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Carers, Employment and Services in their Local Context

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CARERS look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid.

Carers, Employment and Services in their Local Context

This report explores some of the differences in the services and support available to working carers and other carers considering combining work and care, according to where they live in Great Britain.

After summarising the policy context in relation to carers as it has emerged over the past 10-15 years, and highlighting differences in social care arrangements between England, Scotland and Wales, the report presents data about working carers from the 2001 Census, and from the CES study of carers of working age conducted in 2006-7. The way services and support for working carers have developed in recent years in 10 selected localities is discussed, based on documentary analysis and interviews with key stakeholders. The report compares and contrasts local authority strategies and policy implementation in these localities, and considers how local authorities have worked with other agencies and the voluntary sector in developing their approach. It also presents evidence about the resources made available to support carers, and highlights examples of local innovation and effective practice.

Executive Summary

This report, *Carers, Employment and Services in their Local Context*, arises from the **Carers, Employment and Services** (CES) study conducted in 2006-7 at the University of Leeds, commissioned by Carers UK, lead partner in the *Action for Carers and Employment partnership*. The findings reported are based on 1,909 responses to a national survey targeting carers of working age, and face-to-face interviews with local authority Carers Leads or officers with a carers remit in ten selected localities in England, Wales and Scotland. The report, which also outlines the focus of the other reports available in the CES Series, explores the way services and support for working carers have developed at the national and local level, looking particularly through the eyes of local authorities who have been given funding and, in England and Wales, have some statutory duties relevant to carers who are combining work and care.

Background

Carers Employment and Services in their Local Context is one of a series of publications arising from the CES study, and should be read in conjunction with the other reports. The CES study was commissioned to strengthen the evidence base available to inform future public policy and service development. It builds on previous research, also commissioned through the *Action for Carers and Employment partnership*, and published separately, which looked mainly at what can be done within the workplace to support carers in combining work and care.

Policy developments in England, Wales and Scotland

Devolution of power from Westminster to the Scottish Parliament and the Welsh Assembly has produced legislation and policy with different emphasis. In Scotland the right of carers to work or to enter paid employment has weaker statutory underpinning than in England and Wales, and in England there is no legislative obligation on NHS health services to recognise carers or to work with other agencies to support them.

All three nations have developed Carers' Strategies and committed additional funding to support the development of carers' services; in Scotland this is part of local authorities' General Annual Expenditure allocation, while in England Carers' Grant and in Wales the Carers' Grant Scheme/Mental Health Carers' Grant have both been introduced.

Charges affecting social care services and users vary in the three nations. While Scotland now has free personal care for people over 65, and Wales has free prescriptions, in England charges are made for both.

Carers in England, Wales and Scotland: 2001 Census

The 2001 Census showed that in Wales and Scotland the proportions of working age women who are carers (17% and 15%) as well as the amount of care they provide are higher than in England (14%). Men of working age in Wales are also rather more likely to be carers (13%) than in England and Scotland.

Men and women with 'heavy' caring responsibilities have lower economic activity rates. Nevertheless, even among men providing 50+ hours of care per week, well over a third are combining caring with full-time employment in Scotland (38%), Wales (37%) and England (41%), with small percentages (5% in England and 4% elsewhere) working part-time. Among female carers, over a third of 'heavy end' carers are also in paid employment: in Scotland the figures are 16% in full-time and 18% in part-time work; with in Wales 15% and 18% and in England 14% and 20%.

Carers and services: CES survey

Within the CES sample, a substantial proportion of respondents in England (35%) Scotland (30%) and Wales (28%) said that they and the person they were supporting were not using any formal services; this finding cannot be attributed to very low levels of care need, as the survey respondents were mostly carers with 'heavy' caring responsibilities.

Carers said that the main factors limiting use of services were that services were not flexible enough (almost half of carers in all three nations), not sensitive enough to needs (44% in England and Wales, 38% in Scotland), and that the person cared for did not want to use services (about 44% in all three nations). Over a third of carers in all three nations said their use of services was constrained because they did not know what was available locally.

Very few carers do not want to use services, with only a minority (20% in England, 12% in Wales, and 17% in Scotland) saying they wanted no services. Almost two thirds of carers (60% in England, 62% in Wales, and 58% in Scotland) identified at least one service which they were not currently using but would like to have.

Most carers in all three nations, particularly in Wales, were accessing formal services via social services; in England and Wales 13% of carers in the study were using services from a private care provider (9% of the Scottish respondents).

Across all three nations, carers' services – respite, breaks and sitting services – emerged as the most 'wished for' services that carers did not currently have.

Local arrangements for supporting working carers in the 10 localities

Despite new legal requirements and a policy steer to support carers in combining work and care, most CES authorities conceded that progress had been slow. With no official monitoring requirements exerting leverage, they felt that action relied on changing the hearts and minds of local practitioners. In their experience:

- Carers requesting/receiving support were often not in paid work. Restrictions on Adults' Services budgets and the associated eligibility criteria meant they were only able to support carers at the heavy end of caring; many of those they were in touch with were a long way from the labour market. While it tended to be assumed that these carers could not or did not want to work, in most cases carers were not being asked about their preferences or needs for support in accessing a paid job.

- The allocation of additional funding for carers to local authorities had resulted in other key partners being 'let off the hook', with no reason to take up a working carers agenda.

- Local employers were recognised as a crucial part of any support package to enable a carer to sustain or enter paid employment, but local authorities felt under-resourced and ill-equipped to take on a championing role. A few authorities had attempted to do this by leading by example; concentrating mainly on their own internal carers' policies and their implementation.

- Working with voluntary sector agencies was of key importance: this was a main way of linking carers into services, information and consultative structures. Activities for carers had increased dramatically, and in many cases innovatively, in some of the authorities studied, but in most a focus on working carers was not strongly apparent.

The 10 authorities were structuring their approach to policy on carers in three different ways (outlined in the report). A dedicated post with no other distractions, at an appropriate level in the organisation, emerged as a powerful resource to bring about change.

The 10 authorities had all made extensive attempts to involve, engage and consult with carers in their commissioning and strategic planning processes. Yet there was often an expectation that carer representatives would be economically inactive; opportunities to involve working carers, or to identify ways in which these roles could lead to paid employment, had not been identified.

Challenges for local authorities

The challenge of reaching carers in work, beyond those in local authority employment, has so far been addressed only through pilots, special projects and short-term initiatives; as yet, only very few authorities had begun the process of mainstreaming their support for working carers across the full range of local agencies in health, social care, employment, and education.

The number of Carers Assessments conducted among carers of working age was very small, especially when viewed in terms of the numbers of carers living in each locality. Few, if any, authorities had asked carers of working age about their desire to work, or about the services they needed to combine work and care, yet evidence in the study (reported in CES Reports 1, 2 and 3) suggests it cannot be assumed that carers not in touch with the assessment and service provision process do not need or want support, or that carers not in work do not want to work. For working carers, the lack of an assessment leading to suitable, responsive services may mean that the welfare and livelihoods of carers and their families are put at risk. For carers who are not working, appropriate support and services could enable them to do so.

Detailed recommendations based on this report, and on the other reports in the CES Series, are presented in CES Report No. 6: *Carers, Employment and Services: time for a new social contract?*

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Carers, Employment and Services in their Local Context

Introduction

This report is about the services and support available to working carers, and other carers considering combining work and care. It examines how these differ according to where they live, and discusses how this support and the services available are being changed and developed. Carers provide regular, unpaid, support or assistance to someone who needs their help because they are ill, disabled or frail. Many carers support a relative, such as an elderly parent, a sick or disabled partner, or a disabled child. In using the term 'carer' we are not referring to parents who are caring for a dependent child, unless that child also has an illness or disability[1], or to 'care workers' who are paid to provide care in the home. The report includes evidence about the way local agencies are developing and providing support for carers, focusing especially on the needs of carers of working age. It emphasises that 'supporting working carers' means much more than providing 'carer-focused' services, such as respite arrangements, and that it requires local agencies of all types to work together. This means rethinking the way they deliver the health and social care services needed by the sick, frail and disabled people who carers assist, and implies some fundamental changes in the way they operate across the whole of their local socio-economic, community cohesion and social inclusion agendas. Carers are now beginning to be recognised in policy and in law as people with rights and entitlements,

and increasingly, guidelines include the right to a 'normal' working life if they choose[2], a development to which local agencies have responded, but which they are sometimes finding challenging and difficult.

In the first part of this report, we outline the policy framework which has been put in place in relation to carers over the past 10-15 years, noting the similarities and differences in social care arrangements between England, Scotland and Wales. In part two, we set out the statistical evidence about carers of working age, and the support they receive, in these three nations[3], and explore the main characteristics of the carers who responded to the CES survey, 134 of whom also gave us a personal interview. Part three of the report then considers how services and support for working carers have developed in the ten localities, drawing mainly on the CES interviews with 'local authority interviewees', and highlights examples of innovation, effective practice and successful policies identified in the ten localities studied.

The report is based on the findings of the *Carers, Employment and Services* (CES) research project, commissioned by *Carers UK* from a team of researchers at the University of Leeds as part of the *Action for Carers and Employment (ACE2)* partnership, and funded by the European Social Fund under the *EU EQUAL Community Initiative Programme*. The study was carried out in 2006-7.

