | 51           | 100 |
| <b>Carer's relationship to person cared for:</b>         |                                   |              |              |     |
| Spouse/partner   | 20                                | 19           | 61           | 100 |
| Child under 18   | 20                                | 24           | 55           | 100 |
| Child 18 or over   | 24                                | 19           | 57           | 100 |
| Parent/parent-in-law                                     | 20                                | 22           | 59           | 100 |
| Other relative   | 20                                | 18           | 63           | 100 |
| Friend   | 15                                | 16           | 69           | 100 |

Source: CwC MI AIF responses.



## 5.4 Carers' experiences of the programme

During the lifetime of CwC its providers delivered the programme through a total of 5,097 face-to-face module sessions. The numbers of carers who attended each of the face-to-face modules, both 'generic' and 'tailored', are shown in Table 5.9. *Finding your way*, usually taken first and acting as the 'gateway' module to the main programme content (six 'generic' modules, intended to be suitable for all carers), was the most frequently attended, experienced by over 8,000 carers. Most of the other generic modules were delivered to between 5,000 and 6,000 carers. *Caring and life* was the least well attended, with fewer than 4,500 participants. Of the 'tailored' modules, designed for carers in specific caring circumstances, *Caring for someone with dementia* was by far the most frequently attended (447 carers). The 'tailored' modules were not intended for all carers and became available later than the 'generic' provision, in part accounting for these very different attendance figures.

**Table 5.9 CwC modules, by number of carers who attended**

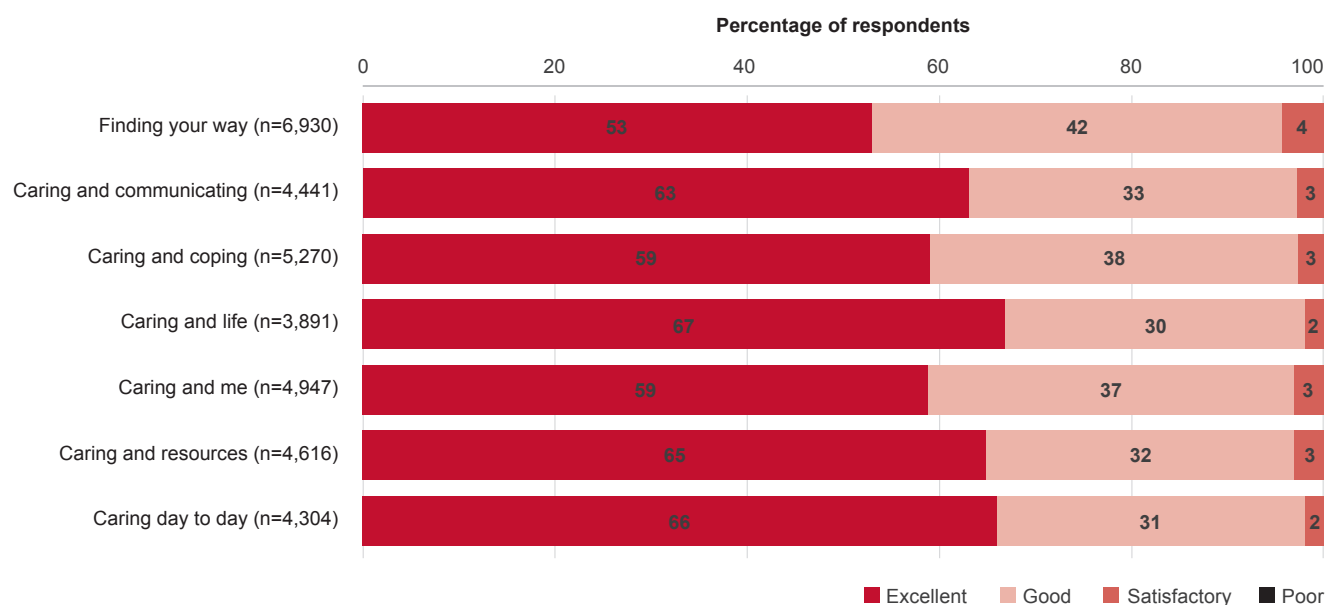
| Module   | Numbers of carers who attended |
|--|--------------------------------|
| <b>Generic Modules</b>   |                                |
| Finding your way   | 8,165                          |
| Caring and communicating   | 5,106                          |
| Caring and coping  | 6,003                          |
| Caring and life  | 4,432                          |
| Caring and me  | 5,647                          |
| Caring and resources   | 5,264                          |
| Caring day-to-day  | 5,000                          |
| <b>Tailored Modules</b>  |                                |
| Finding your way after caring                                    | 9                              |
| Caring and communicating for carers of those nearing end of life | 18                             |
| Coping after caring  | 7                              |
| Life after caring  | 9                              |
| Caring and me for carers of those nearing end of life            | 24                             |
| Caring and resources for carers of those nearing end of life     | 18                             |
| Caring day-by-day for carers of those nearing end of life        | 18                             |
| Caring for a disabled child                                      | 28                             |
| Caring for someone living with dementia                          | 447                            |
| Caring for someone living with mental ill health                 | 97                             |
| <b>Total</b>   | <b>40,292</b>                  |

Source: CwC MI database.

Module evaluation forms (collected at each session<sup>11</sup>) recorded a very high level of participant satisfaction. Most carers (61%) rated the modules (all versions) ‘excellent’; a further 35% rating them ‘good’ and 3% ‘satisfactory’. Very few carers (0.1%), 25 out of 35,011 responses, rated a module ‘poor’. There was little variation in the respondents’ views of different modules. A slightly higher proportion of carers rated the *Finding your way* module ‘good’ (42%); correspondingly a slightly lower proportion rated it ‘excellent’ (53%) compared with other modules. *Caring and life*, *Caring and resources*, and *Caring day-to-day* received the most positive feedback, with about two-thirds rating these modules ‘excellent’ (Figure 5.4). Feedback on the modules tailored for specific groups of carers was also overwhelmingly positive.

Of the carers who completed the survey questionnaire (and of those who took part in the focus groups), many were also positive about their participation in the programme. A very large majority (94%) of those who responded to the evaluation survey said they ‘would recommend CwC to other carers’. Carers participating in the survey were asked about this shortly after completing their involvement with the CwC programme and again six months later (Figures 5.6 and 5.7). In addition, 84% agreed that CwC offered high quality training (Figure 5.8). Subsequent investigation (through the PCS2 questionnaire) was consistent with this, showing that only about a quarter (26%) of respondents thought CwC was ‘similar to other training’ they had undertaken.

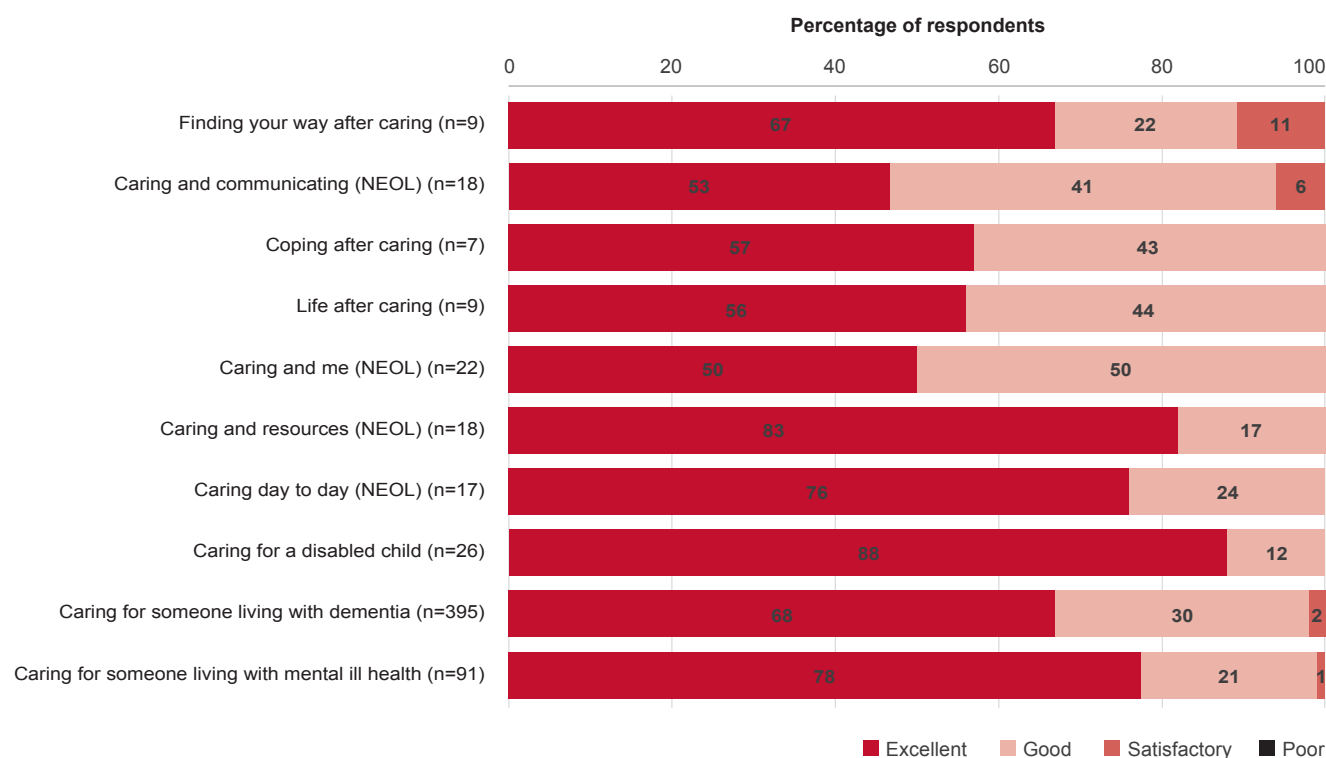
**Figure 5.4 Generic CwC sessions: carer feedback**



Source: CwC module feedback forms, MI database.

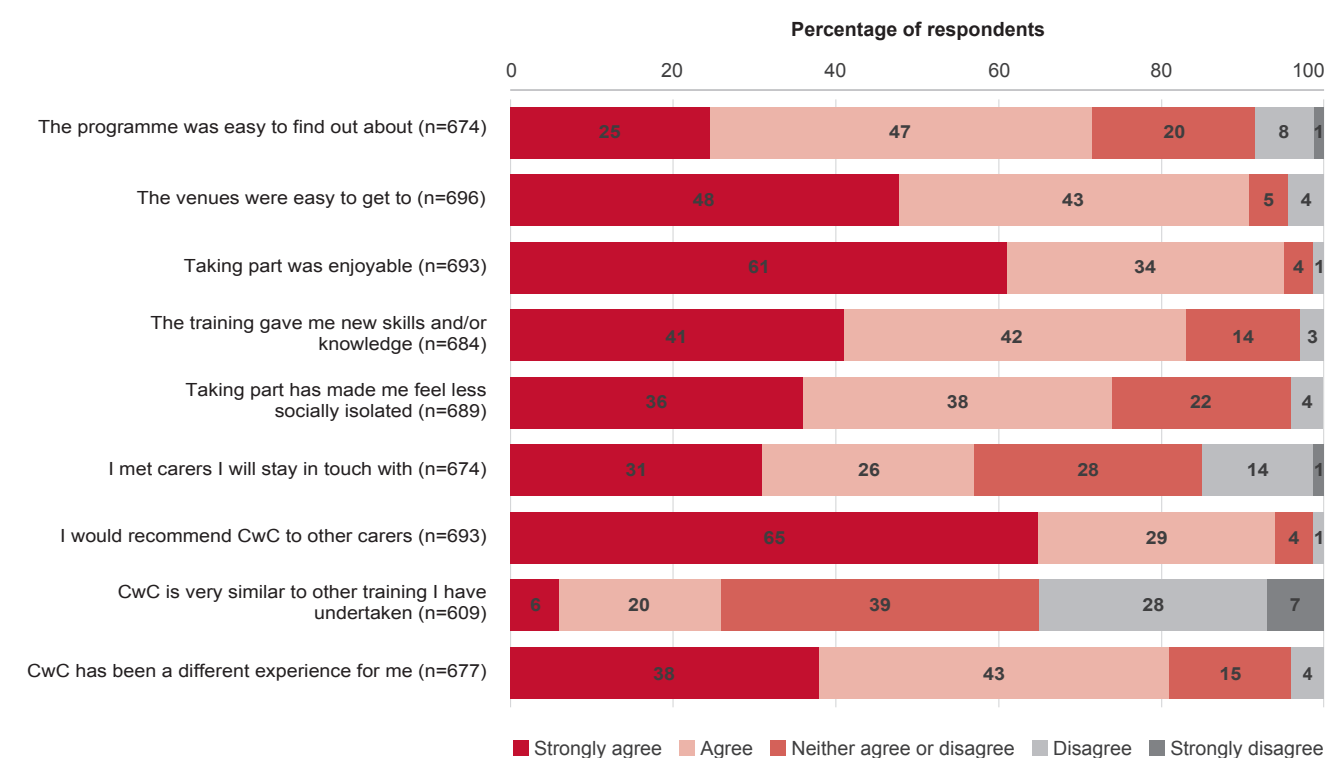
Note: The number of responses received is indicated above. Of carers who attended, these represent response rates for the module specified of: 88% (Caring and coping, Caring and life, Caring and me, Caring and resources); 87% (Caring and communicating); 86% (Caring day-to-day); and 85% (Finding your way).

<sup>11</sup> Monitoring tools designed by the CwC National Team, which providers were required to use at each session (Appendix B).

**Figure 5.5 Tailored CwC Sessions: carer feedback**

Source: CwC module feedback forms, MI database.

Note: Number of responses received is indicated above. Of carers who attended, these represent response rates of: 100% (Caring and communicating (NEOL), Caring and resources (NEOL), Coping after caring, Life after caring and Finding your way after caring); 94% (Caring day-to-day and Caring for someone living with mental ill-health); 93% (Caring for a disabled child); 92% (Caring and me); 88% (Caring for someone living with dementia).

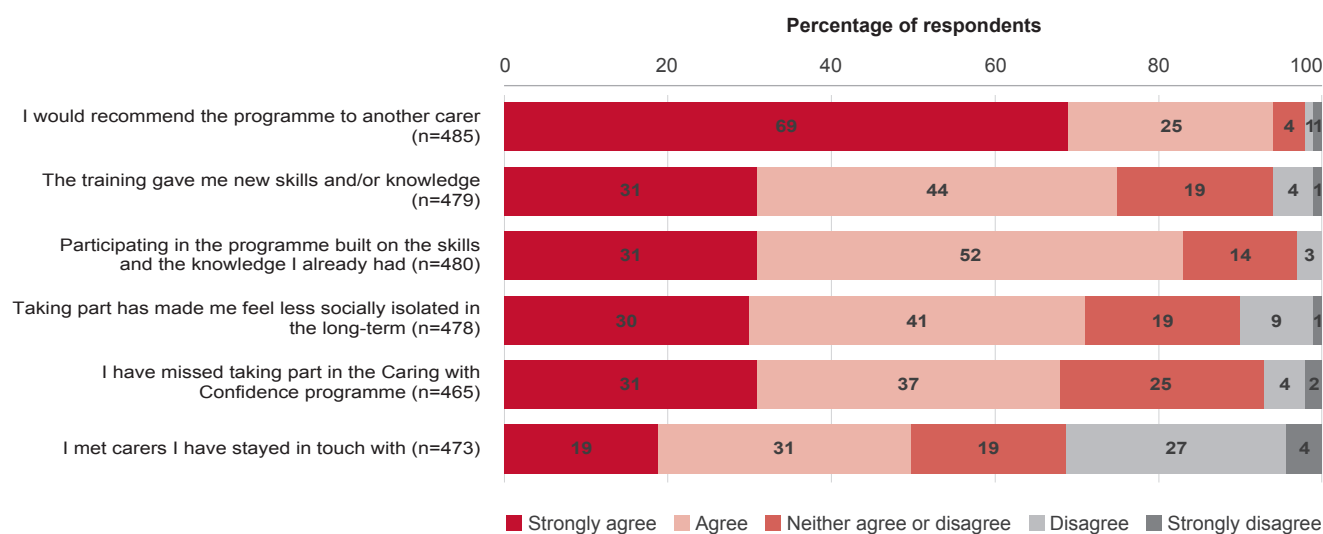
**Figure 5.6 Carers' views about the programme: on completion**

Source: CIRCLE, University of Leeds: CwC survey, phase 2.

Note: n = number of carers who responded to the question / item indicated.