The CES project collected data from a completely new questionnaire survey of carers in England, Scotland and Wales, obtaining 1,909 responses from carers, accessed through a wide range of employers, through carers' and other voluntary organisations, via agencies responsible for the provision of social care, and using other means[4]. The study also included follow-up personal interviews with a sub-sample of 134 carers who had completed the CES questionnaire. Each of these interviewees lived in one of ten localities[5] selected for detailed investigation. In these localities, we collected information about the provision of services – both the services specifically designed to support carers, and those used by the people they care for – and interviewed local stakeholders with specialist knowledge and expertise.

This new evidence about local services is the main focus of this report, *'Carers and Services in their Local Context'*, one in a series of publications arising from the CES study. The full range of study findings is reported in the complete series. In addition, a set of short, specialised *CES Locality Reports* (relating to Scotland, Wales and the six English localities studied) is being produced to assist local agencies in supporting carers who combine work and care in their policy development and planning.

The CES Study Report Series

No. 1 *Stages and Transitions in the Experience of Caring*

Becoming a carer – the impact of caring in the first two years, as experienced by carers of working age; the longer term impact of caring on carers' lives when a caring role is sustained over two or more years; carers' views and perspectives as they deal with the different ways in which caring can come to an end.

No. 2 *Managing Caring and Employment*

Carers who are combining unpaid care with paid work – how they manage and cope and the difficulties which sometimes arise; why some carers have left employment to care, and what this means for them and their families; the perspectives and experiences of carers who want to work but do not have a paid job.

No. 3 *Diversity in Caring: towards equality for carers*

The many different characteristics of Britain's 4.3 million carers of working age – carers in Britain's ethnic minority communities; caring and its challenges for carers in rural and urban contexts; caring in different financial circumstances, and the problems faced by those who are 'caring in poverty'; carers and how caring affects their health; caring in its various personal contexts – the relationships between carers and those they support, and the different conditions and needs of those they care for.

No. 4 *Carers and Services in their local context*

Recent developments affecting local service provision for sick, frail and disabled people and their carers; differences in the arrangements made in Scotland, Wales and England under devolved government; carers in 10 local contexts – differences between carers and the demand for care support at the local level; local arrangements for supporting working carers; the resources allocated to supporting carers; examples of best practice and innovation in supporting carers who wish to combine work and care.

No. 5 *Action for Carers & Employment: Impact of the ACE partnership 2002-7*

The objectives, design and outcomes of the ACE projects; the role of research in supporting the ACE strategic aims and summary of the findings of the Carers, Employment and Services (CES) study; the work undertaken by the ACE partners in England, Scotland and Wales, and their main achievements; the role of transnational activities in ACE, and their significance for future policy-making at European level.

No. 6 *Carers, Employment and Services: time for a new social contract?*

Main findings from the CES study about carers in England, Scotland and Wales; description of the study methodology; the implications of the findings for the future public policy agenda on working carers; the rationale for developing better support for working carers at local and national levels; key challenges and how they can be tackled: recommendations about policy and practice for service providers, employers, central/local government and the voluntary sector.

There will also be a series of **CES Locality reports**

The CES reports contextualise the findings of the CES study in the wider body of available evidence, and particularly the detailed statistics about carers available from the 2001 Census, which asked a question about unpaid care in 2001 for the first time.[6]

This report (No. 4) covers:

1. *Policy developments affecting working carers in Scotland, Wales and England*

2. *Carers and employment in England, Scotland and Wales*

3. *Local arrangements for supporting working carers*

1. Policy developments affecting working carers in England, Wales and Scotland

Policy Issues and Developments

In most cases, caring 'happens to you'. Often willingly undertaken, the caring role is not usually desired, hoped for or planned, as parenthood frequently is. So while combining caring with paid work is in some ways similar to being a working parent, the experience of being a working carer also differs in very important ways[7]. Supporting carers who want to work and care has major implications: for employers and organisations; for service providers across the whole health and social care spectrum; for the economy and the state; and for family and personal wellbeing. This is increasingly being recognised by the state, as we will show. Caring is not merely a matter of family or personal preferences and decisions, nor is it simply about identifying resources and setting up workable service arrangements, although these are very important. Care plays a central role in all our lives: our need for it underpins the interdependencies between us, within and across generations, at key stages of life, and across all social groups – indeed the ethical and emotional dimensions of caring, and each person's ability, at some level, to both give and accept care, are fundamental to our humanity. In general, caring remains strongly feminised, but today (as our other reports in this series confirm), both men and women care, many carrying out their caring responsibilities alongside other duties. For most carers, caring and

supporting their loved ones is something they wish to do not in isolation, but as part of active, socially engaged lives which include involvement in paid work or a career too.

For the past decade, demographic and social change has been pushing carers up both the social policy and the employment rights agendas – and the pressures involved are set to continue for some decades. This is true throughout all parts of the UK and indeed across much of the world, with every EU member state expecting a significant increase in the demand for care in the first half of the 21st century[8]. Over the next 25 years, the UK will simultaneously need both 2 million more workers and 3 million more carers. The demography is clear: the population is ageing, with the balance between older and younger people changing very significantly (Table 4.1). Despite differences in the level of overall population growth predicted for England, Wales and Scotland between 2005 and 2025 (with Scotland's total population expected to remain the same), each of these three nations expects to see a more than 50% increase in the number of its people aged 75+. For the population aged 85+, England and Wales both need to prepare for a 75% increase, while Scotland faces the even more challenging situation of an increase of almost 90%, almost doubling the population of very aged residents in Scotland.

Table 4.1 Population projections 2005-25

Source: 2004-based national population projections, GAD, Crown copyright.

	England	Wales	Scotland
2005			
All	50,434,445	2,964,057	5,097,084
Aged 75+	3,866,188	249,502	376,942
Aged 85+	995,533	62,943	90,627
Percentage of whole population aged 75+	7.7	8.4	7.4
Percentage of whole population aged 85+	2.0	2.1	1.8
2025			
All	55,594,202	3,209,556	5,114,403
Aged 75+	5,888,391	387,494	582,851
Aged 85+	1,739,151	110,091	171,984
Percentage of whole population aged 75+	10.6	12.1	11.4
Percentage of whole population aged 85+	3.1	3.4	3.4
Change 2005-2025			
All	5,159,757	245,499	17,319
Aged 75+	2,022,203	137,992	205,909
Aged 85+	743,618	47,148	81,357
All (% change)	10.2	8.3	0.3
75+ (% change)	52.3	55.3	54.6
85+ (% change)	74.7	74.9	89.8

Furthermore, thanks to better healthcare, many sick and disabled people, including babies and children with serious illnesses and disabilities, are also living longer. And those who experience serious illness, and others who require hospital care, are also finding that policies on earlier discharge to the home environment, and the possibility of managing an increasing range of conditions outside of hospital or residential care, mean more time is spent in a home setting, albeit involving significant support, either from domiciliary health and social care staff, from unpaid carers, or, often (and ideally) a combination of both. This is (for most) a welcome development, yet it is not clear that its wider ramifications have been fully grasped by governments, policy-makers or service providers, including those operating at the local level. In this report, we aim to shed some light on recent developments, looking at what has been happening in ten localities in England, Wales and Scotland.

Alongside the major demographic developments outlined above, labour market projections now show that UK and other European economies will continue to need more skilled and experienced labour, just at the point when the working age population is shrinking – the combined effect of extended education, smaller cohorts of young people starting work, and early withdrawal from the workforce[9]. Recent estimates are that 1.3m additional jobs will be created in the UK between 2004 and 2014 alone, with most of the additional demand for labour in the more skilled and higher level occupations[10]. The 40-plus age group, where most caring occurs[11], includes many men and women in whom the state and employers have made expensive qualifications and training investments – and on whom employers, managers and co-workers rely for their experience, organisational knowledge and maturity. Among carers of working age, a large number already combine work

and care, often paying a significant health penalty as a consequence of the pressures they face[12]. This group includes both men and women (about 43% of all carers of working age are men), and carers are distributed fairly evenly across most industrial sectors and across most occupational groups; so facing up to increased demands for care is likely to affect employers and organisations in all segments of the labour market.

The reality is that when caring begins, carers often have 20 or 25 years of working life ahead of them, sometimes more, especially if they are parents caring for a disabled child. Yet (as we show in the other CES Reports) when they seek support, and try to adjust to their new caring responsibilities, they often find the alternative care services they need to support them when they cannot themselves be available, often because of their paid jobs, are a costly and limited resource[13]. Mass early retirement – leaving the workforce in order to care, as many people have done (CES Report 2), is simply not a practical or affordable option. Indeed, a number of major reviews, and almost all policy-making[14] call for extended working lives, with older workers (those aged 50+) encouraged to remain active in the labour market well into their 60s and beyond, underpinned by pension reform and raising the state pension age. Meanwhile alternative care – the services on which those whom carers support rely when their carers are not there – remains expensive and scarce, not only because of public spending constraints, but also because of serious shortages of caring labour[15].

In an earlier report[16], we investigated the situation of those who combine work and care from the organisational perspective, consulting managers, employees, and senior executives and reviewing organisational policy documents. When they took supporting carers seriously, the organisations we studied found that: (i) it makes very good organisational and business sense to have in place effective staff retention strategies; (ii) employees work more effectively and productively when they are offered flexible working conditions; and (iii) treating employees who have care commitments with respect, dignity and consideration pays considerable dividends for their business. We emphasised in that report, however, that employers and managers cannot hope to provide *all* the support carers' need, and that

responsible, progressive and flexible management of carers in the workplace is crucially dependent on the existence of effective, responsive services.