Survey respondents were particularly positive about the level of mutual support the programme provided, with almost all agreeing that it provided 'a safe, supportive environment to meet other carers' (97%), 'a place to share experiences of caring with others' (98%), and 'a place where my point of view was understood and listened to' (94%) (Figure 5.8). The vast majority also agreed that the programme provided them with an opportunity to explore solutions to problems which worried them (87%), that the programme provided high quality training (84%) and gave them materials which were useful afterwards (86%). A high percentage of survey respondents also agreed that taking part in CwC had made them feel less socially isolated (74% at the end of their involvement, and 71% six months later) (Figures 5.6 and 5.7).

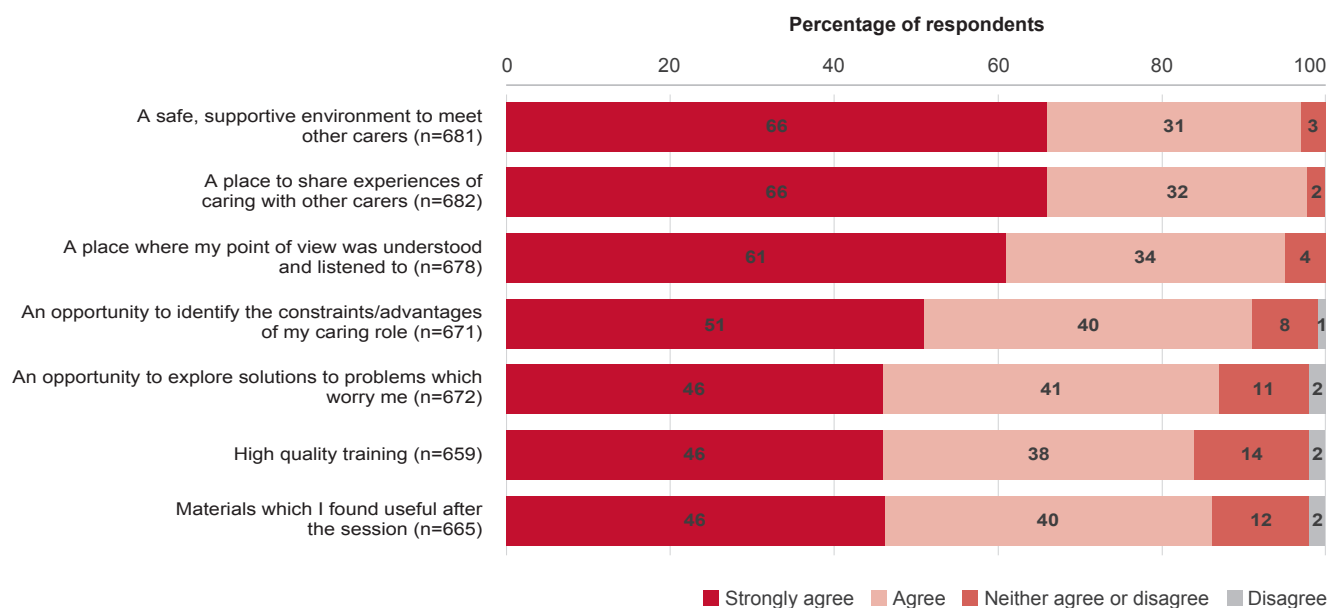
**Figure 5.7 Carers' views about the programme: six months after completion**



Source: CIRCLE, University of Leeds: CwC survey, phase 3.

Note: n = number of carers who responded to the question / item indicated.

**Figure 5.8 Carers' experiences of the programme: on completion**



Source: CIRCLE, University of Leeds: CwC survey, phase 2.

Note: n = number of carers who responded to the question / item indicated.

The discussions in the focus groups were consistent with the survey results. Many participants felt the programme had provided a forum in which carers could gain mutual support, often identifying this as one of the most beneficial aspects of the programme. Most focus group participants thought the face-to-face modules provided quality course materials and assisted participants in gaining key skills, as well as creating opportunities to reflect on their learning experiences and bring them to the next session to share. Many explained that meeting other carers through the programme had helped them realise that there were other carers in similar situations to themselves. The mutual support gained from the programme meant many carers felt less isolated than previously and many said they had continued to meet (as groups of carers) once their participation in the programme had come to an end. Comments<sup>12</sup> included:

*People feel less isolated now....*

*I agree you feel less isolated, that you're not the only one. It empowers you to fight for your rights...*

*It's the interaction that is important; a lot of the information that is given out would be worthless without the interaction.*

The importance of facilitated, structured sessions and the distinction between these and more informal sessions was mentioned in many of the focus groups:

*A coffee morning wouldn't be structured like the course is. It's led, everyone has the chance to talk and the focus is kept on the topic. Here, everybody has a chance to say something, it's really worthwhile, it being led, chaired....otherwise it's just a chat.*

*There will always be a need to have places like Caring with Confidence because it will always be hard to discuss some things with non carers. Not all your friends can discuss such specific issues. This provides a setting where you can vent about caring and explore caring specific problems. People support each other because they understand what it's like. This is the key to the success of Caring with Confidence. It works because you hear from others in your situation who've dealt with the problems that you come across.*

*Seeing people struggling through similar situations provides permission / endorsement of a change in behaviour. People help you to question your own resolution.*

*It leads to a questioning of yourself. But also they work through the objections and find solutions from their differing perspectives.*

*It's important to know there are others. Previously you think you're on your own. Going through people's stories makes you aware of things that can lead to change. The group therapy aspect really works, it's very important.*

The importance of a consistent group, meeting regularly in a confidential and supportive environment, was also mentioned by the focus group attendees:

*It was better as we got to know each other.*

*It means you're more open about what you're saying.*

*You grow to trust each other.*

*Everything was in confidence, and this was reiterated each week - and they meant it, which was good. It was important to meet each other week by week. Having a consistent group means you're looking forward to meeting people week by week.*

<sup>12</sup> All comments quoted in this chapter were made by focus group participants, except where otherwise indicated.

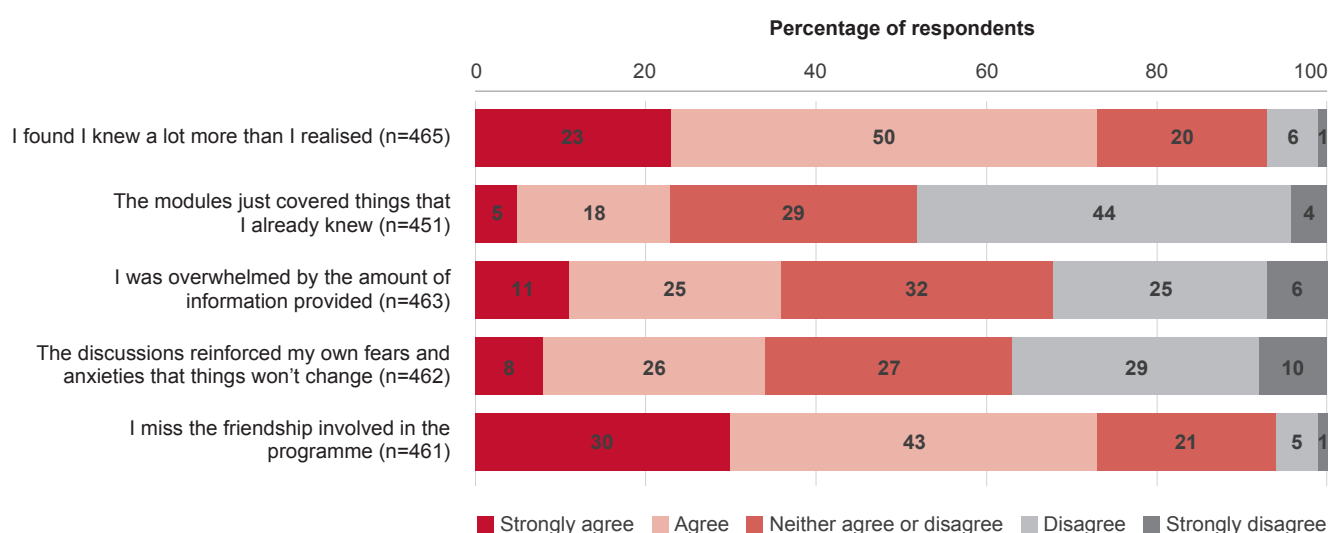
*Caring with Confidence* participants from 'hard to reach' groups (such as LGBT carers) were particularly positive about the mutual support provided by the sessions:

*It was good to be in a gay space. This made people more confident. People knew that the others attending the sessions would be at least gay-friendly, if not gay.*

Some participants had sustained relationships beyond their formal participation in the programme. Many (57%) said they had met carers they would stay in touch with and 50% were still saying this six months after finishing the programme (Figures 5.6 and 5.7). Participants in one focus group, for example, explained that they had continued to meet once a month and had managed to secure funding from their local authority to support this process.

Survey respondents also noted some unexpected outcomes of participating in CwC (Figure 5.9). Most (73%) agreed that they found they knew 'a lot more than they realised', although only 23% said the modules 'just covered things I already knew'. However, 36% felt 'overwhelmed by the amount of information provided'.

**Figure 5.9 Unexpected effects of participation: six months after completion**



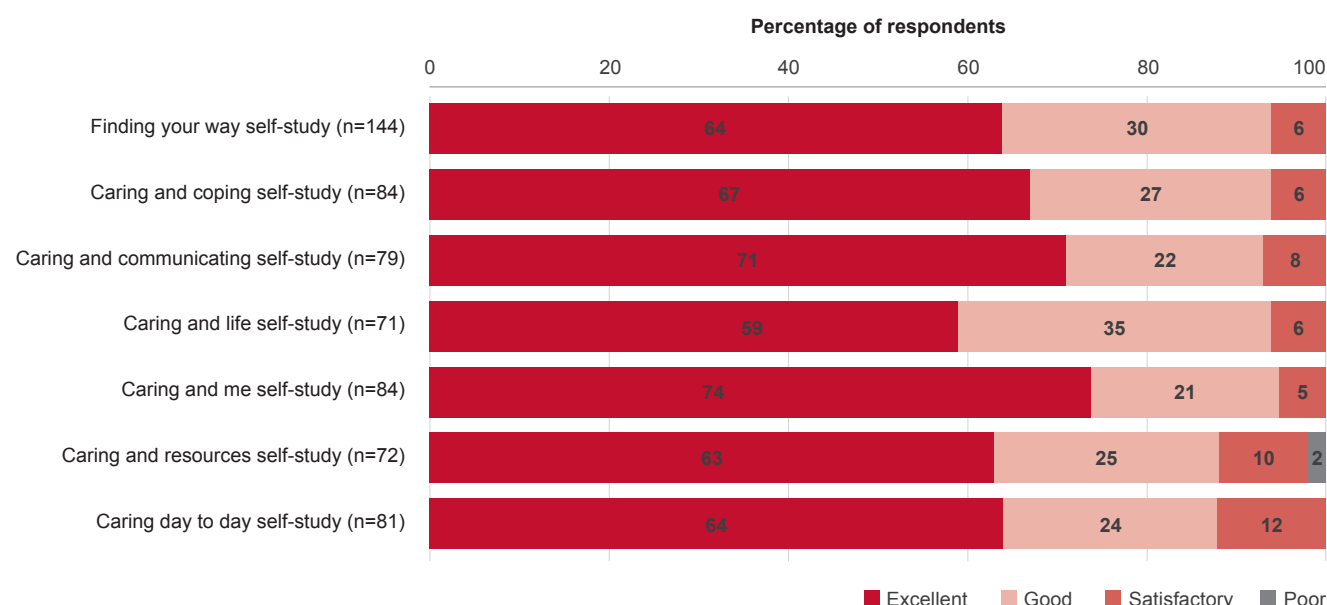
Source: CIRCLE, University of Leeds: CwC survey, phase 2.

Note: n = number of carers who responded to the question /item indicated.

Carers who accessed the modules through self-study were also extremely positive about the programme. Two-thirds (66%) of carers who completed one of the National Teams' internal module evaluations rated these modules as 'excellent' overall, with a further 27% rating them as 'good'. Just 0.2% (1 in a total of 612 responses) rated the self-study modules as 'poor' overall. Data for individual self-study modules is presented in Figure 5.10<sup>13</sup>.

<sup>13</sup> The national evaluation team did not have access to any feedback from carers accessing CwC modules online.



**Figure 5.10 CwC self-study modules: carer feedback**

Source: CwC module feedback forms, MI database.

Note: The number of responses is shown in the figure. These represent the following %s of all carers who attended the sessions indicated: 19% (Finding Your Way, self-study); 11% (Caring and communicating, Caring and coping, Caring and life, and Caring day-to-day, all self-study); 10% (Caring and me and Caring and Resources, self-study).

## 5.5 Outcomes for carers who participated in the programme

As indicated in Chapter 2, the evaluation study included a survey of carers who participated in the CwC programme (the PCS). This provided a way of identifying the programme's outcomes for those who participated in CwC<sup>14</sup>. As the principal aim of the DH in resourcing the programme was to explore ways of improving the support available to carers, the survey was an important element of the evaluation. It comprised questionnaires distributed in three phases, as indicated below:

- PCS1, administered by CwC providers, normally via the *Finding your way* module, as carers joined the programme.
- PCS2, sent to consenting carers (at their home addresses) approximately 12 weeks later.
- PCS3, sent to consenting carers (at their home addresses) approximately 5-6 months later (i.e. approximately 8-9 months after first joining the CwC programme).

In line with the intended outcomes outlined in the Scope of Works for the CwC programme, analysis of the results of the survey, together with further insights obtained from the focus group discussions with carers, was used to explore the impact of the CwC programme on those participating in the following broad areas:

- Caring roles and accessing support.
- Personal development and caring relationships.
- A 'life outside caring'.
- Health and well-being.
- Perceived outcomes for the person cared for.

<sup>14</sup> Data in section 5.5 is primarily from the survey of participating carers, described in Chapter 2. Questionnaires are provided in Appendix B.

This analysis offers a perspective on how, and to what extent, carers themselves (and those they care for) benefitted from the CwC programme<sup>15</sup>. Reference to survey respondents in this part of the report is to those who completed the evaluation team's PCS questionnaires. The total responses achieved in each phase of the survey (as indicated in Chapter 2, Table 2.1) were: 1,278 (PCS1); 741 (PCS2); and 499 (PCS3).

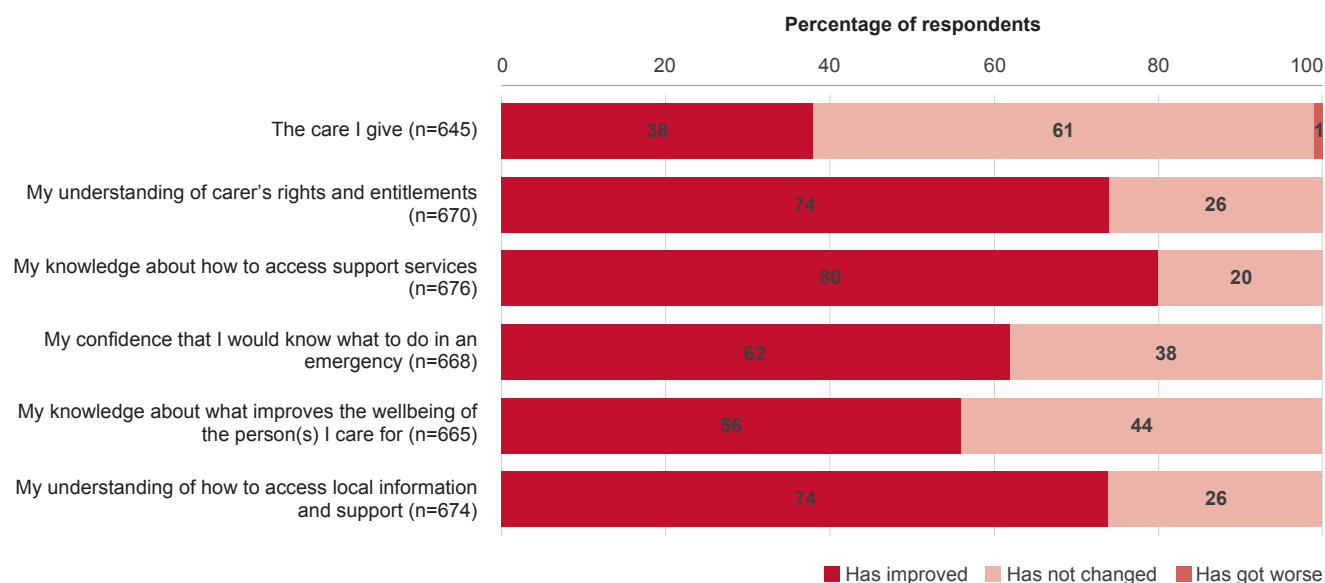
### Training for caring roles and access to support

A substantial majority of carer respondents reported that after their participation in CwC they had more knowledge about 'how to access support and services' (80% of carers soon after taking part; 73% of carers six months later)<sup>16</sup>. Most also believed they had a better understanding of 'how to access local information and support' (74% and 67% respectively) and a 'better understanding of carers' rights and entitlements' (74% and 71% respectively) (Figures 5.11 and 5.12). In all, 11% of carers who returned a PCS3 questionnaire stated that they had claimed additional benefits as a result of participating in the CwC programme.

Carers participating in the focus groups overwhelmingly gave the same message: they had gained greater awareness and knowledge of the services and information available to support them in their caring roles as a result of attending the programme, including greater knowledge about carers' rights and / or benefits:

*We gained more knowledge about what we can claim. Most people are not aware of what they can claim, because there are no proper information sessions for carers telling people what they can claim. Many people don't claim what they're entitled to.*

**Figure 5.11 Impact of the programme on care given: carers' perceptions on completion**



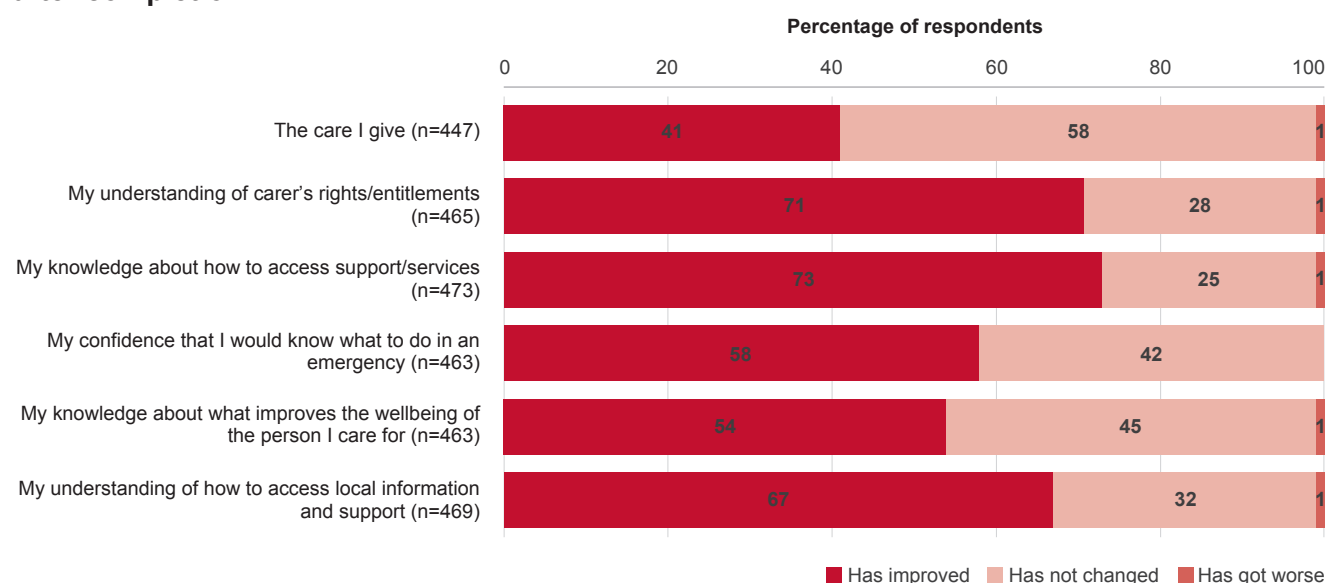
Source: CIRCLE, University of Leeds: CwC survey, phase 2.

Note: n = number of carers who responded to the question specified.

<sup>15</sup> The full results of the survey became available in spring 2011, with analysis for this report due in May 2011. Further analysis is ongoing and will be reported elsewhere.

<sup>16</sup> These are referred to as outcomes 'at completion' and outcomes 'six months later'.

**Figure 5.12 Impact of the programme on care given, carers' perceptions six months after completion**



Source: CIRCLE, University of Leeds: CwC survey, phase 3.

Note: n = number of carers who responded to the question specified.

Most survey respondents also stated that they had 'more confidence in what to do in an emergency' after taking part in CwC (62% at completion and 58% six months later). This was also emphasised by focus group participants:

*In the past I struggled to lift my husband who is a big man, but I was reluctant to dial 999. Before I would have called people, now I'm happy just to call the emergency services. I was reluctant to do so before. I felt bad that I was calling them regularly. Thanks to this course I realise what the services are there for, so I don't feel so bad.*

*Before Caring with Confidence, we would have been reluctant to dial 999 over an episode such as the cared for person falling, now we have more confidence to do so because we were made to feel as if we have a right to use these services by talking to other carers and facilitators, who reminded us that we wouldn't be wasting their time.*

When asked to agree or disagree with a range of statements about the programme, a large minority of survey respondents (38% on completing CwC, 41% six months later) agreed that the CwC programme had improved 'the care I give', and more than half felt they had acquired better knowledge about 'what improves the well-being of the person I care for'; 56% on completing CwC and 54% six months later (Figures 5.11 and 5.12).

Focus group attendees also said that they had more awareness of the needs of the person they cared for and greater confidence in responding to those needs:

*I realised that I had to ask for assistance instead of suffering in silence.*

Many carers said they had started to implement some of their newly acquired knowledge, for example by developing a plan for what should happen in the event of an emergency:

*I was now able to put in place an emergency plan with the emergency services and I got equipment to deal with it. Caring with Confidence told us where to go and helped us put the procedures in place.*

Additional analysis<sup>17</sup> showed that male carers reported this type of benefit more frequently than their female counterparts, 47% of them saying there had been an improvement in the care they gave, compared with 34% of female carers. Carers who were of BME heritage and carers of people in the BME group also seemed to gain more from the programme in this respect: three-quarters (75%) of carers of BME heritage said their knowledge about 'what improves the well-being of the person I care for' had improved, compared with 55% of White carers; and 60% of carers of a person in the BME group said that there had been an improvement in 'the care I give', compared with 37% of other carers. Carers in the LGBT group also reported substantial benefit in this aspect of the programme. Almost two-thirds of LGBT carers (64%) said there had been an improvement in 'the care I give', compared with 34% of heterosexual carers. Carers of people with a long term condition, however, were statistically less likely than other carers to report improvements in the care they gave (32% and 46% respectively saying there had been an improvement in 'the care I give').

Improvement in the care given emerged less frequently and strongly in the focus groups, although there was some discussion about the extent to which the CwC programme had helped carers to understand the needs of the person they cared for:

*I had been taking control and assuming that I knew better than my husband (the person cared for). Caring with Confidence has taught me to listen more to what he wants. Before he bottled it up and wouldn't say what was wrong in a particular situation. There are more shared decisions made now. It was the facilitators that made me realise this.*

*I now tend to listen more and help the people I care for come to decisions themselves instead of making decisions for them.<sup>18</sup>*

For some carers, the programme was the very first time they had seen themselves as carers:

*It's about acknowledging the carer label, realising that you are not just a wife or a parent; that you have become a carer. Meeting people in similar circumstances and with a shared understanding allows you to come to terms with it.*

*Caring with Confidence increased the feeling that I was a carer. It pushed me further to that point.*

*I was probably somebody who had decided that I was a carer, just as I came here. I look after my mother who has got dementia and is frail and is losing her eyesight, so I was just coming to that point. So that was reinforced when I came here that, yes, I was a carer - and it makes you think about things.*

Evidence from the focus group discussions and the survey of carers thus indicated that many carers gained greater skills, knowledge and awareness of caring issues through their participation in the CwC programme, and that this may have had an impact on the quality of care they provide.

- In total, 88% of survey respondents to the immediate post-participation survey (PCS2) reported, on completing CwC, an improvement in at least one aspect of their caring role as a consequence of their participation in the programme.
- For those who subsequently responded (six months later, in PCS3) this figure was still remarkably high, at 85%.

<sup>17</sup> Additional analysis of carer sub-groups, not shown in the figures presented in this chapter.

<sup>18</sup> Response supplied in written form in a completed PCS2 questionnaire.

## Training for caring roles and access to support

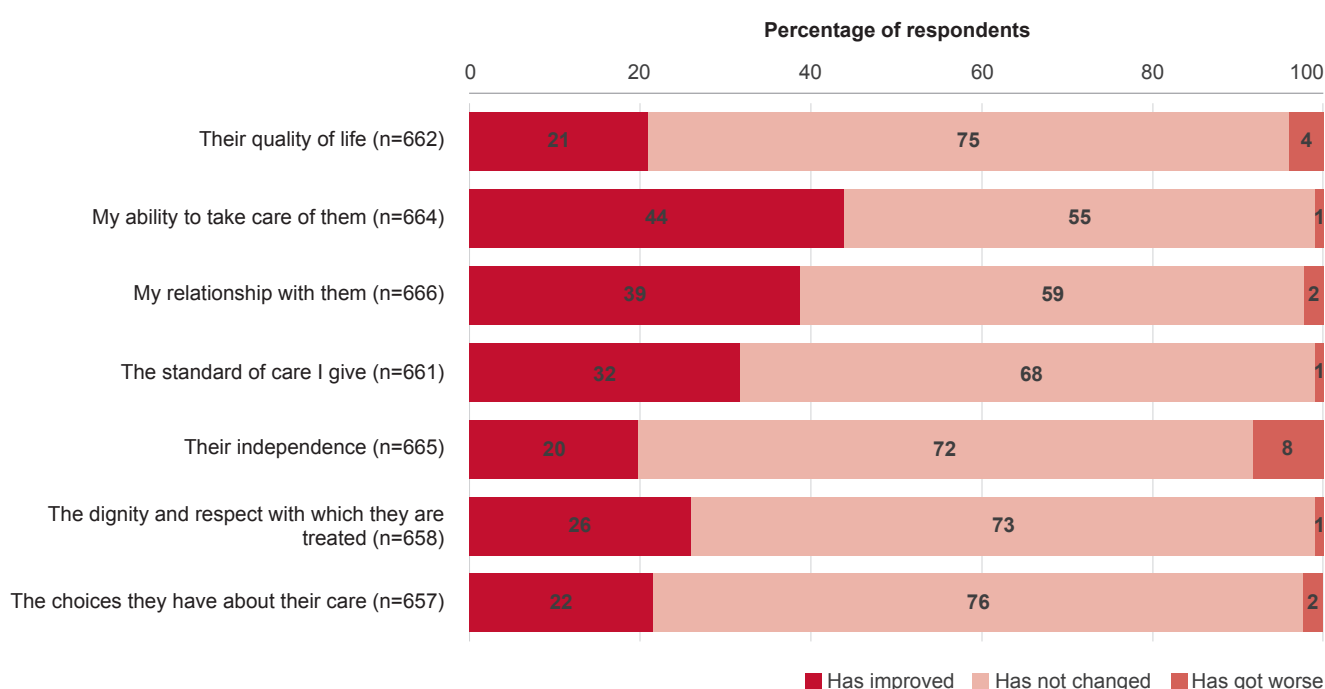
Over a third of survey respondents reported an improvement in their relationship with the person they cared for as a result of attending CwC (Figures 5.13 and 5.14).

While it is evident from Figures 5.13 and 5.14 that many carers who took part in the CwC programme did not report any change affecting the care given to, or the quality of life of, those cared for, this is hardly surprising given that they were still supporting the same person with the same care needs. However, the minorities of carers reporting improvements on the factors considered in Figures 5.13 and 5.14 considerably outweigh those reporting any deterioration. It is also notable that quite large minorities of carers reported longer term impacts on their relationship with the person cared for, the standard of care they gave and, in particular, their ability to take care of them. In the focus groups carers often discussed improvements in their relationship with the person they cared for which they attributed to the programme:

*You feel better, you feel better about the cared for, which gives improved patience, so your relationship with the cared for goes better.*

*As I am more confident and self assured - this has had a ripple effect.<sup>19</sup>*

**Figure 5.13 Impact of the programme on those cared for: carers' perceptions on completion**



Source: CIRCLE, University of Leeds: CwC survey, phase 2.

Note: n = number of carers who responded to the question specified.

One in five carers felt the independence of the person they cared for had improved. One wrote:

*By me stepping back from certain situations, the person I care for has to now take responsibility for his actions and be more independent.*

<sup>19</sup> This response (and the one following) was supplied in written form in a completed PCS2 questionnaire.

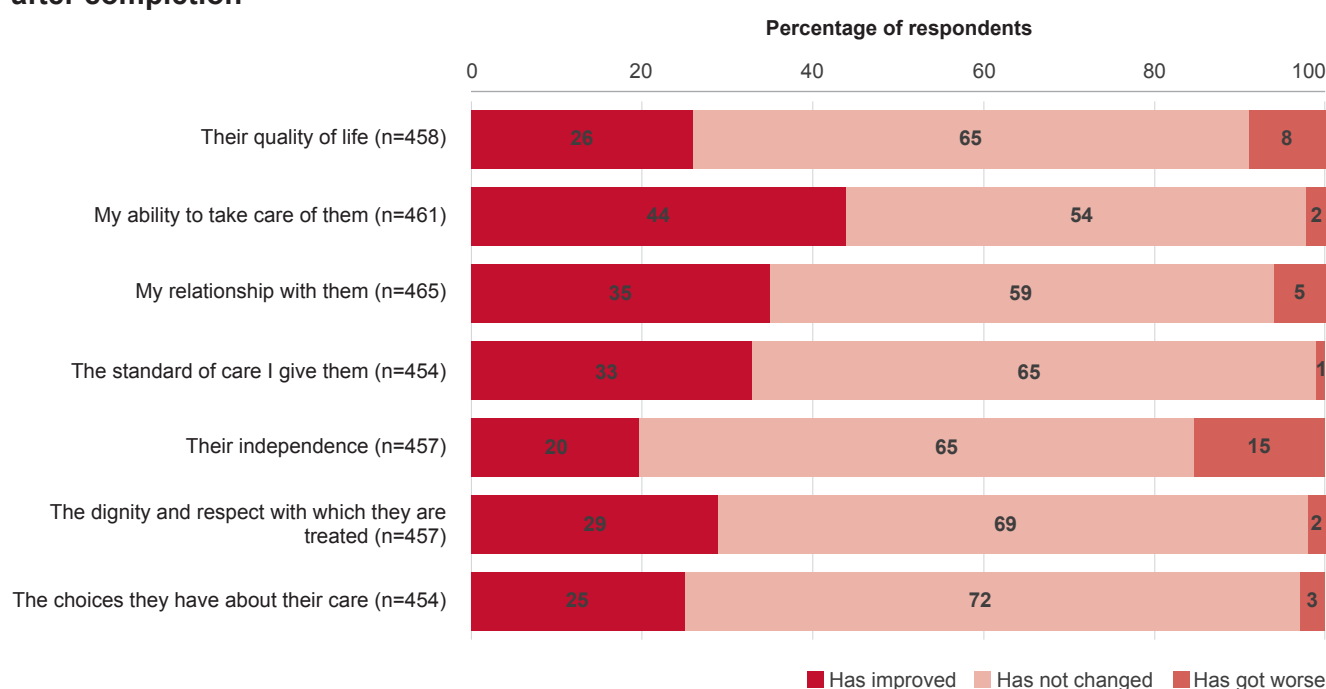
Overall, three fifths of respondents reported some improvement affecting the person they cared for, in at least one of the areas the survey covered, as a consequence of participating in the programme.

Half the survey respondents stated that they felt ‘more confident to take on new challenges’ following their participation in the programme (Figures 5.15 and 5.16).

Quite large minorities of respondents reported having a better balance between ‘my caring and other relationships’ (28% on completion, 35% six months later), and about one in five had started a new leisure activity or joined a new social group.

Gaining confidence, feeling a sense of empowerment and becoming more assertive were key personal development skills which many of the focus group participants mentioned. Carers tended to feel much more confident in practical caring skills, such as how to respond to an emergency situation. Two thirds of survey respondents reported an improvement in this area (Figures 5.11 and 5.12).

**Figure 5.14 Impact of the programme on those cared for: carers’ perceptions six months after completion**



Source: CIRCLE, University of Leeds: CwC survey, phase 3.

Note: n = number of carers who responded to the question specified.