These services provide the main bedrock of support for carers, and need to assist the person cared for in a flexible, person-centred way. In the best situations, service providers and paid care workers operate in a close and respectful partnership with both the care user and their unpaid carer(s); however as we show later in this report, local agencies are mostly only 'scratching the surface' in the support they offer Britain's 2.8 million working carers, albeit with some inspiring pockets of innovation and good practice, often delivered in the face of serious resource constraints, amid the difficult challenges of making multi-agency partnerships effective, and genuinely 'mainstreaming' support for carers.

Responses of the UK Government

In the past forty years, the carers' movement [17] has lobbied hard to secure for carers a range of new rights, entitlements and policies. Underpinning their approach has been a belief that carers should be treated as a group entitled to equal opportunities and human rights – to be treated with dignity and respect; to be able to access education, training and employment; to have a life outside caring; and to enjoy freedom from caring 'penalties' – in terms of poor health, poverty, social isolation and social exclusion. Their campaigning has yielded modest but significant results – the right to leave from work to deal with emergencies and caring crises; the right to request flexible working arrangements; the right to a Carer's Assessment which acknowledges their desire to work as well as to care; and in England and Wales, a statutory right to access education, training and employment (Table 4.2).

These new rights and entitlements form the backdrop to the activities of local agencies with statutory responsibilities. This new legislation has, for the most part, had all-party support; and policy-makers and social care professionals have mostly welcomed the shift towards a more explicit focus on carers' circumstances. Employers' representative organisations (e.g. the CBI[18]) also now welcome and support the limited rights carers now enjoy in the workplace. The carers' lobby, primarily at national

Table 4.2 Main legislative/policy developments affecting UK carers since 1995

* This column highlights selected provisions, and does not aim to summarise all aspects of the development indicated.

Date	Development	Key change for carers*	Coverage: England Scotland, Wales
1995	*Carers (Recognition and Services) Act*	Introduced the concept of a carer's assessment.	ALL
1999	*Caring About Carers: a national strategy for carers*	Stressed that enabling carers to combine paid work and care was a priority for government.	Separate national strategies
1999	*Employment Relations Act*	Gave employees the right to 'reasonable time off' to deal with emergencies.	ALL
2000	*Carers and Disabled Children Act*	Gave carers the right to an assessment for carers of adults and people with parental responsibility for disabled children. Allowed carers to receive services in their own right. Enabled local authorities to give direct payments to carers for their own services and or to parents of disabled children to manage on their children's behalf.	England and Wales
2000	*Changes to Invalid Care Allowance (now known as Carer's Allowance)*	Amendment to the Social Security Contributions and Benefits Act 1992, which included extending carers' benefits to people aged 65 and over.	ALL
2002	*Community Care and Health (Scotland) Act*	Recognised unpaid carers as key partners in the provision of care, and gave them the right to an assessment in their own right. Placed a duty on local authorities to offer Direct Payments to all disabled people, including those with mental illness and learning difficulties and parents of disabled children.	Scotland
2002	*Employment Act*	Gave employed parents of disabled children under the age of 18 the right to request flexible working arrangements.	ALL
2004	*Children Act*	Required local authorities to lead on integrated delivery through multi-agency children's trusts and to develop a children and young people's plan. The Act included a strong policy emphasis on supporting families and carers, described as 'the most critical influence on children's lives'.	England and Wales
2004	*Carers (Equal Opportunities) Act*	Placed a statutory duty on social services departments to inform carers of their rights, and to consider carers' wishes in relation to education, training and employment when conducting Carers Assessments.	England and Wales
2004	*Every Child Matters: change for children policy document*	Indicated that disabled children and children with long term health conditions should 'receive co-ordinated services which allow them and their families to live as ordinary lives as possible.' In 2007, the UK government announced £340m (2008-2011) for services for disabled children in England – £280m for short breaks for families with children with severe disabilities.	England and Wales

Date	Development	Key change for carers*	Coverage: England Scotland, Wales
2006	*Work and Families Act*	Extended the right to request flexible working arrangements to all carers in employment, from April 2007.	ALL
2006	*Childcare Act*	Contained provisions relating to the 'duty to provide sufficient childcare for working parents'; and required local authorities to 'have regard to the needs of parents' for 'provision of childcare suitable for disabled children'.	England and Wales
2007	*New Deal for Carers policy announcement*	Package of measures relating to respite, emergency planning and help-lines for carers.	England and Wales
2007	*Pensions Act*	Recognised carers' situation: reduced the number of qualifying years needed for a full basic State Pension; replaced Home Responsibilities Protection with weekly credits; introduced a new carers' credit for those caring 20+ hours a week for someone who is severely disabled.	ALL
2008	*Revised National Carers Strategy*	The UK government's plans for this were outlined in 2007.	As yet unknown

level but also locally, continues to call for stronger policies, much more public investment in the services which support carers, and heightened employer and managerial awareness of carers' needs, noting that these valuable changes and developments are very far from an adequate response, given the scale and range of carers' needs.

Some aspects of these recent changes move beyond 'enabling' legislation and policies, and give to carers limited but enforceable rights, with statutory obligations on local authorities, employers and others. In reality, nevertheless, delivering new forms of support for carers is held back variously by resource constraints, organisational inertia and blockages, and sometimes, in the workplace and elsewhere, by out-of-date attitudes towards carers, or by ignorance of the ubiquity, importance and necessity of carers' roles. Thus, as we show later in this report, only a minority of carers with significant caring roles have had their needs assessed, as they are entitled, and the quality of the assessment process and its outcomes are highly variable. Some local authorities have been innovative, resourceful and imaginative in developing new support for carers, engaging carers directly in the process of modernising the services they offer – but these examples of excellence are far from the universal situation.

In responding to these developments, carer recognition and awareness has been a complex issue, not least because self-identification as a carer is extremely variable. As we discuss in other reports in the CES series, those enacting caring roles do not always wish to describe themselves as carers, sometimes seeing the loving support they offer as simply an expression of a personal relationship (spouse, parent, child etc.); while for others the word itself remains unfamiliar or is confusing (indeed the word 'carer' continues to be used in much popular parlance and some official documentation to describe paid, domiciliary care workers). For some, it is a difficult step to adopt the 'label' of carer – for others it becomes an important, and 'political', identity imbued with quite specific real and symbolic meaning. The use of the term 'carer' in UK legislation (where it has needed to be specifically defined) and in the collection of official statistics (notably through the question asked for the first time in the 2001 Census of Population) is undoubtedly a significant step in putting carers' issues 'on the map'. Two decades ago, scarcely anyone used this term, and few understood

its meaning – today it is in widespread policy, legal and professional use and increasingly forms part of the everyday lexicon through which we describe our personal and family lives.

We turn now to developments in the three nations, England, Scotland and Wales, since the devolution of power to the Welsh Assembly and the Scottish Parliament in 1998.

National policy developments in England, Wales and Scotland

The devolution of power from Westminster to the Scottish Parliament and the Welsh Assembly has produced different trajectories in legislative and policy development in the area of health and social care, which have, in turn, influenced the processes of commissioning and delivering services, both for those needing care and for the carers who live with them or support them from a distance.

Figure 4.3 summarises the key differences between the three nations, highlighting in italics the approaches and statutory obligations which differ. Most significant is the greater emphasis in Scotland and Wales on the role of the NHS and health services in supporting carers (Section 4 of the figure). For many people, their relationship with care services begins with their GP or local hospital, in the form of a diagnosis or urgent treatment. At this stage, those who require ongoing health services are not always eligible for, and sometimes do not want or require, personal care; the need for these services often comes later in their journey through illness or treatment. But carers play a key role from the beginning; providing support in the community prior to hospital admission, facilitating hospital discharge, sustaining attendance where there are ongoing treatment regimes, and providing the everyday support and care needed by the person who is frail, disabled or ill. As the Scottish Government states, carers are 'key partners in providing care…. who like other service providers need resources to carry out their function'[19]. Like their colleagues in social care, medical staff and health administrators are now required to consider the needs of carers in their own right and to inform them appropriately. The challenges of caring, and of supporting carers, are often greatest when carers are in paid work

or have other dependants. It is in these situations that providing support and care for their loved ones requires the greatest adjustments to daily routines, and sometimes to personal plans and ambitions.

Whilst the *Work and Families Act 2006* applies to all three nations (Section 2 of the figure), the *Carers (Equal Opportunities) Act 2004* applies only to England and Wales. In Scotland, the *Community Care and Health (Scotland) Act 2002* goes some way to ensuring multi-agency approaches to carers' services and prompts local authorities to 'consider' carers' employment during a carer's assessment. The in-depth planning document *Care 21: the future of unpaid care in Scotland* also highlights the issue of carers and employment. Having sought the views of 5,000 carers through a consultation exercise in 2004-2005, it includes the recommendation that a national carers' awareness campaign is needed, targeted especially at employers. However, as yet, the Scottish Executive, noting that this is a devolved issue, has not made any firm commitments in response.

In social care services, each country has adopted different charging regimes (Section 3 of figure), although these all spring from a single assessment process designed to identify eligible needs, combining the data requirements of both health and social care professionals. In Scotland (since 2002) personal care is free to people aged 65 and over. *The Care Inquiry Report 2006* reported that local authorities were managing to sustain this commitment, but noted that waiting lists for social care had emerged. In addition, local intelligence in Scotland indicates that demand has risen since charging was removed, but that not all of those eligible for services would have paid for services under the previous system (due to their low income and personal savings thresholds). In Wales, prescription charges have been gradually reduced since 2004 and were removed altogether in 2007. This may have had a positive economic impact on people suffering from chronic conditions and their carers. The push from Westminster to give greater control and choice over the services they receive to users and carers has been pursued most strongly in England, through the establishment of local authority pilots, including the Individual Budget[20] pilots and the extension of Direct Payments to carers – and least strongly in Scotland.

Figure 4.3 Legislative and policy developments for carers in Scotland, England and Wales

1] CARERS AS PARTNERS IN SOCIAL CARE – safeguarding wellbeing and drawing on expertise

1995 Carers (Recognition and Services) Act (all nations)
- Concept of a Carers Assessment is introduced

National Strategy for Carers (UK 1999, Scotland 1999, Wales 2000)
- Right to a Carers Assessment
- Funding allocation to local authorities: Carers Grant (England) Carers Grant Scheme (Wales) General Annual Expenditure (Scotland)
- Development of support services for carers

Additional funding in the area of mental health:
1999 National Service Framework Mental Health Standard 6 Caring for Carers (England)
2006/08 Mental Health Carers Grant (Wales)

2000 Carers and Disabled Children Act (England, Wales)
- Right to a Carers Assessment

2002 Community Care and Health (Scotland) Act 2002
- Carers are 'key partners in the provision of care'
- Employment situation to be taken into 'consideration' during a Carers Assessment

2006 'Our Health, Our Care, Our Say: a new direction for community services', Department of Health White Paper
- Expectation that local authorities PCTs/Health Boards identify a carers' lead
- Emergency respite care, Expert Carers Programme
- Carers' Helpline, Consultation 'New Deal for Carers'

2] CARERS AS EMPLOYEES and household earners

2006 Work and Families Act (all nations)
- Right for those who care for adults to request flexible working arrangements
- Right to emergency leave

2004 Carers (Equal Opportunities) Act (England, Wales)
- Duty on local authorities to support carers employment if needs are identified during a Carer's Assessment

2005 Care 21: The future of unpaid care in Scotland, Scottish Executive Health Department
- recommends a national awareness campaign targeting employers

3] CARERS AS BENEFICIARIES OF HIGH QUALITY SOCIAL CARE SERVICES – access, user involvement, value for money, care workforce development

Self directed care: Direct Payments for all carers with assessed needs (all nations)

Single assessment process allows carers' input (all nations)

Best value procurement of purchased services, to constantly seek improvements – incl. carers services (all nations)

Social care workforce review (England 2006, Scotland 2006)
- recommends a strong trusting relationship between staff and carers

Social care charges:
- Fair Access to Care Services (FACS) (England, Wales)
- No charge for prescriptions (Wales)
- No charge for personal care to those aged 65+ (Scotland)

4] CARERS AS PARTNERS IN HEALTH SERVICES – carer awareness

GP contract awards (small) number of management points for identifying carers on records (England)

Statutory responsibility for joint commissioning of services between health and social care taking carers' views into account:

- 2002 Health and Social Care and Well-Being Strategies (Wales)
- 2004 Joint Future Policy, Local Improvement Targets (Scotland)

2002 Community Care and Health (Scotland) Act

- Statutory responsibility to inform carers of their rights and the support available via Carer Information Strategies

2. Carers and Employment in England, Scotland and Wales

We turn now to similarities and differences in the caring and employment circumstances of carers living in England, Scotland and Wales, and to some of the evidence which has emerged from the CES survey of carers of working age.

How many carers?

The UK Census 2001 provides robust, comparable data on carers in the three nations. As shown in Table 4.4, there are 4.5 million carers of working age living in Great Britain, over 3.6 million of them living in England. This figure represents 10% of all men of working age living in England and Scotland, and 13% in Wales; and 14% of all women of working age in England, compared with 15% in Scotland and 17% in Wales. We can also see from Table 4.4 that the amount of unpaid care provided in Scotland and Wales (measured in average weekly hours of care provided) is consistently higher there than it is in England.

Carers and employment

Table 4.5 reveals the differences between carers in the three nations in terms of their employment situation. For all residents, whether carers or not, full-term employment rates for both men and women are rather lower in Wales, and a little lower in Scotland, than in England. Where part-time employment is concerned, however, differences between the nations are very small for both sexes.

As can be seen in the table, both male and female carers have lower full-time employment rates, but higher part-time employment rates, than all men and women of working age. Here the fairly small differences between the nations follow the pattern seen for all people, of higher employment rates in England than in Scotland or Wales.

We are able to compare the situation of those carers who provide unpaid care for 20 or more hours per week for England, Wales and Scotland. This reveals that in England, more than half of male carers (53%) providing at least 20 hours of care per week are in employment (47% full time and 6% part-time), compared with 48% of comparable men in Wales and 49% in Scotland. For women, we see that around two-fifths of carers providing 20 or more hours of weekly care are in employment in all three nations (in England, 19% working full-time and 22% part-time, in Wales 19% working full-time and 21% part-time, and in Scotland 22% working full-time and 21% part-time).

Among those carers with 'heavy' caring roles, who provide 50 or more hours of care per week, we see (as might be expected) even lower employment rates for carers of both sexes. Perhaps what is remarkable is that in England, 41% of male carers in this category, and 14% of women are also working full-time, while in Scotland the figures are 38% and 16% respectively, and in Wales 37% and 15%. These

Table 4.4 Carers in the working age population
Source: 2001 Census Standard Tables, Crown Copyright 2003.

	England	Wales	Scotland
Number of carers - ALL with caring roles	3,637,856	253,070	374,783
Carers who provide 20+ hours of care pw	1,012,721	88,510	124,681
Carers who provide 50+ hours of care pw	614,948	56,008	76,539
Carers in the population of working age, as % of all people of working age	12	15	12
Men	10	13	10
Women	14	17	15
Carers who provide 20+ hours of care, as % of all carers	28	35	33
Men	25	33	32
Women	30	37	34
Carers who provide 20+ hours of care who are in poor health, showing % of those caring 20+ hrs pw who are in poor health	15	18	17
Men	18	21	18
Women	14	16	15
Carers who provide 50+ hours of care, as % of all carers	17	22	20
Men	15	21	20
Women	18	23	21
Carers who provide 50+ hours of care who are in poor health, showing % of those caring 50+ hrs pw who are in poor health	17	21	19
Men	20	24	25
Women	15	18	18

figures represent the 151,727 carers in England, 19,473 in Scotland, and 13,640 in Wales who combine their 'heavy' caring responsibilities with a full-time job.

Services used by carers in the CES study

While the 2001 Census provides a clear picture of how many carers there are, and of the extent to which carers in England, Wales and Scotland are combining paid work with unpaid care, it cannot answer other important questions relevant to our concerns here. In particular, it can tell us nothing about the kinds of services these carers and those they support use, or about the types of services they would ideally like to have. For this, we use data from the CES survey of carers, which obtained responses enabling us to identify the country in which they live from 1,699 carers, almost all of them (86%) carers of working age. Their responses are shown in Tables 4.6-4.10. Table 4.6 shows how the carers in England, Wales and Scotland who are included in the CES sample compare with all carers in these three nations (as revealed in the 2001 Census)[21]. This enables us to understand how far the CES sample is representative of all carers (a topic discussed in more detail in CES Report 2).

Table 4.6 shows that our respondents in the three nations, especially in Wales, were more likely to be female than the total population of carers recorded in the 2001 Census, meaning that the situation of male carers is less well captured in our data. Our data also has fewer carers aged 65+, as we would expect (given the focus on carers and employment in the CES study). In Tables 4.7-4.10 we report only

Table 4.5 Carers in the working age population and economic activity

Source: 2001 Census Commissioned Tables, Crown Copyright 2003. Note: ** Data not available due to disclosure control

	England	Wales	Scotland
All people in full-time employment	55	50	54
% of all **men** working FT	70	64	67
% of all **women** working FT	39	35	40
All people in part-time employment	15	14	16
% of all **men** working PT	5	5	6
% of all **women** working PT	26	25	27
Carers in full-time employment	47	44	47
% of all **male carers** working FT	65	60	63
% of all **female carers** working FT	32	32	36
Carers in part-time employment	20	18	19
% of all **male carers** working PT	7	6	6
% of all **female carers** working PT	30	27	28
Carers caring for 20+ hrs pw in full-time employment	30	29	31
% of all **male carers** caring 20+ hours pw working FT	47	43	45
% of all **female carers** caring 20+ hours pw working FT	19	19	22
Carers caring for 20+ hrs pw in part-time employment	16	14	14
% of all **male carers** caring 20+ hours pw working PT	6	5	4
% of all **female carers** caring 20+ hours pw working PT	22	21	21
Carers caring for 50+ hrs pw in full-time employment	25	24	25
% of all **male carers** caring 50+ hours pw working FT	41	37	38
% of all **female carers** caring 50+ hours pw working FT	14	15	16
Carers caring for 50+ hrs pw in part-time employment	14	12	12
% of all **male carers** caring 50+ hours pw working PT	5	4	4
% of all **female carers** caring 50+ hours pw working PT	20	18	18

data from those who were in the 16-64 age group. As shown in our other reports, 82% of women carers in the CES survey cared for 20+ hours per week (compared with 33% of those in the Census), and the poorer health of our three national samples (in England, Wales, and Scotland) compared with all carers in the UK (shown in Table 4.6) is probably attributable to this. The CES carers were more likely to be highly qualified (particularly those in England), and more likely to be out of the labour force (that is, not in employment, self-employed or actively looking for work, especially in Wales and Scotland). In England, our sample of female carers in fact had

employment rates very close to the average for all UK female carers, but in Wales female carers working full-time are under-represented in the CES sample. The CES sample has a lower proportion of male carers working full-time and more male carers working part-time than found in the total population of male carers. In Wales, a particularly high proportion of our respondents were caring for a child or grandchild, and (linked to this) looking after someone with learning difficulties, and this needs to be borne in mind when interpreting the Welsh data.