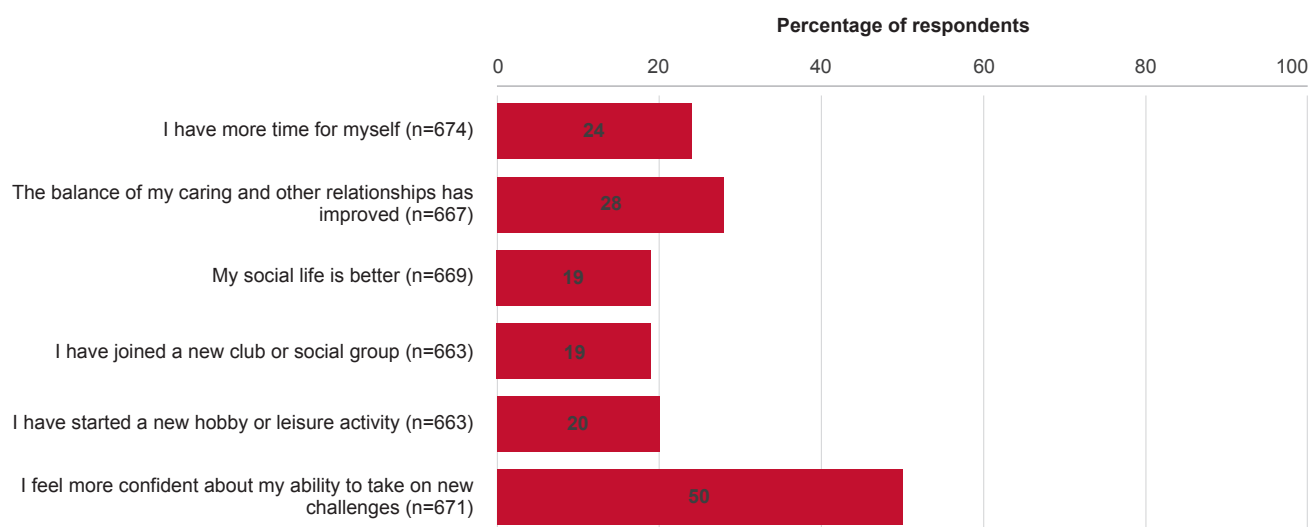
Some focus group participants stated that since *Caring with Confidence* they were no longer afraid to say ‘no’ or to admit that they could not cope:

*The course doesn’t solve problems - it gives you tools to solve the problems yourself.*

*Sometimes you have to take difficult steps yourself to get where you want to be. It allows you to step back and reflect on what you do. The course involved specific exercises teaching you to say ‘no’.*

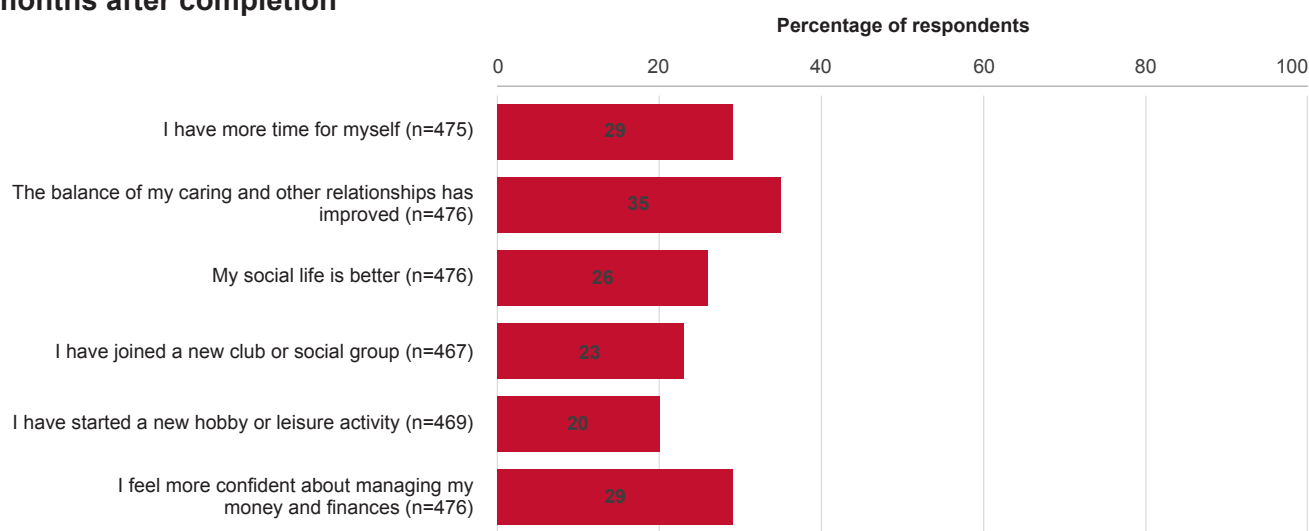
Nevertheless, focus group participants often pointed out that there were many issues CwC could not influence, and for some there were continuing frustrations. One carer, for example, explained that although she was now more assertive and felt able to say ‘no’, or that she cannot cope, her five siblings, who do not do ‘their share’ of caring, still have not changed their behaviour, which upsets her very much.



**Figure 5.15 Impact of the programme on carers' own lives: carers' perceptions on completion**

Source: CIRCLE, University of Leeds: CwC Survey phase 2.

Note: n = number of carers who responded to the question specified.

**Figure 5.16 Impact of the programme on carers' own lives: carers' perceptions six months after completion**

Source: CIRCLE, University of Leeds: CwC survey, phase 3.

Note: n = number of carers who responded to the question specified.

The greater carer confidence which seems to have been a clear outcome of the programme for many participants (as exemplified in both the focus group discussions and the survey results) may have wider implications for the health and social care system, with possible potential for financial savings, as one carer pointed out:

*I now feel more confident that I can cope, so my mother won't have to go into a home. Thinking about it, I always assumed that when my mother got that bad with her dementia or whatever, that she would go into a home. But I think I feel more confident and able to cope with things, and I think probably now she would, somehow, we would find a way that she could come and stay with us. It's the confidence; it's a really good title for the course.*

Focus group participants also said they were now more likely to ask questions of professionals and service providers, which they had previously been reluctant to do:

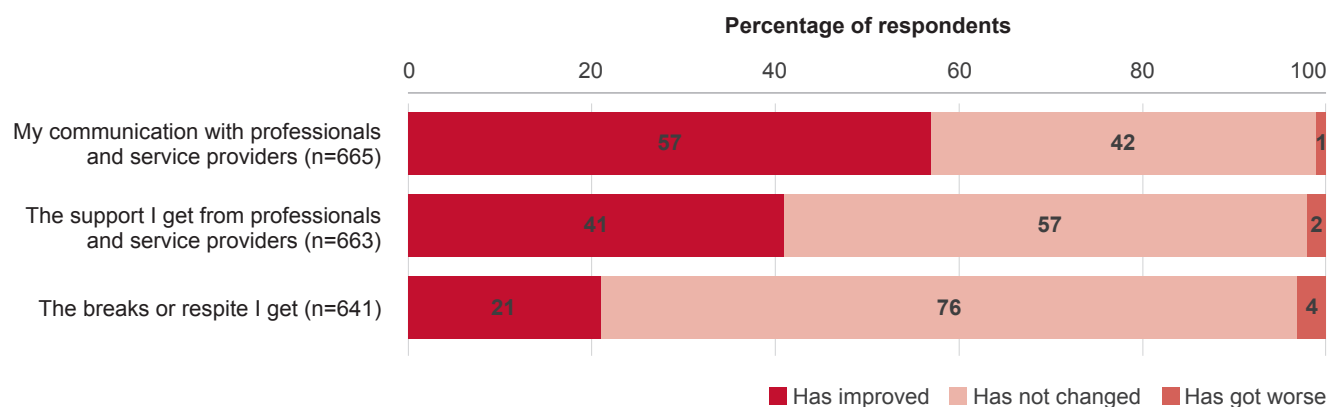
*Being part of the group gave me the confidence to get in touch with social services. It allowed me to assert my rights. You don't always want to assert your rights even if you know them, Caring with Confidence gives you that confidence.*

*It [Caring with Confidence] reinforces the idea that these are people's rights. It's not charity but an entitlement.*

*As a result of Caring with Confidence giving me confidence, I went to speak to a Patient Advisor Liaison [person] at the hospital. I was more assertive with the consultant and that wasn't well received.(...) But I stood up to him and even though I didn't necessarily benefit medically it was beneficial to me and my partner.*

Most respondents to the survey (57%) felt their communication with professionals and service providers had improved following their participation in the CwC programme (Figures 5.17 and 5.18). Some also reported improvements in the support they got from professionals and in their access to respite and breaks. Analysis of this data by age showed that carers aged 18-64 were statistically more likely than older carers (aged 65+) to say there had been an improvement in this (62% and 53% respectively). Carers of BME heritage also seemed to gain particular benefit from this aspect of the programme, 79% saying that there had been an improvement in their communication with professionals and service providers, compared with 56% of White carers. There were no significant differences between carers who had had a Carer's Assessment before joining the CwC programme, and those who had not, on these variables.

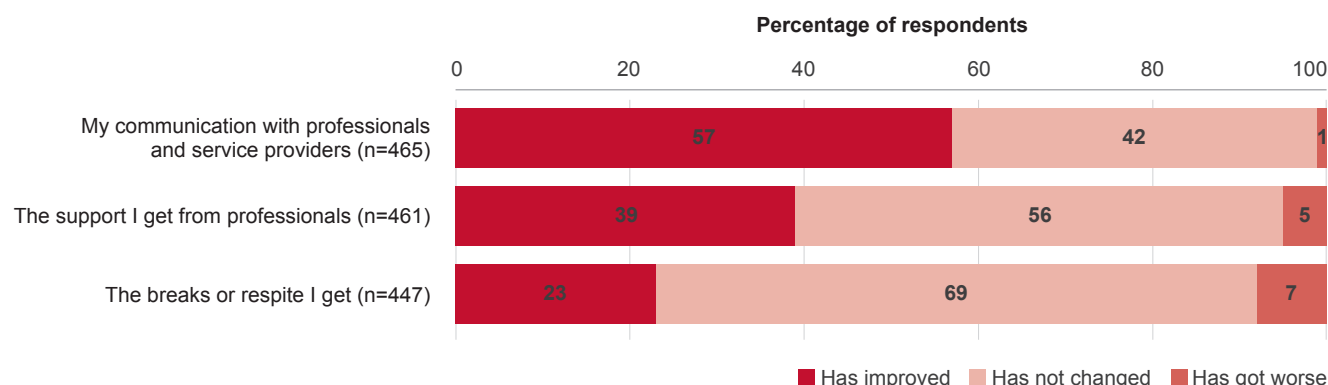
**Figure 5.17 Impact of the programme on selected aspects of their caring circumstances: carers' perceptions on completion**



Source: CIRCLE, University of Leeds: CwC survey, phase 2.

Note: n = number of carers who responded to the question specified.

**Figure 5.18 Impact of the programme on selected aspects of their caring circumstances: carers' perceptions six months after completion**



Source: CIRCLE, University of Leeds: CwC survey, phase 3.

Note: n = number of carers who responded to the question specified.

### Training for 'a life outside caring'

Some respondents (just under one quarter) said that they now had more time for themselves following their participation in CwC (Figure 5.15 and Figure 5.16). Recognising the importance of having 'a life beyond caring' was a key outcome of the programme for survey respondents and focus group participants, and many carers said they felt 'less guilty' about needing time for themselves having participated in CwC.

*I've just been trying to sort of get out more and socialise and it was the 'rip up the guilt'.... you know, write the guilty word down and rip it up. That's what I learn here, that it's OK to go out and have a coffee with a friend for half an hour, an hour. I was feeling very, very guilty, quite mixed up when I came, because obviously I had all these different things going on.*

*It has helped me to not feel as guilty when I take time for myself - although that is still quite a difficult thing.<sup>20</sup>*

*I have to think about me, too - and don't now feel guilty about it or feel I'm being selfish. It's essential to stop me from 'going under' with my responsibilities<sup>21</sup>.*

However, taking the step of actually spending more time on themselves was not so widely reported. Some participants pointed out that this was more difficult to achieve in practice due to their need for alternative care, which was often either not available or not acceptable to those cared for. This may explain the relatively small proportion of survey respondents who felt they had more time for themselves.

Following their involvement in the programme one fifth of survey respondents had started a new hobby or leisure activity (Figure 5.15) and some focus group attendees also said the same, pointing out that the CwC programme highlighted the need for carers to have some leisure time:

*It [Caring with Confidence] reinforces that thinking of yourself is part of helping the cared for. You need leisure time.*

*You may know the solution, but it is difficult to make yourself do it. Having someone turn round and tell you to do what you say makes you do it.*

<sup>19</sup> Response supplied in written form in a completed PCS2 questionnaire.

<sup>20</sup> Response supplied in written form in a completed PCS3 questionnaire.

Almost one fifth of the survey respondents agreed that their social life was better following participation in the CwC programme (Figure 5.15). In the focus groups there was a mixed response when carers were asked about any improvements in their social life and their ability to take breaks from caring, however. Some focus group participants stated that although they felt this was important they still had difficulties finding time and arranging alternative or respite care so that they could take a break:

*Your caring role remains the same despite the course. The course doesn't change that role. It isn't a miracle cure. You're still the same person with the same responsibilities. It doesn't suddenly fix one's social life. Responsibilities don't disappear.*

One carer in a focus group became emotional when talking about breaks away from caring as she felt unable ever to leave the person she cared for overnight. Some carers who attended other focus groups reported similar experiences, while others felt that since participating in CwC they were now better able to take a break:

*It [Caring with Confidence] teaches you how to give time to yourself, not just taking holidays but taking a break such as going out into the garden or drinking a cup of tea.*

The discussions about carer breaks in the focus groups led to debates about what constituted a break from caring. For some carers, a regular short break was important but difficult or impossible as, in their experience, funding was available only for annual short breaks of a few days. One in five of the survey respondents reported an improvement in their ability to take a break or access respite since taking part in the programme (Figure 5.17 and 5.18). Further analysis showed that those caring for 50 or more hours per week were more likely than other carers to report an improvement in the breaks or respite they could get (24% compared with 15%). Prior to taking part in CwC 22% of survey respondents said they had never had a break from their caring role; statistical analysis of their responses to the question about access to respite and breaks showed no significant difference between this group and other carers, however; they were just as likely as other carers (21% on completion, 23% after six months) to report an improvement in their access to this type of support.

Among the survey respondents, 28% stated that they now had a better balance between caring and relationships with other family and / or friends, and this was also an outcome mentioned by some of the focus group participants. It was an important benefit for one male focus group participant, who explained:

*My family and friends are now more aware of my role. Simply putting the label on – 'a carer' has made a lot of my friends more inquisitive - that's not the right word - [They're] wanting to know who I am, more than one would expect, and actually going into some depth about how I feel about some things.*

Another carer at a focus group said:

*I've tried to have better time management since Caring with Confidence. Not just in my caring but with my partner. I've made an effort to bring things together.*

Just over one in ten survey respondents (among those for whom the question was applicable<sup>22</sup>) indicated that, since their participation in CwC, they were considering returning to paid work, and a similar proportion had applied for a training course. This may be a quite positive outcome as only 7% of the 55% of survey respondents who said they had specific goals they hoped to achieve by taking part in CwC identified 'accessing employment and / or training' as one of those goals. The personal goals most respondents were hoping to achieve included 'getting to know other people in a similar situation' (82%), 'access help and support' (77%), and 'improve my knowledge or skills' (74%).

<sup>22</sup> That is, excluding those already in paid work and those over state pension age.