Among the CES sample, about a third of carers in England (35%) and Scotland (30%), and well over

Table 4.6 Carers in the English, Welsh and Scottish samples: selected characteristics and comparison with UK 2001 Census

Sources: CES Survey, University of Leeds, 2007; 2001 Census, Crown Copyright. The 2001 SARs are provided through the Cathie Marsh Centre for Census and Survey Research (University of Manchester), with the support of the ESRC and JISC. All tables containing Census data, and the results of analysis, are reproduced with the permission of the Controller of Her Majesty's Stationery Office and the Queen's Printer for Scotland.

* i.e. caring for their own sick or disabled child or grandchild, of any age.

** Data for the 'Whole CES sample' do not reflect the average of those responses for England, Scotland and Wales since some respondents did not give information about where they were living.

.. Indicates data not available; no question about this was asked in the 2001 Censuses.

Characteristics	England (%)	Wales (%)	Scotland (%)	Whole CES sample** (%)	GB 2001 Censuses (%)
Female	79	87	79	79	58
Aged 65+	16	6	16	13	18
Non White	12	3	2	8	6
In 'not good' health	27	25	23	26	12
Highly qualified	28	22	23	27	19
16-64 and not economically active	41	60	54	43	40
16-64 & in full-time employment women	27	10	22	25	24
men	37	28	29	36	45
16-64 & in part-time employment women	25	25	24	25	23
men	15	16	5	15	4
Caring for 50+ hours per week	58	74	68	62	22
Caring for a child/grandchild*	36	63	49	40	..
Caring for a spouse or partner	37	14	29	34	..
Caring for a parent/parent-in-law	27	25	20	26	..
Caring for person with dementia	15	9	13	13	..
Caring for person with learning difficulties	29	59	43	34	..

a quarter of those in Wales (28%) said that they and the person they were supporting were not using any formal services (Table 4.7). This notable finding cannot simply be attributed to very low levels of care need, since CES survey respondents are carers who typically have 'heavy' caring responsibilities, (59% care for 50+ hours per week, and only 19% for less than 20 hours per week). Indeed, as shown in Report 1, among those of working age who care for 20 or more hours per week, 33% of those caring for two years or longer, and 48% of those caring

for less than two years, were not using any formal services. Nor can we explain this finding by saying that these carers do not want to use services, since only a minority (20% in England, 12% in Wales, and 17% in Scotland) said they wanted no services (Table 4.9). In fact almost two thirds of carers (60% in England, 62% in Wales, and 58% in Scotland) identified at least one service which they were not currently using but would like to have.

Our respondents in Scotland were the most likely to be using respite services, and those in Wales and

Scotland (where many lived in rural areas) were less likely to be using community transport than elsewhere. Bearing in mind that some of the country differences in service use are related to differences in the caring circumstances of our samples, in terms of their relationship to the person cared for and the condition of that person, we can note that sitting services were being used by about one in ten carers (fewer in Wales); that domiciliary/home care services were used by more carers in our English sample (26%) than elsewhere; and at least one in ten carers mentioned that they would like other (unspecified) services (Table 4.7).

Most carers in all three nations, and particularly in Wales, were accessing formal services through social services, but it was notable that in England and Wales almost 13% of carers in the CES survey were using services from a private care provider (compared with just 9% of Scottish respondents) (Table 4.8). Welsh carers were the most likely to say they would like to have carers' services (e.g. carer's breaks) and sitting services available (32% in both cases), and indeed across all three nations, carers' services emerged as the most 'wished for' service that carers did not currently use (Table 4.9).

We asked carers in the CES survey what factors, if any, limited the use of services in their particular caring situation. The top three reasons given, as shown in Table 4.10, were that services were not flexible enough (almost half of respondents, 46-47% in all three nations), that the cared for person did not want to use services (44-45% in all three nations) and that services were not sufficiently sensitive to individual needs (38-44% in all three nations). Well over a third of carers, in each country, said that they did not know what is available locally, a striking figure given that our respondents included many who were recruited through carers' organisations and social services (as well as those recruited directly from a wide range of employers).

Carers in Scotland and Wales were particularly likely to say there were no suitable services in their area (43% and 41%), and those in England were the most likely to say they do not like the way services are organised. Over a third of carers in all three nations said services were too expensive (Table 4.10).

The carers' perspectives and attitudes measured in the CES survey, just described, need to be set in context in two ways. First, they need to be set in the context of the individual circumstances and complexities of each carer's own situation. In the CES study, we have done this through our in-depth follow-up interviews with 134 carers who took part in the CES survey, as reported in CES Reports 1, 2 and 3. Second, they need to be understood in the context of local arrangements for supporting carers provided by local authorities and other agencies. We turn now to our evidence about these, in the ten localities selected for detailed study.

Carers, Employment and Services in their Local Context

Table 4.7 Types of services currently used[22]

Source: CES Survey, University of Leeds 2007.

	England	Wales	Scotland	All
QUESTION: Do you or the person you care for currently use any of the following services? N=	946	206	290	1442
(% of carers identifying:)				
Domiciliary / Home care	26	22	23	25
Day centre	19	19	23	20
Specialist / nursing care / palliative care	12	9	10	11
Community mental health services	13	12	15	13
Respite care	21	22	28	22
Carers' services (carers' breaks etc)	8	11	14	10
Sitting services	10	8	10	10
Residential care	4	2	5	4
Community transport	11	6	8	10
None	**35**	**30**	**28**	**33**
Other	10	18	11	11

Table 4.8 Providers of the services currently used

Source: CES Survey, University of Leeds 2007.

	England	Wales	Scotland	All
QUESTION: Who provides these care services? N=	946	206	290	1442
(% of carers identifying:)				
Social Services	42	54	51	46
GP / NHS	23	16	19	21
Voluntary organisation	13	12	21	15
Private care provider	12	13	9	12
Someone employed through Direct Payments scheme	8	9	6	8
Other	2	6	3	3

Table 4.9 Types of services carers would like
Source: CES Survey, University of Leeds 2007.

	England	Wales	Scotland	All
QUESTION: What other type of services would you like to have available? N=	946	206	290	1442
(% of carers identifying:)				
Domiciliary / Home care	19	13	14	17
Day centre	13	9	11	12
Specialist / nursing care / palliative care	8	9	9	8
Community mental health services	9	7	9	9
Respite care	22	27	23	23
Carer's services (carer's breaks etc)	22	32	26	24
Sitting services	21	32	20	22
Residential care	7	9	5	7
Community transport	15	12	16	15
Any of the above	**60**	**62**	**58**	**60**
None	20	12	17	18
Other	12	11	13	12

Table 4.10 Carers' views about limitations on use of services
Source: CES Survey, University of Leeds 2007.

	England	Wales	Scotland	All
QUESTION: Is your/their use of services limited by any of the following factors? N=				
(% of carers identifying:)				
Services are too expensive	34	34	35	34
Don't like the way services are organised	34	23	27	32
Don't like the people who deliver services	17	12	15	17
No suitable services in area	30	43	41	33
Services not reliable	31	28	30	31
Services not flexible	47	46	46	47
Services not sensitive to needs	44	44	38	43
Cared for person doesn't want to use services	44	45	44	44
Don't know what is available locally	37	38	35	37

3. Local arrangements for supporting working carers

The CES study focused in depth on the strategy and implementation activities of ten local authorities, two in Wales (Anglesey and Swansea), two in Scotland (East Ayrshire and Falkirk) and six in England (Hertfordshire, Leeds, Sandwell, Sheffield, Southwark, and West Sussex). These authorities were chosen to give coverage of a diversity of situations in which carers would be living, rather than because particular service structures were in place. They included localities of different size, nature and composition: an inner city London borough; county and district councils; authorities with high proportions of ethnic minority residents; areas which were rural and urban; and both affluent and poor areas. Two of the local authorities, Hertfordshire and West Sussex, were partners in the ACE2 Partnership[23], and had been proactive on carers' issues for some time. Each had also played a prominent national role in the unfolding developments in social care. Hertfordshire held Beacon Status[24] for its work on carers' services (2004, Round 6), sharing its learning nationally through the ACE partnership, and regionally with the East of England Regional Assembly to influence its 2007-2010 Social Inclusion Strategy. In 2005, in recognition of its development and implementation of carers' policies as an employer, it received the Working Families award for Employer of the Year (carers section), jointly with BT. West Sussex was one of the national pilots for Individual Budgets and has pioneered new workforce arrangements to improve support to those who rely on personal assistants to live independently (see CES Report 5 for further details).

In this section of the report, we examine both documentary evidence (an Appendix, detailing these sources, is available separately[25]) and what local authority interviewees[26] told us about their strategic approach to carers, the services being commissioned/provided for carers, and the challenges they faced in fulfilling their vision for local carers. It is clear from their organisations' Carers Strategies, and from what they told us, that within the broader agenda of supporting carers as partners in the delivery of social care, they were aware of carers' right to an independent identity which includes access to employment, and of their duty (in England and Wales) to facilitate and support carers in sustaining employment, or taking up new employment opportunities where they wished to do so. The range of activities for carers which they have developed over the past decade has responded to developments in national policy and to the legislation on carers and employment outlined in Table 4.4, albeit within the limits of resource constraints. All had made use of targeted funding[27] to achieve their goal of improving support for carers. Figure 4.11 summarises the range of activities undertaken by the CES local authorities as a whole.

Figure 4.11 Activities undertaken by local authorities in the CES study to support working carers

Approach to strategy and implementation

- Appointment of carers lead or other designation of carers' remit.

- Carers strategy groups set up to steer implementation and commissioning of Carers Grant.

- Carers involved as representatives, or consulted in planned activity, identifying gaps.

- Mainstreaming carers' agenda to other local authority departments.

- Building links between Adults' and Children's Services around carer issues.

Approach to Carer Involvement

- Information strategies.

- Consultation exercises conducted 'in-house' or by external partners.

- Training for carers to sit as representatives on strategic boards.

- Training and guidance for social care staff and health colleagues to engage with carers.

- Carers acting as trainers, reviewers and interviewers in social care processes and activities.

Supporting carers' employment and training

- Promotion of short breaks services to further carers' training and development opportunities.

- Information about programmes that support carers to return to employment.

- Advice services for carers in employment about benefits and employment rights.

- Engaging local employers about the needs of carers in employment, and the importance of flexible working patterns.

- Promotion of carer-friendly employment policies for local authority employees.

- Flexible use of Carers Grant to assist carers to access back-to-work training and career advices services and to increase their mobility so that a greater number of job opportunities can be considered.[28]

Partnership working

- Improving the experience, take-up and outcomes of Carers Assessments.

- Building the capacity of the voluntary sector to deliver services as contractors, and as experts.

- Strengthening referrals of carers from primary care and health services.

- Involving a wider range of partners beyond health and voluntary sectors; raising awareness of carers as a disadvantaged group in local social inclusion strategies.[29]

Resources allocated to supporting carers

- Protecting and allocating all Carers' Grant monies.

- Mobilising core funding to support carers.

- Improving the capture of information about carers and about outcomes for carers through new IT systems, staff training, and tailored assessment forms.

Supporting carers' employment and training

Despite new legal arrangements and a policy steer to support carers in combining work and care, most CES authorities conceded that progress had been slow. With no official monitoring requirements to exert leverage, they felt that action relied on changing the hearts and minds of key stakeholders. These included: social workers; those carrying out Carers Assessments; internal and external staff who provided information/advocacy services to carers; and local employers, including the local authority.

In the daily work of Adults' Services, interviewees told us that they had struggled to insert a focus on employment into systems and job remits which were set up to deliver care packages to users. Whilst several interviewees spoke of the work which their social work teams had done to support users to sustain or take up employment through the imaginative use of Direct Payments, none highlighted success stories for carers. Local authorities which employed dedicated staff to carry out carer's assessments appeared to have made some headway, as these individuals had been appointed with a brief to promote carers' employment. However, even with this perspective built in from the outset, carer employment support was not delivered by these officers; instead they referred carers to separate services, or a special project set up for this purpose. The type of specialist support included: advice about in-work benefits, cost benefit analysis of employment opportunities, courses to build confidence and support carers' interviewing and application preparation.

Several interviewees explained that the restrictions on budgets and the associated eligibility criteria meant that they were only able to support carers at the heavy end of caring; these individuals were often thought to be a long way from the labour market. In their experience, these carers were either unable to find local jobs which fitted around their caring commitments, or had few or no qualifications and low aspirations to seek paid employment. In most cases, it seemed usually to be assumed that these carers could not or did not want to work, and there was very little evidence that local authorities were asking carers of working age about their preferences, or their needs for support in accessing a paid job.

Several authorities had developed training courses which supported those carers whose preferred option was full-time caring, and were designed to formalise and accredit the skills and qualities they had developed in their unpaid caring role. As well as adding to their CV, these courses built up carers' self esteem and gave them access to a larger social network. This was particularly important for people who had been out of the labour market for a long time:

We have developed good links with [two local further education colleges] and they have been arranging a lot of courses to develop skills, personal development skills or special interest skills for carers, either to boost their confidence or prepare them for returning to training, education and employment… we helped [carers] with carers' support and costs and attendance as well.

(Senior manager, Type 1 authority[30])

Our interviewees considered that issues around carers' employment had also been difficult for their voluntary sector partners to grasp and deliver. A small number of local authority interviewees identified the problem as the sector's historical focus on lobbying for better services. They felt that some voluntary organisations had found it hard to broaden their view of carers' rights and needs to include their needs as employees and their right to earn an income; and that as a result they were often failing to raise the aspirations of the carers they were supporting:

When we start pressing buttons around employment issues and training, they're not things that necessarily our local carers keep banging on our door about. And it has been quite a struggle at times to engage local carers in the employment agenda and the [employment] project [which the authority is running]. It's been quite difficult to get them to make it their priority. It's more our priority I think in some ways. … they're catching up and they're realising obviously there's money attached to it and people are starting to think through what the implications are.

(Senior manager, Type 1 authority)

Some of the authorities had recognised in their current Carers Strategies the need to look at their own organisation's employment policies and

practices; as one of the largest local employers, their actions could improve the circumstances of a significant minority of carers. These policies were in place in a few of the CES authorities, but had taken place at a corporate level with no involvement of the Carers Lead. It was unclear to what extent emphasis had been given to effective implementation, and to promoting take-up of the policies by managers on behalf of carers in their teams:

[Human Resources are] developing a carers policy in relation to employment, so that carers could access flexibility in relation to their working hours… It [is] going to be part of the whole work life balance and flexibility working for any member of staff. It's part of a holistic policy, not just specific to carers.

(Senior manager, Type 1 authority)

In one case, actions had been taken within Adults' Services to raise the profile of employees with caring responsibilities, by setting up a support group:

We have had for a while within the social services a group for carers, staff carers. We will be looking to replicate that within the Care Trust, assuming there is an interest.

(Carers policy officer, Type 1 authority)

Talking to and influencing the practices of other local employers was seen by our interviewees as important, but they admitted that this was an activity which the organisation had not been effective in doing, not only Adults' Services. Our interviewees had focused their efforts on influencing the practices of their delivery partners in health services, and often this was detailed in their Carers Strategy. Only one interviewee mentioned an intention to reach other groups of employers:

Our Carers Steering Group have had some discussions that we need to strengthen our links with the local Chamber of Commerce. We all need to do more of that. I'm hopeful that the freeing up of my time [through the appointment of six carer support officers] will allow me to concentrate on those things… to encourage other local employers to have carer policies. It's a big action in our new strategy.

(Carers policy officer, Type 1 authority)

While interviewees alluded to the opportunities in the local labour market and the potential input of other services across the authority to adopt a focus on carers' employment, none had yet done any concrete work to identify actions for these areas, for example in the policy development of colleagues in regeneration, and economic development services, who were leading on job creation and workforce development across the locality.

Local carers' strategies and organisational approaches to implementation

As mentioned earlier, all the CES authorities had produced local Carers Strategies[31]. In the English and Welsh authorities these included an explicit commitment to uphold and support carers' rights to sustain their employment or to develop opportunities to enter paid employment. In some cases a profile of the characteristics of local carers was included, which served to highlight the significance of supporting working carers. Many included action plans identifying the steps they needed to take and the key actors who could make these happen.

All the CES authorities had identified a named officer(s) based in Adults' Services to lead on carer support[32]. In some cases this post had been in existence since the mid 1990s, created to respond to the *Carers (Recognition and Services) Act 1995*. The designation of the remit usually reflected the perceived political importance of carers' issues, and in some cases fell to individuals who already had responsibility for respite care. The CES authorities had gone about this in three main ways, shown in Table 4.12.

The seniority of the post and degree to which the remit was exclusive of other duties appears to be important for the focus on and the development of support for working carers.

For many of the carers' leads we spoke to, there were difficult pressures to resolve. They questioned the extent to which it was possible for them to mainstream an awareness of carers' needs and rights – in all dimensions – into the actions and plans of all staff in social services and the local authority a whole. As research in other areas of service delivery has shown[35], for an agenda to be effectively mainstreamed, significant investment is

Carers, Employment and Services in their Local Context

Figure 4.12 Designation of the carers' remit in CES authorities

Type 1 Carers remit given to a senior manager in Adults' Services

Has access to managers in all services areas (older people, learning disabilities, physical disabilities and mental health) and in Children's Services, enabling the needs of parent carers to be addressed.

Responsible for commissioning carers' services; supported by a dedicated policy officer (full time or on a FTE equivalent position) funded from Carers Grant.

Policy officer runs day-to-day coordination of partnership structures, monitors key performance indicators for carers (e.g. Carers Assessments), and is involved in writing the authority's carers strategy. In one case this officer's role was also structured around carrying out carers' assessments.

Includes: West Sussex, Sandwell, Hertfordshire, Falkirk, East Ayrshire, Anglesey, Swansea[34]

....

Type 2 Designated Carers Lead Officer post in Adults' Services

Post-holder has a single remit to facilitate the planning and delivery of carers' services to meet appropriate statutory duties.

Writes the Carers Strategy, manages the commissioning and monitoring of carers' services, and facilitates partnership working and carer engagement.

The post-holder acts as a 'catalyst' in work with other service areas. These include those within the authority and among statutory partners in the health service.

Carers Lead Officer is supported by and accountable to a Carers Strategy Group, which is the decision making body for grant allocation:

"My role is to devise a Carers Strategy, to manage the delivery of the strategy and to manage the consultation element of that. We have a Strategy Group. We do consultation events, and liaising with other partners who are part of the Strategy Group, which is multi-agency. I do quite a lot of chivvying and awareness raising and hassling, particularly with NHS bodies, to push them along." (Carers Lead)

Includes: Leeds, Southwark

....