There were mixed responses when carers were asked in the focus groups about their ability to apply for new training or agree more flexible terms or working arrangements with their employer. A small number of focus group attendees had started working again since the Caring with Confidence programme:

*I have started working again, which has been a great bonus for me, not just financially, it gets my brain ticking again. Thanks to Caring with Confidence. Having the confidence to actually say yes I will do the work that I'm asked to do, whereas in the last 12 months I've turned it down on every occasion.*

However, carers in the focus groups pointed out that despite the Caring with Confidence programme many barriers to (re) entering paid work remained, including a lack of jobs with flexible working hours that would enable them to combine their caring with paid work, a perceived reluctance on the part of employers to recruit carers, difficulties finding appropriate and suitable respite care, and the benefits system, particularly the eligibility rules for Carer's Allowance, which many felt discouraged carers from taking paid work:

*There aren't jobs out there that you can just dip in and out of. So Caring with Confidence doesn't make a difference. It's not viable at all. There are no jobs with the flexibility required by carers. I'm interested in doing a university course but I can't see how I can fit it in.*

*The reality of the job market is that you can't work, Caring with Confidence course or not. People don't want to employ someone who is looking after a disabled child at home.*

*Earning limits make it not worth the effort. You're not allowed enough to make it worth the hassle.*

*It's difficult to find a job. They don't want to know you if you have a disabled child at home. Then there's all the complications, like finding respite care - and then they don't let you earn enough to make it worthwhile.*

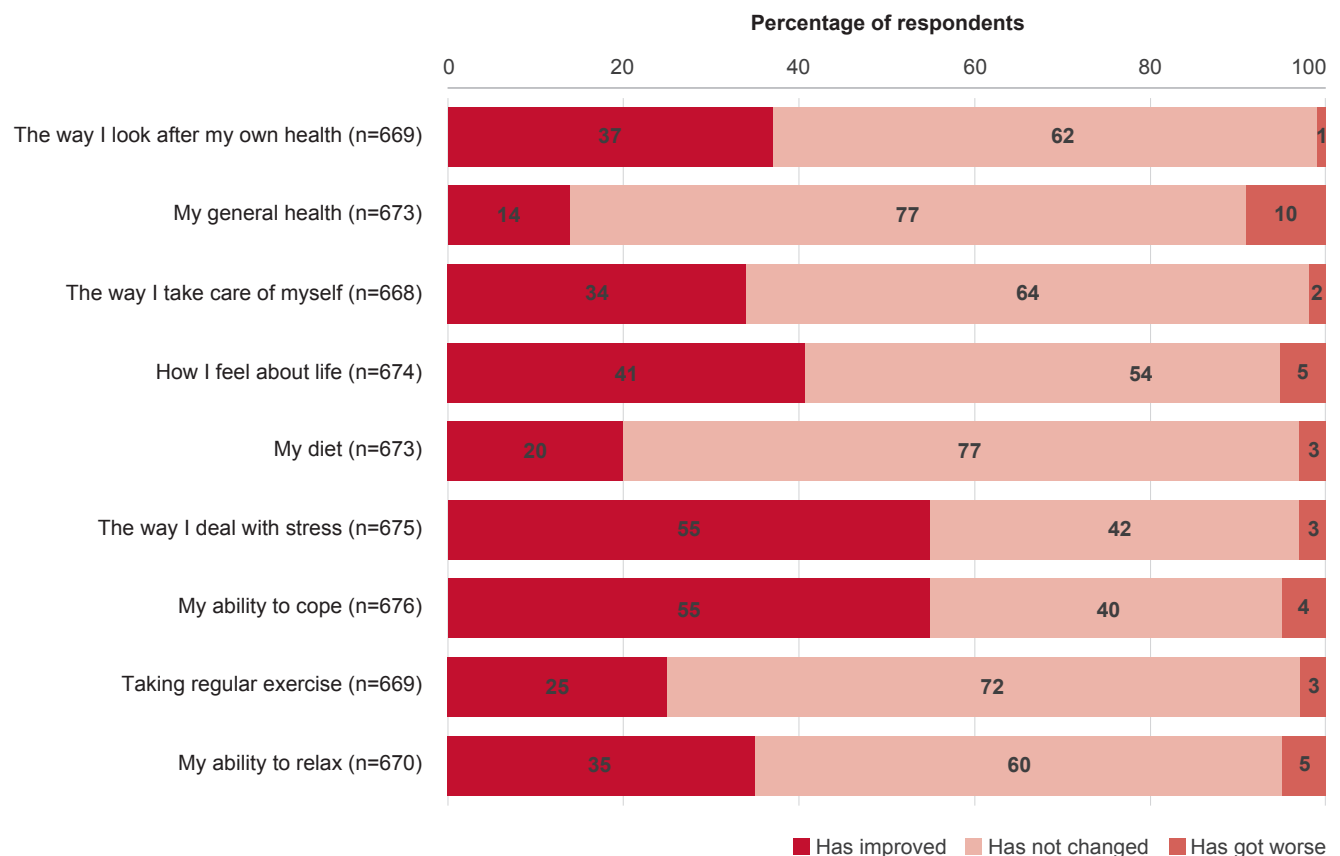
This highlights the additional support that carers need in order to (re) enter paid employment or training. In all, 294 carers (40%) who responded to the survey at the end of their CwC participation (PCS2) reported that there had been at least one measureable outcome of this type for them, that is: joining a club or social group; starting a new hobby or leisure activity; applying for or starting a new job; increasing their hours at work or negotiating flexible working arrangements; applying for or starting a new course; applying to or becoming a student in further or higher education; or starting volunteering.

### **Training to sustain carer health and wellbeing**

Over a third of the survey respondents (37%) said the way they took care of themselves and the way they looked after their own health had improved following their participation in the programme (Figure 5.19). Some (14%) indicated that their general health had improved, and substantial minorities (in some cases almost half) of survey respondents reported that there had been positive improvements in their health and well-being generally, including diet, stress, ability to cope and relax and taking regular exercise (Figures 5.19 and 5.20).

There were, however, some statistically significant differences in the impact of the programme on carers, dependent upon their personal characteristics. Female carers were statistically more likely than male carers to say that there had been an improvement in: ‘the way I take care of myself’; ‘how I feel about life’; and ‘my diet’. Older carers (aged 65+), perhaps unsurprisingly, were less likely to say that there had been improvements in many aspects of their health and well-being following their involvement in the programme. There were also some differences by target carer group, for example in relation to Target Group One (Table 5.6). Within Target Group One, LGBT carers were almost twice as likely as heterosexual carers to say there had been improvements in ‘the way I look after my own health’ and more than twice as likely to say that there had been improvements in relation to ‘the amount of regular exercise I take’. Similarly carers of BME heritage were more likely than their White counterparts to say there had been improvements in ‘the way I take care of myself’ and in their diet.

**Figure 5.19 Impact of the programme on their own health and well-being: carers’ perceptions on completion**

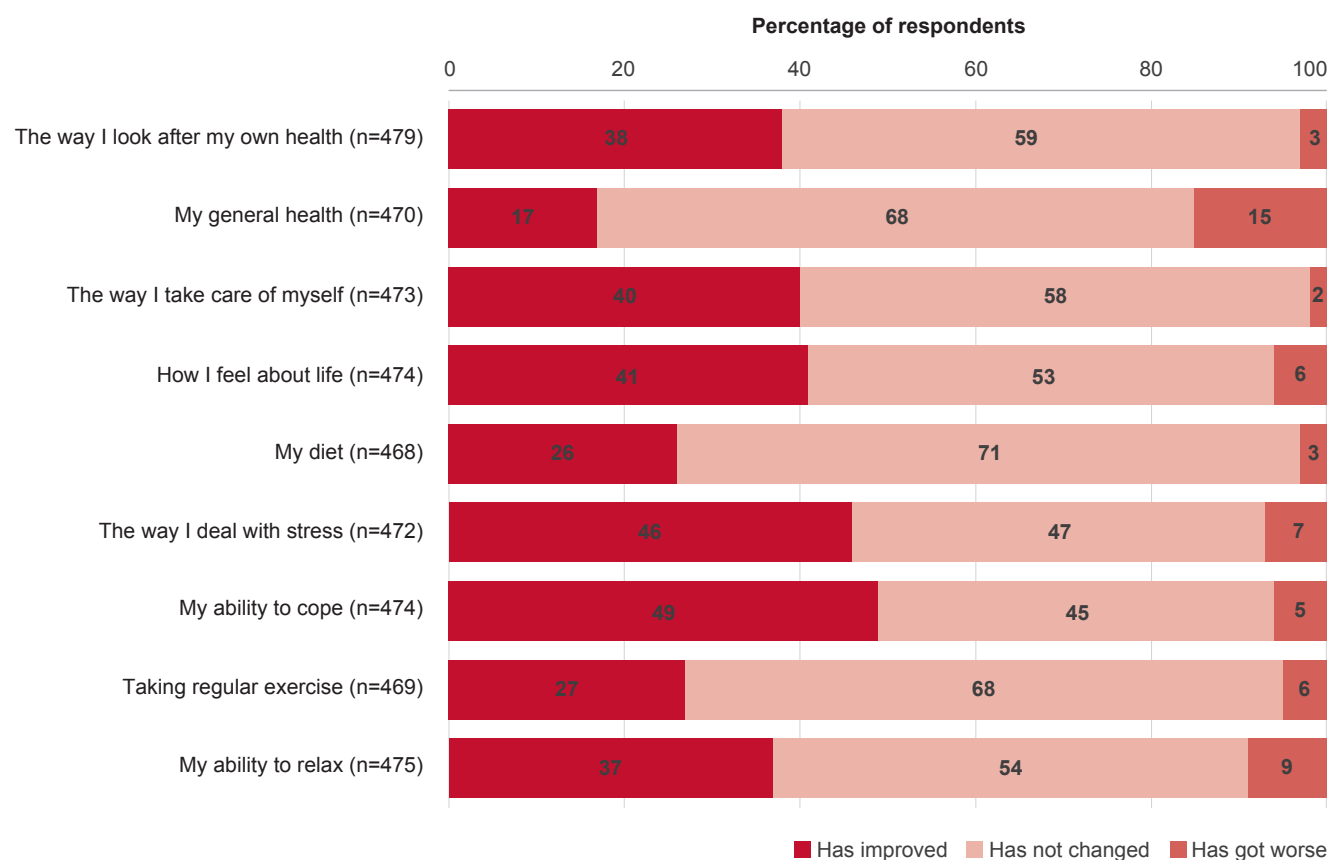


Source: CIRCLE, University of Leeds: CwC survey, phase 2.

Note: n = number of carers who responded to the question specified.



**Figure 5.20 Impact of the programme on their own health and well-being: carers' perceptions six months after completion**



Source: CIRCLE, University of Leeds: CwC survey, phase 3.

Note: n = number of carers who responded to the question specified.

Some carers were statistically less likely to benefit from *Caring with Confidence* in terms of certain aspects of health and well-being. This applied particularly to carers of: people with complex needs; long term conditions; dementia; and those nearing the end of life, suggesting that additional support may be required to improve the health and well-being of carers with particularly difficult and / or long term caring responsibilities.

There is some evidence to suggest that carers who attended only one session were less likely than carers who attended two or more sessions to feel that the CwC programme provided a 'place where their point of view was understood and listened to', an 'opportunity to explore solutions to problems which worried them' and 'high quality materials that were useful after the session'. These carers were also less likely to have found the venues accessible and the sessions enjoyable.

Overall, a large majority (73%) of respondents who answered the survey at the time they finished their CwC participation reported an improvement in at least one aspect of health or well-being covered by the survey (PCS2); six months later this figure was still very high (71%).

More than a third (36%) of carers reported an improvement in their well-being over the period of time they were engaged with the programme (as measured by the WHO-5 Well-being Index<sup>23</sup>) and 37% reported an improvement six months after they had finished their participation in CwC. When they joined the programme, 81% of carers had a WHO-5 score indicating that their well-being was 'poor'; at

<sup>23</sup> The WHO-5 index is a positive psychological well-being index which covers positive mood (good spirits, relaxation), vitality (being active and waking up fresh and rested), and general interests (being interested in things) ([www.who-5.org/](http://www.who-5.org/)).

the point when they completed their participation in CwC, this figure had fallen to 75%, and six months after this it had fallen further to 71%. This suggests that the programme had an identifiable positive effect on carer well-being, using a widely accepted measure.

There were also discussions in the focus groups relating to how participants had improved looking after their own health. Carers reported that the programme had made them aware of the importance of the health of the carer, not only for themselves but also for its impact on the person cared for. Some reported that, following their participation in the programme, they had been inoculated against influenza to reduce the risk of the person they cared for becoming infected, something they had not previously considered. Improving the health and well-being of carers is important as it can mean that carers can continue to care without jeopardising their own health and without adversely affecting the care of the care recipient.

The CwC module *Carers and resources* addressed the financial issues carers often face, and carers seemed to find this session particularly useful. Almost two-thirds of carers (65%) rated this module 'excellent', one of the highest scores achieved for the generic modules (Figure 5.4). One survey respondent wrote:

*I have told a number of carers that they should attend the CwC course to gain a lot of knowledge about the money part and what other services are available<sup>24</sup>.*

Three-quarters of survey respondents reported that their understanding of a carer's rights and entitlements had improved as a result of their participation in CwC (Figures 5.11 and 5.12). In all, 7% of respondents reported an improvement in their financial situation and 11% indicated that they had made a claim for additional benefits as a result of attending CwC. One carer who attended a focus group had applied for new benefits as a direct result of the CwC programme:

*Since we've been here (CwC), I've persuaded my husband to fill in the form for Disability Living Allowance, which he has got! It came through within a month. (.....) I had known about the benefit before, but had not realised that we were entitled to it. The facilitator helped in this.*

These figures are quite a positive outcome for the programme, given that (of the 55% of respondents who had specific goals they wished to achieve) only a minority (23%) identified 'improving my financial situation' as among these, although at the start of their participation in CwC, just under a third of survey respondents (30%) indicated that it was 'a constant struggle' to manage on the money they had coming in.

Carers who attended only one CwC module benefitted less from their participation than those who attended four or more modules. Carers reported most benefit to their own life or health, or to the person cared for, if they attended seven or more modules, with benefits on these aspects quite similar for those who attended five or more modules. Improvements in the caring role were most evident among those who attended four or more modules. Overall, the data on this point suggest that the decision to view attendance at four or more modules of CwC as 'successful' participation in the programme was justified.

## 5.6 Conclusions: what carers gained from the programme

This chapter has drawn on both the management information collected by CwC providers and the three-phase survey of participating carers conducted by the evaluation team to explore carers' experiences of participating in the programme and its outcomes for them. The evidence paints a very positive picture, showing that most carers liked the way the programme was organised and delivered and very much appreciated the content of the modules they attended, often deriving lasting benefit from their participation.

<sup>24</sup> Response supplied in written form in a completed PCS3 questionnaire.

Of the almost 14,000 carers who registered for the programme, well over 10,000 attended at least one CwC module. These carers were reasonably representative of the wider population of carers, although rather older and more likely to be female than the entire carer group. Some ethnic minority groups were well represented, and efforts were made to draw carers in the LGBT population into the programme, with some success. The caring circumstances of those taking part indicated that the programme reached many carers with a wide range of demanding and time-consuming caring roles, and that some, though not all, of the programme's target groups of carers were successfully recruited.

The available data indicate that most carers who took part in the programme attended four or more modules (59%) (although one in five participants took only one module) and show that attending four or more modules was associated with more positive outcomes. The 'gateway' module to the programme was attended by over 8,000 carers. Carers could also access a variety of 'tailored' modules', and although these became available later, and were not designed for all participants, the module for carers of a person with dementia was attended by almost 450 carers. The feedback on the individual CwC sessions was almost uniformly positive. Percentages of carers rating the modules 'poor' were extremely small, and all modules were rated 'excellent' by a clear majority of participants.

The survey, which collected data about participants and their perceptions and experiences at three points in time - as carers joined and completed the programme, and six months after they had completed their last module - confirmed this very positive picture. Carers were very complimentary about the opportunities the programme provided for them to learn new skills, meet other carers in a supportive environment, improve their knowledge of how to access support and address issues affecting their own health and wellbeing in a positive way.

The outcomes for carers were very good also in terms of helping them enact their caring role more effectively, with better access to support and services. Some carers used the financial guidance and information to identify benefits they had not previously claimed. Six months after taking part, 44% of carers said that their ability to take care of the person they supported had improved, and a third felt that the standard of care they gave was better than before they took the course. Overall, 85% reported an improvement in at least one aspect of their caring role six months after they had completed their chosen CwC modules.

Many carers completed their participation feeling considerably more confident and better informed, perceptions which stayed with them after the programme ended. Substantial minorities of participants reported positive outcomes for themselves as well as for those they supported; this included taking up new social, leisure or health activities and (for a few) commencing a new training course or finding paid work.

The programme did not, however, succeed in recruiting its target number of carers - 27,000 for face-to-face provision and 10,000 for online and self-study. Recruitment to the latter modes was particularly disappointing with only about 13% of the target number achieved by the time the programme was closed. The programme also fell well short of its face-to-face target, although it did succeed in recruiting most carers to participate in four or more modules.

While the analysis presented is based on data relating to over 6,000 carers (management information) and on data from sufficient numbers of survey participants to permit comparative statistical analysis on carers with different personal characteristics, neither set of data was as complete as had been hoped. The delivery problems described elsewhere in this report, and the early termination of the programme undoubtedly had some impact on this.

## Chapter 6

# Providers' Experiences of Programme Delivery

Gary Fry and Andrea Wigfield

### 6.1 Introduction

This chapter explores the experiences of provider organisations contracted to deliver the *Caring with Confidence* (CwC) programme in its face-to-face delivery mode. These organisations comprised 32 providers contracted in the 2009 procurement exercise and 14 recruited as part of the additional recruitment in 2010, which formed part of the National Team's contingency planning to address disappointing carer recruitment. As mentioned previously, six of the organisations did not deliver CwC.