Type 3 Mainstreamed responsibility for carers

Responsibility for carers is mainstreamed as a part of every senior manager's brief.

Allocation of Carers Grant rests with one manager, as part of their overall commissioning role.

"I coordinate the Carers' Strategy and commission services. The expectation is that all the other service areas will mainstream carers' support as part of their strategies. So we've got Learning Difficulties, Physical Disabilities, Mental Health in Adults' Services – and they all have responsibility for supporting carers within their own area." (Senior Manager)

Includes: Sheffield

needed in dedicated staff and resources to promote, train and encourage all members of the organisation to change the way they think and act. In all the CES authorities, but particularly in those relying on senior staff as 'figureheads' to sell and safeguard the carers' agenda (Type 1 and 3), insufficient resources have been available for them to fulfil a mainstreaming remit and to pursue all elements of the carer agenda, including carers' employment:

Other area managers have had similar [additional] responsibilities but probably not one which has as much work behind it, frankly – because of the diversity and complexity of the carer agenda and the profile that it has nationally and locally regarding service delivery and monitoring performance.

(Senior manager, Type 1 authority)

It's difficult, because I'm not just a Carers Lead and don't do anything else…. in terms of the amount of time that I can devote to carers, it's obviously affected by the number of other jobs that I've got.

(Senior Manager, Type 3 authority)

Some of our interviewees were worried that a key group of working age carers – parents of disabled children – were in some authorities falling through the net of carers' support provision, following the reorganisation of social care services into Adults' and Children's Services in line with the Gershon recommendations[36]:

We have passed over the parent carers into Children's Group Services, and trying to coordinate it [alongside Adults' Services] is, frankly, nigh on impossible.

(Senior manager, Type 1 Authority)

All leads had attempted, with varying degrees of success, to influence the thinking and action of colleagues in health services. We found examples where Carers Leads had delivered training to joint groups of staff about new statutory obligations towards carers, and had consulted them about the content and length of Carers Assessment forms. Very few expressed an awareness of needing to engage colleagues beyond health and social care in delivering the carers' agenda:

What I can't do is be responsible for environment, leisure, transport, – all the other services and how

they manage their support to carers, including the carers that they employ. We've got to find a way of making sure that there are key people within each of the separate departments who take a lead responsibility for carers. And that's yet to be decided [although] it's got [support] signed up from the top.

(Senior manager, Type 3 authority)

In Type 2 authorities it appeared that the dedicated Carers Leads had undertaken more activity targeted on the carers and employment agenda. This included conducting a survey of carers about their employment circumstances and service needs (distributed via local voluntary sector partners) and a Jobs' Fair for carers involving other statutory agencies and including local colleges and JobCentre Plus.

Approach to carer involvement: engagement, consultation and representation

Our interviewees stressed that the priorities outlined in their Carers Strategies had been identified by listening to carers' views. The CES authorities had sought out carers, both to engage them in using services and to consult with them in a more formal way: about the quality of existing services and the types of service still needed; and to involve them in decision making, as a representative voice on strategic and funding boards. Our interviewees in authorities with diverse populations confirmed that additional resources had been put into outreach work to engage black and ethnic minority carers. Very few authorities had identified working carers as a distinct consultation group, or taken action to boost carers' involvement using outreach workers. The nearest most authorities came to recognising carers at different stages of their own lives, as opposed to in different caring situations, was in their insistence on getting information to carers, at the point when they needed it, through a range of different messages:

It's not necessarily just about an exclusive message for carers, because carers aren't a static group. People move in and out of caring.

(Senior manager, Type 1 authority)

We've had a 'bus shelter' publication strategy; we've had stuff in the local media… one of the obvious places for information on caring, are things

like pharmacy bags. So we're going back to our communications team, and re-looking at how we promote identifying carers.

(Senior manager, Type 2 authority)

All our local authority interviewees spoke of the need to reach 'hidden carers', whom they defined as: those new to caring; those who do not see themselves as a 'carer'; and those who have made no contact with social services departments. In struggling to identify the profile of 'hidden' carers, most of our informants did not seem particularly aware that they were missing engagement with working carers, or that often the carers' perspectives and the carers' voices going unheard were those of the large number of working carers in their locality with whom they had no contact:

Our demographics suggest we've got 25,000 carers – but we only know, across the whole system, 5 or 6,000. So that was a setback – take it on the chin – we need to redouble our efforts.

(Senior manager, Type 2 authority)

Most of our local authority interviewees felt local voluntary sector organisations supporting carers represented a key channel of information to all carers, as they offered mechanisms such as members' newsletters, telephone help-lines, internet sites and leaflets displays in their centres. Few noted that these organisations too tend not to count many working carers among their clientele, and that working mainly through these agencies, they were unlikely to significantly increase their awareness of unmet need among the group.

Several authorities had held large (free) conferences for carers and practitioners, often timed to coincide with Carers' Week[37], and held during normal working hours. While some of these had included a focus on working carers and carers and employment issues, they provided only limited opportunities to engage with those carers in work (and indeed were not really designed to do so). Thus while conferences were seen as an effective way of giving different types of support for carers a high local profile, and efforts were made to engage local media and to attract carers not previously in contact with support agencies, they did not actively reach out to the large numbers of working carers not currently in touch with services.

GPs were regarded as a key group through which it was possible to access those new to caring. In several of the English and Welsh authorities, 'patient and carer involvement officers' had played an important role in setting up referral systems through GP surgeries. In Wales this was promoted via recent contractual requirements on GPs to keep a register of carers, and to inform social workers of their need for assessment in their own right; district nurses had also been important in enabling these referrals to take place. However in all this activity, the employment status of the carer was rarely accorded much significance.

Some authorities had invested their Carers Grant resources to employ outreach workers as part of social work teams or as employees of a local voluntary service provider. While these posts had an explicit remit to liaise with community leaders and groups as a way of making contact with individual carers, none held an explicit employment remit, although they were expected to pursue the authority's Carers Strategy, including its commitments relating to carers and employment. These investments were considered effective for reaching black and minority ethnic carers and were important in county localities, where local districts offered variable levels of infrastructure support for carers.

Some local authority interviewees felt using 'carers' literature would only ever attract those who identified with that 'label', and advocated the use of generic information. One authority had recently developed a checklist to help people in caring situations to 'self identify' and to articulate their needs more clearly, and had invested time to ensure they were not 'put off' from contacting support agencies through language which might make services appear inappropriate:

We've also introduced a checklist that an assessor, or the Carers' Centre, could give to a carer, which helps them to maybe start to realise the extent of what they do, and actually that they are a carer.

(Senior manager, Type 3 authority)

Local consultation activities had sometimes raised carers' awareness of the services available, or of local authority decisions, but our interviewees stressed that they were mainly designed to listen to carers' experiences and preferences, so that

their perspectives could inform funding decisions or service developments. Again it was striking that few mentioned the lack of a voice for working carers in most of these activities, or its implications:

It's an opportunity for people to say what's not working for them, for us to find out from them what the issues are. Often they're personal [experiences] – but if they're personal to one person, they'll probably be affecting a number of people, and we have made changes to things as a result of some of the consultation that we've done. It's a group where people get an opportunity to have a say and make a difference.

(Senior manager, Type 3 authority)

Representation remained a difficult problem for many of the authorities in our study. We found different aspirations: some were more concerned than others to engage 'grass roots' carers – individual service users who could base their judgement on personal experience. All authorities had representation from carers' organisations, and among some of these representatives there were those who were wearing 'two hats' as they were also simultaneously carers themselves.

We were given a number of explanations of why it was a 'struggle' to recruit carers to Carers Strategy Groups and Partnership Boards. Some interviewees had observed a limited understanding of and communication to the general population about the role of these groups; others considered that the composition of boards – 'mostly men with ties' – was off-putting. Our interviewees often had very low expectations of the carers they hoped to engage with, and spoke of the need to provide basic level training. There appeared to be very little awareness of the additional contribution carers who were skilled or qualified employees could make:

There is a pretty good ongoing piece of work which is around building the capacity of both users and carers to get engaged – whether it's Partnership Boards (PBs) or other Forums, and that training is ongoing. It talks about inducting people into the PBs themselves, it talks about how to get things onto the agenda, really helpful and quite basic, but I think right to be basic stuff, to help people engage.

(Senior manager, Type 1 authority)

Many interviewees recognised that the role of board member would be a difficult time commitment for many carers to make, however very few attempts had been made to try to understand the barriers for different groups of carers, particularly of working carers:

There's the sort of double whammy of – when you are a carer – actually having the time and resources to do something as involved and challenging as taking part properly in being on a partnership board – it is an issue. And I suspect that when you stop being a carer, you want to kiss goodbye to all that goes with being a carer.

(Senior manager, Type 2 authority)

Several interviewees likened Board membership to paid work, and asked why it was not possible to remunerate representatives appropriately without an impact on the state benefits they might receive; this lack of payment was sometimes seen as undermining the notion of the 'expert carer', yet also implied an expectation that carer representatives would be economically inactive:

I think the rules around [carers'] involvement and what effect it might have on benefits is still a real minefield. It would be really helpful if that could get sorted out at a stroke – if you're an expert carer, if you're representing carers on partnership structures, everybody's got partnership structures, everybody knows that they should have carers on them, then let's get rid of all that nonsense, and say – [we should pay them with no effect on benefits].