The evidence drawn on in this chapter includes: the Management Information (MI) data supplied by providers to the National Team, using its on-line system; the case study evidence collected by the evaluation team from six face-to-face providers (described in Chapter 2); a provider survey distributed to all providers in autumn 2010 after the closure of the CwC programme was announced; and relevant information available from the evaluation team's documentary analysis and interviews with CwC key informants.

The chapter begins by providing a brief discussion and presenting summary data of the evidence available from the six case study providers, all of which were recruited to deliver the CwC programme during the main procurement exercise undertaken in spring 2009. This highlights some of the issues encountered by these providers, helping to provide an understanding of the operational and management issues raised in the remainder of the chapter. The chapter includes exploration of:

- The case study providers' experiences of delivering the programme (section 6.2)
- Selected practical issues in delivering the programme to carers (section 6.3).
- The organisational and managerial challenges providers faced (section 6.4).
- The relationship between the CwC programme and providers' existing provision and services (section 6.5).
- How the CwC programme acted as a stimulus to new approaches to supporting carers (section 6.6).
- Some lessons which can be learned from the CwC programme about future delivery of training to carers (section 6.7).

Achieving visibility, recognition and respect for the CwC programme and developing a supporting infrastructure capable of continuing beyond the initial funding period was an objective of the National Team and Project Board in developing the programme. This chapter also explores a range of issues relevant to the assessment of its success in this area of its work and concludes with a consideration of how the experience of CwC providers might inform future provision of support and training to carers.

## 6.2 Delivering the programme: experiences of case study providers

An outline of key information about each of the six providers included in the evaluation team's case study work is presented in Table 6.1, where key statistical evidence, together with brief reference to other contextual data and provider activities (as reported in interviews, noted during case study visits, and derived from official monitoring data) is presented.

Each provider had different targets and its own delivery budget, timescales and operational objectives. Each also had attributes, experience and capacity which differed from that of all other providers, although all six case study providers had been through the National Team's phase one procurement procedures (described in Chapter 4) which included a due diligence assessment. The differences between providers mean that direct comparison of the performance of the case study organisations is neither possible nor appropriate. It was always understood, by all parties, that some providers would need more funding (and have different support needs) than others and that certain targets (for example those relating to especially hard-to-reach groups, or to delivery of especially innovative provision), were more challenging than others and would require more time and resources to achieve. The data shown in Table 6.1 nevertheless include information relevant to understanding some of the challenges the CwC programme faced, and some of the reasons for its difficulty in achieving target carer numbers. Key points are that:

- None of the case studies succeeded in recruiting even one third of its target carer numbers (although case study B came close to this).
- Two of the case studies (B and E) succeeded in getting more than half of their registered carers to attend four or more CwC modules, but even here (as in all the case study providers) there were significant numbers of carers who did not attend even one module, or who attended only one.
- One case study provider (F) achieved an average figure for the number of carers attending each module which was within the range of '10-16 participants', expected to be the optimum way of delivering the programme face-to-face. Some outcomes on this measure were well below this anticipated optimum number.
- All case study providers (except F) cancelled a significant proportion of their planned / arranged CwC module sessions; in one case (C), half of all planned sessions appear to have been cancelled<sup>1</sup>. In most cases sessions were cancelled because there were too few carers registered to attend.

The outline picture of the case study providers shown in Table 6.1 highlights the fact that case studies B and F (both of which were delivering CwC face-to-face at the local level) performed comparatively well on some of the indicators. One was an NHS Trust, the other a well-established carers' organisation and both used the CwC resources available to fund alternative care for carers attending the CwC programme, a feature which appears to differentiate them from the other providers in the case study group. Neither was tasked primarily with delivering the CwC specialist training modules or with recruiting carers from the hardest-to-reach carer target groups, however – in contrast to case studies C and E, both of which faced these additional challenges. Provider E also had the additional objective of being contracted to deliver to carers at the national, rather than only at the local, level. Marketing approaches used by providers B and E included some innovative or original aspects, but do not seem to have been dramatically different from those used by other providers in this group.

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<sup>1</sup> It is possible that providers varied somewhat in their practices in recording 'planned' and 'cancelled' sessions.

**Table 6.1 Case study providers: selected monitoring data**

| Case study and CwC start date | Total spent | Carer places delivered |                | Target carer places | Sessions |       |         | Average carers per session |         | Carers attending by number of modules attended % |        |    |    | Use of alternative care     | Marketing   | Delivery type                   | Organisation type    |
|-------------------------------|-------------|------------------------|----------------|---------------------|----------|-------|---------|----------------------------|---------|--|--------|----|----|-----------------------------|---|---------------------------------|----------------------|
|                               |             | No.                    | % <sup>1</sup> |                     | PLA no.  | CAN % | DEL no. | Average no.                | %       | 0  | 1 only | 1+ | 4+ |                             |   |                                 |                      |
| A 5/09                        | 186,191     | 908                    | 23             | 4,000               | 179      | 24    | 136     | 6.7                        | 10-16 % | 36   | 19     | 64 | 33 | Minimal                     | Mailing list, newspaper ads, local events                 | Local, face-to-face, generic    | Vol/com              |
| B 6/09                        | 194,664     | 1,305                  | 32             | 4,050               | 216      | 19    | 172     | 7.6                        | 26      | 14   | 17     | 86 | 52 | Used by 25% <sup>2</sup>    | Website, DVD, recruitment bus, prescription pad ads       | Local, face-to-face, generic    | NHS Trust            |
| C 5/09 <sup>3</sup>           | 143,690     | 432                    | 9              | 4,620               | 165      | 50    | 82      | 5.3                        | 1       | 14   | 26     | 87 | 31 | None recorded               | Website, newsletters, community magazine                  | Local, face-to-face, specialist | Non-carer vol/com    |
| D 5/09 <sup>3</sup>           | 47,600      | 381                    | 15             | 2,500               | 94       | 29    | 67      | 5.7                        | 9       | 28   | 28     | 73 | 31 | Minimal                     | Leaflets, awareness sessions, support groups, newsletters | Local, face-to-face, generic    | Carers' organisation |
| E 5/09                        | 217,593     | 984                    | 6              | 15,850              | 127      | 20    | 101     | 9.7                        | 36      | 7  | 47     | 93 | 26 | Low, but increasing         | Local media, specialist journals, GP surgeries            | Local, face-to-face, specialist | Vol/com              |
| F 9/09                        | 125,904     | 2,147                  | 29             | 7,344               | 203      | 0     | 203     | 10.6                       | 59      | 18   | 11     | 82 | 58 | Used by 10%, and increasing | Radio, newsletters, mailing list, posters                 | Local, face-to-face, generic    | Carers' organisation |

Sources: CwC MI system, provider returns; case study visits.

Notes: <sup>1</sup> % of target carer places actually delivered. <sup>2</sup> In dementia group 60%. <sup>3</sup> These dates were marked 'TBC' in official documentation.



Analysis of the achievements, challenges, difficulties and strengths which emerged in the evidence collected from the case study providers reveals some interesting contrasts and differences. In terms of achievements and positive outcomes, all case study providers mentioned that participating in CwC had extended or enhanced the range of services they provided. Several felt that 'carer visibility' had increased within their organisation or among their partners and networks, and some were confident that they had made a 'new commitment' to carers or had built sustainable new partnerships with other organisations. These providers indicated that they were keen to offer CwC modules under new arrangements after the DH funded programme terminated (or reported that they had already started to do this).

The challenges and difficulties highlighted in the case study evidence included (in one case) inflexible management systems and an inadequate project support infrastructure, with poorly defined staff roles. Several case study providers felt the early termination of the programme had posed a risk to their organisation or to its local reputation. All the case study providers reported that delivering within cost and on time had been challenging, a few attributing their difficulties to limited knowledge of carers or to competition in the local area, and several mentioning difficulties in engaging with local authorities, Primary Care Trusts (PCTs) and local GPs. Some felt that the monitoring arrangements put in place for the CwC programme by the National Team had contributed to their difficulties. Other issues raised included competing internal priorities (one case); limited marketing expertise and capacity; and the lack of an existing register of local carers from which to work.

Evidence from the case study provider sites also suggested that different providers brought different strengths to the programme, variously contributing well-established partnerships, a wealth of experience of the carer group, well-located and suitable venues for delivery of the CwC modules to carers, and a strong commitment to the programme at the very top of their organisation.

The case studies gave depth and detail to the evidence available in the MI data which clearly indicated that: recruitment of carers was difficult; that carers quite often registered for the programme and then either did not attend or attended only a small number of modules; and that providers were putting considerable energy into marketing and planning sessions which sometimes had to be cancelled, making cost containment challenging. These points should be borne in mind in the remainder of this chapter.

### **6.3 Practical issues in delivering the programme**

In this section providers' perspectives on some of the practical issues they faced in developing and delivering the programme at the local level are presented. These are matters which may be relevant considerations for training provision for carers in the future. The issues raised include finding suitable venues to deliver CwC and the length, timing and other arrangements for face-to-face module sessions.

#### **Venues and the location of training sessions**

Most carers found the practical arrangements for face-to-face delivery of the CwC programme (venues, session scheduling, group size, etc.) satisfactory, with only very small numbers saying (when completing module feedback forms) that the sessions they attended would have been improved by being held in a different venue (4%) or a different location (3%). Written comments (volunteered by a small number of carers responding to the participating carer survey) emphasised that venues should be easily reached by public transport, fully accessible, and close to carers' homes. Some providers in the case study group reported selecting venues on the basis of a combination of location, accessibility and cost considerations (some preferring venues which were free of charge or where they could negotiate a discount). There was some evidence that providers were responsive to carer feedback on venues (and in some cases involved carers in the selection of venues), with issues highlighted as important for carers including the 'attractiveness and ambience' of the venue and its 'proximity to public transport'.

Difficulties encountered in arranging suitable venues, particularly in unfamiliar areas, included finding reasonably priced venues which were wheelchair accessible.

### **Length of CwC module sessions**

Carers' opinions about the length (3 hours) of the CwC module sessions were largely favourable, with very few carers completing module feedback forms saying sessions were either too short (9%) or too long (5%). Written comments on the Participating Carers Survey (PCS) carried out by the evaluation team suggested that a few carers felt that more time was needed for discussion or to fully cover module content. Others, by contrast, would have preferred shorter sessions, usually because they were concerned about the length of time they were away from the person they cared for. Evidence from the key informant interviews indicated the importance of flexibility on this issue. One interviewee noted, for example, that three hours was 'too long' for many carers of people with dementia. Facilitators in one provider site reported that carer interactions and the exchange of contact details between carers added about twenty minutes to the end of sessions. They reduced their facilitator input to accommodate this, viewing building relationships between carers as an important part of the programme.

Some provider staff reported that arranging sessions at times which suited carers was extremely difficult. Experimenting with sessions held over lunchtimes was not especially successful as carers often needed to attend to the person they cared for at this time. In practice, most providers offered sessions at regular fixed times (during the day), believing it was important to enable carers to make arrangements for the person they cared for in advance. Some organised evening sessions in response to the stated preferences of some carers, and some carers who were in paid work commented (on their completed questionnaires) that evening sessions would be more suitable for them.

### **Group size**

A small number of carers (6%) said (on module feedback forms) that they would prefer CwC sessions to be delivered in larger groups than those they had attended; a very small proportion (2%), by contrast, felt a smaller group would have been better. Some who wrote comments on the evaluation questionnaires mentioned that small groups (but not fewer than six to seven people) would allow for more interaction, but pointed out that groups of more than 15 carers would be too impersonal. Generally there was agreement that the target session group size (10-16 carers) was about right. Facilitators reported that in larger groups, one or two participants tended to dominate the session, making it difficult for less vocal members to contribute.

### **Alternative care**

In most cases providers took their obligation to offer to pay for or provide alternative care to carers attending CwC module sessions seriously and made attempts to ensure carers were aware of this possibility. Take-up of alternative care support or funding was low in most provider sites, however. The reasons offered in explanation of this included carers being unused to receiving offers of respite support and carers being reluctant to use respite services in place of a known person (such as a family member or friend). One provider found that requests for alternative care increased significantly as the programme became established locally, and by 2010 about 25% of carers were using this support. In this provider site, staff claimed that among carers of a person with dementia take-up of alternative care was about 60%. Some staff interviewed in provider sites felt carers were often unwilling to use alternative care if there was insufficient time for a personal relationship with the person cared for to be established. Others pointed out that, for some of those cared for, coping with another person looking after them could be difficult.

When asked about alternative care arrangements in the Participating Carers Survey, 29% (206 / 685) of carers responding to the immediate post-participation version of the questionnaire (PCS2) said they had needed to arrange alternative support in order to attend CwC modules. Of these, 31% (63 /

204) said their CwC provider had arranged this support. Among the carers taking up alternative care arranged by the CwC provider, a very high proportion (93%) were 'very satisfied' or 'satisfied' with the arrangements made. However, a small number of respondents said (in the survey responses) that they did not know they could get help with alternative care from their provider, and a few said they had found out about this service too late (when attending their first session) and had by then already made their own arrangements.

## **6.4 Organisational and managerial challenges experienced by providers**

Some providers had previous experience of delivering projects like CwC, but for others the programme was a completely new kind of service, presenting some unexpected organisational and management challenges. Evidence from the key informant and provider case study interviews showed that some providers had existing organisational characteristics which suited the development and provision of CwC better than others. As a manager in one of the case study providers pointed out, organisations which had staff with extensive experience of the social care sector, a large data base of local carers, a high profile / existing relationships with other local organisations and well situated premises were at a distinct advantage in delivering the programme over providers without these attributes.

In one example, case study B, senior staff highlighted the advantages of their staffing structure, described as hierarchical yet flexible. This included: a senior / project manager (taking a strategic view of developments); a coordinator (managing day-to-day activities such as marketing and venue hire); and facilitators (delivering the modules to carers). While admitting it had taken some time to get this structure in place, this provider noted that once it was established, project delivery had run noticeably more smoothly, helped by its dedicated resource centre (to which all CwC enquiries could be directed). Administrative support at this office was 'highly focused on achieving CwC goals' and helped make it 'visible' in the locality. Staff here also emphasised that the board of directors had taken an active interest in the development of CwC, giving the delivery team much needed support in the early stages when establishing the CwC programme locally had been challenging. These factors were thought by staff to be a crucial reason why they had managed to deliver CwC quite successfully; Table 6.1 shows that this provider had achieved 32% of its target number of carers engaged with the programme, the highest proportion among the case study sites.

Some of the case study interviewees stressed the importance of establishing partnerships with other organisations, seeing this as an essential component of delivering the CwC programme, a point also emphasised in many responses to the provider survey. One provider gave examples of valued partners which included voluntary organisations (the Alzheimer's Society, MIND and Age UK) and healthcare providers (local PCTs and GP surgeries). The project manager here claimed these relationships had been crucial in enabling it to reach out to carers beyond its usual clientele.

The provider survey confirmed that developing or establishing partnerships with a wide variety of organisations was the approach most organisations delivering CwC had adopted. The carer recruitment difficulties most providers experienced do not, therefore, seem to have been a result of inattention to this aspect, as all providers seem to have worked hard to build appropriate partnerships. Different providers had engaged, for example, with agencies as diverse as the Stroke Association, the British Heart Foundation, Mencap and Rethink. Some had focused much of their networking and partnership efforts on GP surgeries, PCTs and local authority social services departments. One had targeted a local employment initiative as well as other local carers' centres like itself. Engagement with these partners had provided a range of benefits: new carer referrals; local intelligence about how to target specific

groups of carers; and access to suitable venues in which to deliver the programme. Nevertheless, filling carer places on planned sessions and getting close to target carer numbers remained a difficult challenge for most providers at all stages.

Some of the case study providers reported difficulties establishing suitable partnerships and it was clear that in some cases such problems hindered capacity to deliver CwC as intended. In one case, detailed evidence was given of repeated failures to engage the local authority, which meant the provider's plans to target carers who were 'in touch with social services' could not be implemented, and wasted a great deal of time and resources.

Evidence from the case studies also indicated some other types of problems encountered in delivering CwC, with local factors sometimes significant in impeding progress. Issues raised included: bureaucratic or inflexible systems of accountability; few prior contacts with local carers' organisations and / or carers (and difficulties in establishing these); staffing difficulties (including difficulty in recruiting or retaining staff on short-term contracts); and a lack of clarity about staff roles in local delivery of the programme. The case study visits and responses to the provider survey highlighted some examples of: 'bureaucratic' organisational practices disproportionately focused on internal organisational administration; unexpectedly burdensome administrative tasks associated with monitoring the programme in accordance with National Team requirements; and staff recruitment and retention problems. One provider, enacting a policy of avoiding temporary staff contracts, employed its CwC facilitators as regular rather than sessional staff, but subsequently found that facilitators had little to do when recruitment was low, causing a range of staffing tensions and difficulties in managing the local CwC budget.

Some providers mentioned that they felt somewhat constrained by what staff perceived to be overly prescriptive aspects of CwC. Points mentioned by some provider staff included that certain aspects of the course materials were rather repetitive and that for some carers' situations, the methods of module delivery were not entirely suitable. These providers would have welcomed greater flexibility to adapt the programme to their local circumstances. However, there was a fairly widespread perception that there was very limited scope to vary programme delivery arrangements, and that the National Team was unwilling to allow providers this type of discretion.

The evaluation evidence thus suggests that the CwC programme had a considerable impact on its provider organisations. Some found it extremely challenging to manage and organise the necessary activities, requiring much more support from the National Team than had been anticipated. Certain providers, for example case studies B and F, were able to accommodate delivery of the programme more easily than others, having staffing capacity and existing suitable infrastructures and local connections in place at the outset, all of which were a distinct advantage.

## **6.5 The relationship between *Caring with Confidence* and existing services and support**

For many provider sites, CwC was an entirely new form of support for carers. This came through in interviews with managers at case study provider sites and in the focus group discussions held with carers. There was considerable emphasis on the programme being 'unlike anything else' they were aware of, with the programme's variety and flexibility making it 'one of a kind'. Most provider staff knew of no similar programmes in their locality (the only exceptions being the Expert Patients Programme, with its carer-focused module *Caring and Me*; a Jobcentre Plus initiative designed to help carers into work; and one or two specific local projects).

Despite this, when responding to the provider survey, most organisations indicated that they had some prior experience of providing training or support for carers. For most, this had involved practical support, such as first aid and manual handling courses or sessions focused on rather specific carer issues which lacked the comprehensive scope of the CwC programme. For example, many providers had previously offered carers services such as relaxation days, drop-in support centres, and telephone help-lines. In the sites completely new to work with carers, providers generally saw CwC as a ‘first step’ towards developing services for this group.

In provider sites where carers were already the focus of provision, staff regarded CwC as a ‘comprehensive’ and ‘flexible’ programme which made an important addition to the support they could offer carers. For providers new to offering support to this group, it presented an opportunity to ‘pump prime’ a new form of client support, or to supplement other services, including existing information and advice work, self-help groups, and signposting to other services.

There was no evidence in information provided to the evaluation team that providers delivering CwC were ‘cost-shunting’ by using the programme resources to fund similar support which had existed before CwC or to displace any existing training programme for carers.

Inevitably, CwC fitted with their other or existing range of services better in some provider sites than it did in others. One case study provider was already managing its region’s carers’ centre and running a dedicated helpline for carers, a drop-in centre, and several breaks / respite services before it applied to deliver the CwC programme. The project manager here reported that CwC built on this existing support and complemented it, while also allowing the site to market different services to other groups (sometimes cross-referring carers from one project to another). The senior manager here spoke of an ‘absolute synergy’ between the previous / ongoing activities of its carers’ centre and the CwC programme.

Some providers described plans they had to ‘embed’ the CwC programme within their other services for carers. In one case study organisation, efforts had been made to develop links with a local initiative for carers based on the DH National Demonstrator Sites project (a DH pilot programme designed to provide carers with breaks, health checks or NHS support and advice which was being piloted in the area at the same time<sup>5</sup>). The aim of these plans was to facilitate cross-referral of carers between the two programmes, and to combine the marketing and outreach strategies of the two activities in an attempt to achieve greater impact and efficiency.

Some organisations openly asserted that, although it was an important part of their activities, CwC was not their ‘core business’. These providers tended to find it especially difficult to implement the programme: some reported facing competing services in the local area which they felt made recruitment of carers challenging; some lacked experience in delivering short term projects; some considered it was a disadvantage to have no existing database of clients (carers) to ‘kick-start’ local delivery of the programme; and some said they had limited (or non-existent) prior partnerships with other organisations offering carer support.

## **6.6 *Caring with Confidence* and new approaches to delivering carer support**

Many of those providing evidence in the case studies and provider survey felt that delivering the CwC programme would leave a lasting impact on their organisation, and that it had brought significant changes in their own ‘organisational culture’. The changes referred to included: a new commitment to sustain carer training programmes; a much greater ‘visibility’ of carers in the local health and social care system; and new, sustainable partnerships with other organisations.

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<sup>5</sup> This programme is described in Yeandle and Wigfield (eds) 2011.



Some providers were clear that, despite being new to providing services for carers, they intended to sustain this type of work and widen the portfolio of services they offered in the future. One of the specialist providers explained that delivering CwC had proved a positive experience, involving new challenges outside its normal remit. This had encouraged staff to consider other ways of providing a wider range of services to its client group.

Some of the innovations and new approaches mentioned by case study providers are indicated in Box 6.1.

### **Box 6.1 Developing new, additional or ongoing support for carers**

*Case study providers included some which had:*

- Secured local authority funding to enable carers who had established friendships and mutual support groups after participating in the CwC programme to continue to meet together in a supportive environment.
- Created new ‘packages’ of support for carers by combining CwC with existing carer programmes, using separate funding to promote CwC alongside existing services.
- Adapted some existing services, including a counselling service and a helpline, to meet carers’ needs, and provide a pathway for carers into other services.
- Developed an on-line support forum for its specialist target group of carers.

Case study interviewees also reported that delivering CwC had made carer issues more ‘visible’ within their own organisations and in the wider locality. One manager claimed that, although it had taken eight to 12 months to ‘embed’ CwC locally, after the first year, referrals from within the health service had started to come through regularly. One of the specialist providers noted that, towards the end of the programme, local authority staff had become more aware of CwC and other carers’ services, and reported a new ‘visibility’ for the organisation which would not have been possible without its role in delivering CwC. Generally, providers noted that delivering the CwC programme had brought carer issues to the attention of their own organisations and their partners. The examples in Box 6.2 illustrate these points.

### **Box 6.2 Examples of how CwC helped providers promote carers’ issues**

*Case study providers included some which claimed that:*

- The experience of delivering CwC had contributed to widening the organisation’s mission to take a ‘broader view of well-being’, with a focus on developing preventative measures for health and social care.
- CwC had assisted in ‘legitimising’ carers’ needs in a health and social system it felt was not always ‘fully mindful’ of them. One organisation was planning to employ a carers’ champion in the future, tasked with changing the ‘hearts and minds’ of carers and staff in the various local organisations which served them.
- External agencies involved in delivering CwC (e.g. via marketing or referrals) had become more aware of carer issues. The impact had been particularly beneficial among healthcare professionals, leading to a greater understanding of carers’ roles.

Thus for some organisations, CwC was a positive experience helping them to develop new strands of support for carers. Some organisations felt they had succeeded in establishing the programme locally and were now benefiting from the new connections made with other organisations. Others emphasised that CwC had also made a positive difference to how carers were regarded in the health and social care system.

## 6.7 *Caring with Confidence* and the future of training for carers

In 2010, when recruitment of carers to CwC continued to fall behind original targets, a 'contingency plan' was developed and implemented by the National Team<sup>6</sup>. This resulted (from June 2010) in 14 more organisations becoming involved in CwC, all recruited on the basis of a new funding model, involving a 'pay as you go' (PAYG) 'tariff' system in which providers were paid £85 per carer place<sup>7</sup> (inclusive of carer travel and alternative care costs). Even before the early termination decision was announced in June 2010, implementation of this model was quite difficult as the programme was in any case due to end in March 2011. The National Team nevertheless felt some providers would be able to adapt these arrangements and make the programme sustainable in the longer term. The new funding arrangements came into wider use in August 2010, after any existing CwC providers which chose not to participate on the new 'tariff' funding basis had been given notice of contract termination (July 2010<sup>8</sup>).

The early termination of CwC left many providers feeling they had no option but to cease programme delivery when their funding expired. The three months' notice of termination came as a surprise to local providers, giving them limited time to plan ways of continuing to deliver the programme without a funding stream to support them. Staff in all case study provider sites expressed disappointment that the programme was ending earlier than expected. Immediate concerns included threats to staff contracts and in some cases to the viability of the organisation as a whole, but there was also a feeling that an important local service for carers was being lost or jeopardised. In the sites participating in the provider survey, many staff expressed great concern about local carers, both those who had previously taken part in CwC and those who might have liked to do so in the future, pointing out that carers had few existing services. Some were concerned that without CwC carers would be denied the opportunity of a 'potentially life-changing' experience.

Explanations given by those providers which decided not to move to the new funding arrangements included a perception that to recruit '500 carers'<sup>9</sup> in six months at an all-inclusive cost per place of £85 was 'not achievable', and that delivery on the revised terms would 'compromise the integrity' of the programme, possibly requiring some providers to cut back the funding available for 'alternative care' support to participating carers or ask module facilitators to 'work for free'.

<sup>6</sup> Five options were considered: (i) work with existing network to deliver more; (ii) set up a gateway provider scheme; (iii) utilise the reserve list; (iv) national (carers') organisations with existing infrastructure to be utilised; (v) expand the unfunded network. After consideration at CwC review meetings with the DH, options (i), (iv) and (v) were initially considered viable (June 2009). Subsequently option (iii) was also identified as an acceptable way forward. Implementing its contingency plan, the National Team approached several national organisations and carer organisations with a view to increasing delivery, and also gained permission from the DH to allow the EPP to deliver CwC.

<sup>7</sup> This figure was determined by the National Team on the basis of its review of provider cost forecasts in the later stages of programme delivery.

<sup>8</sup> At this stage both providers and the National Team already knew that the DH funded CwC programme would terminate in September 2010.

<sup>9</sup> In this instance, quoting from a National Team presentation in which the figure of '500 carers' was given as an illustrative example.



Provider sites which began implementation of the 'PAYG' tariff model knew the DH programme was terminating but were keen to sustain CwC in the future. By agreement with the DH, the National Team put a range of measures in place in summer 2010<sup>10</sup> to help providers achieve this aim, including:

- Setting up a licensing agreement to ensure future providers of CwC adhered to the programme's established standards.
- Arranging additional training to build up the number of facilitators available to deliver CwC. All facilitators were to be registered on a National Register to indicate their accredited status.
- Uploading CwC resource materials on to the NHS Choices website, enabling providers to download and use them.

Some of the providers continuing on the 'PAYG tariff' model were also applying to appropriate agencies for additional funding. Some felt strongly that CwC could make a difference to carers' lives and (conscious also of the positive impact the programme had had on their own organisation) took steps to sustain the programme beyond September 2010. In some cases this included running 'reunion events' for carers who had completed their participation in CwC, enabling them to continue meeting regularly to offer each other mutual support in a relaxed setting. Providers running such sessions reported that these were proving successful and popular with carers. An example of how one provider modified the programme in accordance with its perception of local carers' needs and to deliver it more cheaply is provided in Box 6.3.

Other providers bid for further resources from a variety of other funders and some hoped to sustain CwC in the future by changing the way it was delivered, including (in one case) exploring the possibility of offering CwC in shorter, lunchtime, sessions at employers' premises. There were mixed views about the best way forward. Some providers felt retaining the two facilitator model for face-to-face delivery of CwC was critically important, while others were more relaxed about this. Those approaching organisations within the NHS for funding mentioned the importance of demonstrating the potential health benefits of the programme, and highlighting its scope for reducing pressures on GPs or preventing some types of hospital admission. Although uptake of alternative care provision had been less than expected in some provider sites, staff in others felt very strongly that funding for alternative care was absolutely essential to maintain CwC's inclusiveness for carers, and were unwilling to compromise on this aspect of the CwC model.

Notwithstanding the arrangements put in place to support delivery of CwC in the future, some key informants interviewed in autumn 2010 expressed concerns that, without an overarching body governing CwC, it would be difficult to 'quality assure' the CwC programme and that, if free to use the CwC course materials as they wished, some providers might adapt them inappropriately, damaging programme quality and reputation.

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<sup>10</sup> The EPP took over the management of financial and contractual issues from the National Team after the termination of the programme in September 2010.

### Box 6.3 Example of a provider continuing to deliver CwC

This organisation began delivering CwC on the tariff model in autumn 2010, having already established CwC in the locality in 2009 and 2010 (the project manager felt the tariff model could only sustain ongoing delivery and would not be adequate for a project starting 'from scratch'). Its aim was to provide a similar service to that offered when CwC was delivered on the 'fully-funded' basis. To cut costs, it reduced the amount spent on refreshments during CwC sessions and accepted offers from some facilitators to deliver the course for free. Supplementary financial support was obtained from a local Primary Care Trust, which agreed to underwrite the basic programme running costs (marketing materials, venue hire, administrator's and project coordinator's salaries), on the condition that CwC was shown to represent 'value for money'. Between autumn 2010 and March 2011, this organisation continued to offer CwC, making the following modifications to its delivery:

- Reduced the length of each session from three to two-and-a-half hours (in response to feedback from carers claiming the original session was too long).
- Became flexible about group numbers and less insistent on larger groups; small groups were regarded as 'workable'.
- Developed a tailored module specifically geared to carers in the locality, including targeted information about locally available services and support.

This organisation hoped to continue delivering CwC beyond the tariff funded period, although this was uncertain, in view of expected changes affecting PCTs, and depended on its ability to secure future funding.

## 6.8 Conclusions: providers' experiences

This chapter has addressed issues relevant to the visibility, recognition and respect achieved for the programme, and its potential to continue beyond the initial funding period. The evaluation team's overall assessment of the CwC programme's achievement of these objectives is summarised in Appendix E.

For some organisations, continued provision of CwC has been possible, with funding drawn from the tariff model and other sources. This continued delivery has resulted in some modification of course materials and delivery arrangements, which some interviewees felt might affect programme quality. It is too early to conclude whether these concerns are justified, but it seems clear that many providers wish to continue delivering the programme and plan to do this on the basis of what was learned during the initial, DH funded, period.

The evidence considered in this chapter, based on providers' experiences of developing and delivering the CwC programme at a local level, suggests that:

- Delivery costs became more manageable for some providers after the programme had become established locally. Some providers felt the PAYG tariff model had the potential to deliver CwC more cheaply than the 'fully-funded' provision, although some emphasised that the new funding arrangements would have provided inadequate resources to set the programme up locally 'from scratch'.

- A few providers had begun to identify alternative sources of funding for CwC (usually from other publicly funded agencies). None suggested that charging carers fees to attend the CwC courses would be a workable approach. Many were concerned that securing adequate resources to continue offering the programme would be very challenging.
- Many providers felt that in developing CwC locally they had been offering a really different and high quality service to carers, compared with anything previously available to them. There was widespread disappointment among staff about the decision to terminate the programme early.
- Although establishing the local partnerships needed to deliver the CwC programme had been difficult for many providers (especially those new to working with carers), most felt their organisation had benefitted significantly from the relationships that had been built, and many were committed to continuing to work with these partners to offer further support to carers in the future.
- Within the National Team, some felt that without a national body to guide and support the programme's development or a funding stream to sustain it, organisations would find it difficult to continue to offer the programme to carers and that it might be hard to protect the integrity and quality of the programme. Some providers offered a slightly different perspective, feeling that without central control of programme delivery they might have greater local discretion and be able to offer the CwC modules to carers on a more flexible basis.
- During the lifetime of the CwC programme, considerable practical expertise was built up among the face-to-face providers, including: intelligence about suitable venues; workable delivery arrangements; strategies for recruiting carers and establishing referral pathways; and the best ways of offering carers alternative care support.

## Chapter 7

# ***Caring with Confidence: Conclusions, Policy Implications and Recommendations***

Andrea Wigfield and Sue Yeandle

The *Caring with Confidence* (CwC) programme was an innovative £15.2m DH initiative which aimed to provide support to 37,000 carers (27,000 face-to-face and 10,000 through self-study and online) as part of the New Deal for Carers (DH, 2007). It was the largest programme of training for carers ever planned in the UK and was well-resourced. The management of the programme was commissioned from a consortium of partners led by EPP, with delivery implemented through a network of local training providers. The programme operated for two and a half years of its intended three-year lifespan. In summer 2010 the CwC contract was terminated early by the DH due to lower than expected numbers of participating carers and high average costs per carer place.

The programme was well received by most of the 10,238 carers who accessed it. Module feedback was extremely positive and carers reported gaining greater choice and control in key aspects of their lives through the programme, such as improvements in their: health and well being; access to social care support; and (in a few cases) access to paid work and training. However, the numbers of carers accessing the programme fell well below the initial targets and the costs per carer place were correspondingly considered to be unacceptably high.

This final chapter of the report summarises the key findings of the evaluation of the programme, comments upon the extent to which the programme objectives were met, and outlines the resulting lessons learned, identifying policy implications and making recommendations for future training and support for carers.

## **7.1 Key evaluative findings and recommendations**

The key evaluative findings and resulting policy recommendations cover a range of topics which are summarised below: management and governance structures; flexibility of programme design; contracting with providers; monitoring and supporting delivery; recruitment, marketing and publicity; milestones, outputs and costs; supporting carers; and providing support through local providers. A summary of the extent to which the programme objectives were met in each of these key areas is summarised in Appendix A.

### **Management and governance structures**

By contracting the programme through a 'limited tender' process to a consortium (of carers' organisations led by EPP) a group of leading organisations in the health and social care sector was able to work together in partnership to deliver the programme. This enabled CwC to draw on these organisations' collective experience of working with and for carers and of delivering training and support to users of the health and social care system. An inclusive and comprehensive governance structure was established which enabled the programme to be supported by a Project Board and guided by a Reference Group, both of which had the potential to offer a wide range of expertise and knowledge. However, a lack of clarity concerning some aspects of roles and responsibilities, and some misunderstandings, meant that the governance structure worked less well than had been hoped, with the consortium partners at times having some difficulty in working together as a team. As a result, the governance structure and the consortium leading the programme was less cohesive and effective than was desirable.

The DH held regular review meetings to manage the contract with the consortium and on the whole these proved to be a useful method of monitoring development and progress. However, early on in the programme there were differences in interpretation of contractual obligations which affected relationships between consortium partners and the DH. The ambiguities and uncertainties about key deliverables and / or outputs within the contractual documentation became key points of discussion early in the programme, and delays and difficulties in resolving these issues at times compromised the effectiveness of programme implementation.

These delays were problematic as the programme was already operating to what proved to be an overly optimistic delivery schedule. As a result the programme management found they were constantly struggling to meet tight deadlines and this, together with a failure to prioritise developing the provider network in the early months, led to procurement of providers, programme delivery and recruitment of carers inevitably falling behind schedule.

### **Recommendation 1**

When commissioning future programmes / projects to external agencies, commissioners should ensure that transparent governance systems are put in place through which all parties (commissioning body, contractor, consortium parties, sub-contractors) are clear from the outset about their individual and collective roles and responsibilities at all stages of the programme. Clear and ambitious, but achievable and measurable targets, outputs and outcomes, each set against a realistic timeframe, should be specified in all contractual documentation. Commissioners should be confident that all parties have the same interpretation and understanding of targets. Regular review meetings should be held with contractors and remedial action taken immediately contractors start to fall behind schedule or targets.

### **Flexibility of programme design**

Following DH guidelines, a prescriptive and centrally planned approach to the programme design was taken, which was consistent with the commitments made in the consortium bid. Experts in the field were drawn upon to design a high quality, standardised training programme in which facilitators were highly trained through a Facilitator Development Programme to deliver a flexible, modular training programme in which only approved training materials could be used. However, implementation of such a model had the unintended effect at times of being unresponsive to carers' specific needs, as it offered limited scope for local adaptation. This aspect of the training programme development was costly and time consuming to set up and (at least initially) was prioritised ahead of establishing the provider network, leading to early slippage against project implementation timescales.

## Recommendation 2

Future programmes of support for carers, whilst needing to be appropriately quality assured, should have a greater degree of flexibility in terms of local delivery and responsiveness to specific carer needs. Highly prescriptive delivery arrangements, set centrally, are not necessary for organisations which have been through a thorough selection process and have prior experience of providing training to carers. Organisations new to offering services to this group, by contrast, require additional support with identifying and engaging carers and with marketing and publicising carer training. This is particularly important for organisations tasked with meeting the needs of harder-to-reach groups, and its policy relevance extends beyond programmes of support for carers.

## Contracting with providers

The National Team carried out a rigorous initial provider procurement process which led to the recruitment of 32 fully or partially funded local training providers based on a 'hot spot' model designed to ensure a geographical spread throughout the country. However, due to the combination of factors discussed above (including a tight delivery schedule, prioritisation of a prescriptive programme design, ambitious targets and ambiguities and uncertainties about key deliverables and / or outputs), the National Team was slower to implement the provider procurement process than perhaps was desirable.

A second wave of provider procurement, based on a different model of funding (PAYG), was later developed in response to DH concerns about subsequent low number of carers recruited. This resulted in a total of 40 providers delivering the CwC programme around the country in 2010. The new method of funding appeared to result in a lower cost per carer place, but also introduced inconsistencies between provider contracts, contributing in some instances to competitiveness rather than co-operation between providers.

## Recommendation 3

Future programmes of training and specific support for carers should consider output-related funding payment models rather than fully-funded models of support. While these will need to recognise the set-up and carer recruitment costs of organisations new to supporting carers, the PAYG model explored towards the end of the CwC programme seemed to offer a more resource-efficient means of extending the reach of the programme than could be achieved with the funding models originally in place. Further work on those organisations continuing to deliver CwC modules (after the programme was terminated) may be needed to gain a detailed understanding of how this was achieved. Output-related payment systems (already operating widely within Welfare to Work programmes) provide additional incentives to contractors to meet their target outcomes and outputs and discourage contractors from making overly ambitious offers.

## Monitoring and supporting delivery

A specialist external agency was contracted to develop a Management Information (MI) system capable of monitoring the performance of individual providers and of the CwC programme overall. Providers were supported to deliver the programme and monitor their own delivery through the National Team's dedicated Provider Development Managers, provider development days and a series of guides, frameworks and toolkits provided by the National Team. However, some providers needed more support than anticipated and the MI system was less effective than planned: there were inconsistencies in the way data on carers were collected; some providers were unwilling or unable to comply with the data inputting required; and some carers (and providers) did not provide the data requested, leading to substantial gaps in information.

### Recommendation 4

Commissioners of programmes of support and training for carers, and other relevant groups, should ensure that effective Management Information (MI) systems are put in place from the outset, to record full details of the performance of contractors and subcontractors and assist evaluation of policy implementation. All parties (including any subcontractors) should be contractually obliged to record adequate monitoring data on the MI system, with mechanisms in place to ensure such obligations can be enforced and appropriate support and guidance available to assist them. Detailed points to focus on (which caused problems in monitoring and evaluating CwC) include:

- Ensure programme managers can regularly monitor providers' compliance with data inputting, so that prompt action can be taken with respect to specific providers when necessary.
- Enable local providers to check and monitor inputting of their own data from the outset. Without this facility, providers cannot identify those carers for whom data has not been entered and take steps to rectify this.
- Provide all providers with a coding booklet so that data entry (including coding of non-response) is consistent.
- Programme managers should consult closely with evaluators about all data collection instruments prior to implementation, and should pilot these instruments.
- The temptation to include questions about everything programme managers would like to know, without adequate piloting of the impact of specific questions, should be resisted. Sensitive questions about sexuality should have been excluded (from the CwC AIF), despite their relevance to programme targets, as it is highly likely that these significantly reduced the response rate.
- Providers should be contractually obliged to collect, input and upload agreed data, and penalised for non-compliance. Some CwC providers failed to input any AIF data at all, apparently without penalty.



## Recruitment, marketing and publicity

The CwC programme was launched nationally in a way which gained a lot of positive initial publicity. Local marketing was also encouraged and supported through the National Team's provision (to local providers) of standardised marketing templates and other guidance. A wide range of marketing strategies was developed by providers and some ran effective, innovative marketing campaigns. However, the restrictions on the marketing budget made it difficult to run a high-profile, on-going, national marketing campaign. Some provider organisations had very limited experience of marketing and carer recruitment and needed additional support.

### Recommendation 5

Future training and support programmes for carers and other hard-to-reach groups need to use innovative marketing and recruitment techniques which have been successfully applied elsewhere to recruit a wider pool of beneficiaries (including those that are 'hidden'). Options to consider include:

- Centrally co-ordinated marketing to provide a national profile for programmes. (This could be integrated with implementation of planned improvements to information and advice available to carers in line with recommendations made in the 2011 reports of the Law Commission and the Commission on Funding of Care and Support.)
- Marketing guidance for individual providers. This should go beyond providing draft copy for advertising and include professionally informed guidance on available advertising options, their costs and how to access these.
- More vigorous outreach work, which may require the employment of specialist outreach workers, at least in the short term.
- More consistent use of GP and NHS referrals, through locally agreed but standardised arrangements, so that carers get the same level of support in all their contacts with health and social care professionals in primary care and hospital services.
- Working with employers, employer bodies and employment initiatives. Jobcentre Plus Care Partnership Managers, the Employers for Carers group, the CIPD and other employer bodies all have experience of supporting working carers and providing them with training and guidance. This is likely to be of value in providing advice on the implementation of carer training in the future.

## Milestones, outputs and costs

Ambitious targets were set relating to carer numbers, which individual providers and the programme overall had great difficulty meeting: 27,000 were to be fully trained (by attending at least four modules) face-to-face, but only 5,427 were fully trained by the end of the programme; 108,000 carer places were to be provided but only 40,292 were filled; an additional 10,000 carers were to be trained through self-study or online but only 1,318 accessed the programme through these mechanisms. The programme had greater success, however, in meeting its targets for specific groups of carers, particularly: BME carers; carers caring for 35 plus hours per week or in receipt of Carer's Allowance; carers of people who are disabled, with complex needs; or who have a long term illness or condition. Providers had difficulties recruiting LGBT carers, carers of people who are LGBT and carers of people who have dementia. There was some lack of clarity about why some targets were so specific, while targeting on age, gender and employment status was omitted.

Although there was never a specific target cost per carer place, the lower than expected levels of carer recruitment meant that cost per filled carer place was relatively high for the duration of the programme. As delivery developed, initially high delivery costs became more manageable for some providers, and some felt the introduction of the PAYG tariff model had the potential to deliver CwC more cost-effectively than the 'fully-funded' provision. However, some providers felt the revised funding method would have been impractical or less effective without substantial initial resources to set the programme up.

### **Recommendation 6**

All parties involved in future programme delivery (commissioners, contractors and sub-contractors) should fully assess the achievability of milestones, targets and costs prior to agreeing to contractual obligations. Targets should be ambitious and wide-reaching but also cost effective and achievable, with intelligence relating to the challenges of delivering to groups fully explored.

### **Supporting carers**

Although target number of carers were not met, the programme succeeded in registering almost 14,000 carers, 10,238 of whom attended at least one CwC module, with many of these (59%) being fully trained (attending four or more modules). These carers were reasonably representative of the wider population of carers, and the programme achieved a degree of success in meeting its targets for some particularly hard-to-reach groups.

Most participating carers had positive experiences of CwC. Many carers liked the way the programme was organised and delivered and very much appreciated the content of the modules they attended, often feeling they had derived lasting benefit from their participation. Carer feedback (through module evaluation forms and through the evaluation team's three-phase survey of participating carers) was almost uniformly positive. The carers surveyed were complimentary about a number of opportunities the programme gave them to: learn new skills; meet other carers in a supportive environment; improve their knowledge of how to access support; address issues affecting their own health and well-being in a positive way; help them enact their caring role more effectively, with better access to support and services; and enable them to be better informed and gain more confidence. Some carers used the financial guidance and information they received to identify benefits they had not previously claimed and substantial minorities reported positive outcomes for those they supported as well as for themselves; this included taking up new social, leisure or health activities and (in some cases) commencing volunteering, a new training course or finding paid work. Well after their participation in the programme was complete, many carers reported benefits affecting their caring role.

## Recommendation 7

Carers derive considerable and sustained benefit from the kinds of support offered in the CwC programme. Innovative ways of continuing to provide similar support in the future need to be identified. This will be increasingly urgent as population ageing, the longer lives of sick and disabled people, and new ways of delivering healthcare lead to growing numbers of carers and greater pressures upon them. The future sustainability of carers' roles, widely recognised as crucial for the wider system of health and social care, will depend upon providing them with: adequate support; timely access to appropriate services; help in keeping themselves well; and assistance where appropriate to remain in or return to work, training or education. Given the importance of this, carers will need access to appropriate training and support of the type provided by the CwC programme in the future and innovative ways will need to be developed to provide this, drawing on partnerships with independent sector providers and on the resources of those who support, engage with or employ carers. Carers' training needs, and the plans indicated in the Coalition Government's 'Next Steps' document (HMG, 2010), provide opportunities to address this.

Available mechanisms and channels for delivering this support include:

- Local health and social care partnerships should ensure health professionals and social workers have regular opportunities to refer carers who would benefit from it to training support.
- Employers and human resources professionals may wish to build on the CwC programme modules to develop training carers can access in the workplace or through their trade unions or professional bodies.
- Voluntary sector organisations (including, but not exclusively carers' organisations) could be encouraged to offer CwC modules or related carer training, as part of local carers' strategies.
- The experience gained in the CwC programme (and other programmes of carer support) in targeting ethnic minority carers and carers in other communities (such as LGBT carers) should be drawn upon to ensure future training programmes consider their needs and provide appropriate access arrangements and resource materials.

## Providing support through local providers

Despite the challenges faced by many local providers in delivering the CwC programme (including difficulties in: meeting target numbers of carers registered and successfully completing the programme; keeping average cost per carer place down; and delivering the programme on time), for many providers CwC was a new form of support which: extended and / or enhanced the range of services they were able to offer; enabled them to develop or deepen their commitment to carers; allowed them to build new partnerships; and raised local awareness of carer issues. There was no evidence that providers were 'cost-shunting' by using the CwC resources to fund similar support which existed before the programme or displacing existing training services for carers.

During the lifetime of the CwC programme, considerable practical expertise was built up among the face-to-face providers, including: intelligence about suitable venues; workable delivery arrangements; strategies for recruiting carers and establishing referral pathways; and the best ways of offering carers alternative care support.

Despite the early termination of CwC, for many providers the programme will almost certainly lead to longer term impacts on their organisations. There was evidence, for some, of significant changes in their organisational culture, including: a new commitment to sustaining carer training programmes; greater 'visibility' of carer issues in the local health and social care system; and sustainable partnerships. Some providers, recognising the change CwC could make to carers' lives and the positive impact of the programme on their own organisation, had attempted to sustain CwC beyond the programme's termination date (in some cases acquiring new funding for this from other sources) and have continued to deliver a modified version of CwC. This continued delivery has resulted in some modification of course materials and delivery arrangements, although it is too early to establish if this has affected programme quality. Securing adequate resources to continue offering the programme in 2011 and beyond will be very challenging for most, but the availability of the CwC programme resources and module content provides an important legacy on which future carer support can be built.

### Recommendation 8

Local organisations providing support and training to carers and other hard-to-reach groups should assess very carefully the practicalities of their provision and ensure that the needs of the target group are considered prior to offering the programme of activities. To maximise uptake of training and support, key issues to be considered include: identifying suitable venues; establishing workable delivery arrangements; developing well thought through and tailored strategies for recruitment; establishing effective referral pathways; and identifying the most appropriate ways to offer any additional provision necessary for the target group to participate, such as alternative care support.

At its closure, the *Caring with Confidence* programme, despite its missed targets and struggle to contain costs, had delivered effective support to a larger number of carers than had been achieved in any previous programme of support for carers. Carers who fully participated in it reported gaining great benefit from joining the programme; much knowledge about how to offer and deliver support to carers was also obtained by the organisations involved. The National Team, Project Board and provider network contained many staff whose commitment, efforts and resourcefulness led to the carer benefits achieved, which should be recognised and acknowledged. Many providers noted that *Caring with Confidence* offered a new form of support to carers which was previously lacking, and emphasised the importance of finding new ways of delivering support to carers in the future of the quality achieved by *Caring with Confidence*.

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## About CIRCLE

**CIRCLE** (*Centre for International Research on Care, Labour and Equalities*) is a research centre of the University of Leeds, based in the School of Sociology and Social Policy. CIRCLE is directed by Professor Sue Yeandle.

For all enquiries contact:

**CIRCLE**  
School of Sociology and Social Policy  
University of Leeds  
Leeds LS2 9JT  
UK

Tel: +44 (0)113 343 5003

Email: [CIRCLEadmin@leeds.ac.uk](mailto:CIRCLEadmin@leeds.ac.uk)

Web: [www.sociology.leeds.ac.uk/circle](http://www.sociology.leeds.ac.uk/circle)