(Senior manager, Type 2 authority)

Partnership working: role of voluntary and community sector

It was clear from our evidence that voluntary sector organisations were key partners in achieving the ambitions laid out in the Carers Strategies; one senior manager described them as the authority's 'ambassadors to carers', without whom they would be unable to meet their targets:

It's dawned on us that if we're to make headway around individual budgets, self-directed support, particularly around older people; then whatever we have in place needs to have the confidence of carers, otherwise it will not apply. Personally, I don't

think it is possible to achieve our target numbers without the close involvement of the voluntary sector and carers.

(Senior manager, Type 1 authority)

In many instances partnerships with the voluntary sector were formalised through service level agreements or contracts following a tendering process. Carers' Centres and condition-specific carers' support organisations were contracted to deliver respite provision, emotional support and information services, and to coordinate local fora or to run consultation exercises. Many were also representatives on key strategic boards and had participated in fashioning the Carers' Strategy and its subsequent revision(s). Sometimes these organisations were the preferred provider because of the scale of their membership; in other cases they had specialist expertise about a health condition not available within the local authority. Many local authority interviewees had tapped into the knowledge, insights and ideas of their local organisations, and felt individuals in those organisations had played a very important role over a number of years in challenging and improving practices. One authority had explicitly recognised the expertise outside its own organisation, and had devised a non-prescriptive commissioning process which allowed organisations to suggest the best methods to meet a set of identified goals:

We asked organisations to put together bids that weren't specified by the local authority or health, but bids that were designed by them, that would meet the outcomes that we were seeking from the strategy and the priorities. [as a result] I think we've boosted our numbers of carers that are making use of those services – and I think that's demonstrable from the information that we have been supplying in the DIS[38] – and I think there's been much greater clarity about what our priorities are.

(Senior manager, Type 1 authority)

Drawing in the external knowledge of specialist organisations had sometimes proved difficult, due to the stringency of the local authority Best Value tendering/procurement processes, and the level of monitoring. Building the capacity of small local organisations has taken place alongside the allocation of budgets for carers' services.

A small number of local authority interviewees in England spoke of a tension between carers' organisations and carers. They felt these organisations had effectively become part of the local authority system and were now less able to articulate an independent view. This fuelled the desire to connect with authentic 'grassroots' carers[39].

Partnership working: health services

Our local authority interviewees emphasised the key role health colleagues play in a carers' journey, whether from hospital diagnosis or discharge, or from the need for nursing care and services at home, and they were aware that often, their health colleagues were making key decisions about the services which carers need to have available. However, the focus of interviewees' relationship with health colleagues was often primarily on raising their awareness of carers' issues, and none mentioned any discussion about the particular challenges involved in working in partnership to provide effective support for employed carers.

In England, most of the interviewees felt their local Primary Care Trust (PCT) was failing to recognise carers as clients of services in their own right and as key partners in the delivery of care. Some felt the lack of joint 'ownership' of the carers' agenda was in part due to the allocation of Carers Grant to the local authority:

All the funding with the Carer tag attached to it comes through the local authorities. It doesn't really come through health. So in a sense – you aren't working with health on this. I don't think that's right.

(Senior manager, Type 1 authority)

I think we fail carers a lot in acute care settings. There is a disincentive for ward-based staff to ask probing questions about carers. Their interests are around delayed transfers, moving people out as quickly as possible. There's a lot of glossing over carers' needs. We try to influence that within hospitals, in terms of our work and discharge plans. (But) it doesn't feel (as if) there is an incentive in health to address that.

(Senior manager, Type 1 authority)

The main exceptions to this were in areas of chronic illness where the cared for person is not able to

articulate their wishes, giving greater powers of decision making to their carer. Here, the advocacy of voluntary sector organisations on behalf of carers was well established:

There's a specialist worker in the learning disabilities (LD) area who's working especially with older carers of people with LD, and has done a really fantastic job. Part of the brief has been about working with and talking to those carers about the inevitable – their death, what's going to happen to their looked after person with LDs. And I think mental health do a quite good job – they've got some quite coherent services.

(Senior manager, Type 1 authority)

In a number of the authorities, closer alliances had been formed between the local authority and the local PCT or Health Board (in Scotland and Wales). In these cases, this had given rise to jointly funded Carers Lead posts. However, closer working and joint financing was not a panacea, and many felt the culture of health provision still involved an exclusive focus on the patient, with the role of carers poorly recognised.

Resources allocated to supporting carers

'Carers Special Grant' was first introduced in England in April 1999 as an additional financial allocation to all local authorities, and is now known as 'Carers Grant'. The overall allocation has been stabilised at £185 million for 2006/7 and 2007/8, having been increased by £60m to £185m in 2005/6. Since late

2003, Carers Grant has ceased to be a ring-fenced allocation, although guidance is still issued to local authorities on the government's policy intentions in allocating this funding. In 2005/6 the guidance indicated that Carers Grant was intended to help local authorities to further develop innovative, high quality carers' services including: breaks for specified groups of carers; and pragmatic approaches to Carers Assessment, taking this forward using the Single Assessment Process. Emphasis was placed on better consultation processes with carers and stakeholders about the strategic planning of services and about how the Carers Grant would be spent locally. Funded activity was meant to advance the provisions of the *Carers (Equal Opportunities) Act 2004*. In 2005/06 the Commission for Social Care Inspection's (CSCI) assessment of adult social care performance[40] noted that an average of 9% of carers were receiving specific carers' services and 35% of councils had a voucher scheme enabling carers to take flexible breaks under their own control. It should be emphasised that Carers Grant does not represent all spending on services which support carers. As both carers and service providers told us, high quality services to users, funded out of local authorities' Adults' Services and Children's Services core budgets, are also extremely important in supporting carers.

In Wales, a statutory basis for payments to local authorities of the 'Carers Special Grant' was established in 2000. The grant rose from £3 million to £4.6 million in 2003 when it was renamed the

Table 4.13 CES local authorities (England): Carers Grant allocation 2004-2006

Source: Department of Health, Carers Grant 2004/5 Guidance; Determination of a grant under Section 31 of the Local Government Act 2003: Carers Grant for 2005/2006, Department of Health, Crown Copyright 2005. Latest available figures.

Local Authority	Total Carers Grant (£s) 2004/5	Children's element (£) 2005/6	Adults' element (£) 2005/6	Total Carers Grant (£) 2005/6
Hertfordshire County Council	2,342,763	526,570	2,929,669	3,456,239
Leeds City Council	1,807,717	516,911	2,135,539	2,652,450
Sandwell Metropolitan Borough	942,844	275,932	1,111,577	1,059,958
Sheffield City Council	1,520,588	383,670	1,839,384	2,223,054
Southwark London Borough	1,195,294	637,921	1,157,217	1,795,138
West Sussex County Council	1,640,014	342,577	2,056,420	2,398,977
England Total	**125,000,000**	**37,000,000**	**148,000,000**	**185,000,000**

Table 4.14 CES local authorities in Wales, allocation of Carers Grant Scheme and Mental Health Carers Grant (MHCG) since inception

Source: Department for Health and Social Services, Welsh Assembly Government. Latest available figures.

Local Authority	Carers Grant Scheme (£s) 2005/06	MHCG (£s) 2006/07	MHCG (£s) 2007/08
Isle of Anglesey County Council	144,401	73,606	97,660
Swansea City & County Council	490,082	246,744	328,245
Wales Total	**8,897,574**	**3,000,000**	**4,000,000**

'Carers Grant Scheme'. It has continued to increase year on year. In 2006, carers of people with mental health problems were singled out for additional support, in the form of a £3 million 'Mental Health Carers Grant'. Intended to support carers of people with dementia particularly, the fund is also open to carers of people with mental health conditions that co-exist with other disabilities or people with other mental health conditions. Local authorities are able to use their allocations to support a range of services; to provide carers with information, mutual support, leisure opportunities, respite at home or in residential settings, and crisis management arrangements. The Minister for Health and Social Services has recently extended the Mental Health Carers Grant to include the provision of emergency respite services for <u>all</u> carers, increasing funding by £1 million in the year 2007 until 2008 when a review is planned to take place.

In Scotland, funding allocated to local authorities following the launch of the Strategy for Carers has been in the form of a £10 million Grant Aided Expenditure (GAE) allocation to develop more flexible services for carers, including respite care at a local level. This funding has not been ring-fenced, but has continued to be increased each year since 1999. The only allocation from the Scottish Government made especially for carers came recently, in June 2007, in the form of a single grant of £400,000 to support a young carers' festival and to develop training for carers in the skills they need to carry out their caring tasks. At the local level, it is unclear how GAE has been divided between services such as carers' centres and respite, in its many forms, as most authorities have not been required to report this level of detail to the Scottish Government. However, in general, most authorities have

established carers' centres/projects where they were not already in existence.[41]

Official local authority returns about users of their services and the assessments they undertake provide a comparable source of data about the resources allocated to supporting carers in the localities studied. As data for England, Wales and Scotland are not available in exactly the same form, they are presented here in separate tables (Tables 4.15-4.19).

In the six English authorities included in our study, the official data suggest large variations between authorities, and, at the national level and locally, a focus in the conduct of assessments and in the provision of services on only a small minority of all the carers known (from the 2001 Census) to be resident in the locality. Our CES data presented in this report suggest that it would be quite wrong to assume that those not in touch with the assessment and service provision process do not need or want support, or have only very light caring duties, or that assessment and services only affect carers with the heaviest caring responsibilities. Our evidence in fact indicates that many working carers need and want better support and services, including more suitable services for those they care for, and that many of them do not know how to secure these, are poorly informed about what is available, lack confidence in the ability of statutory agencies to respond quickly and appropriately to their situation, and may be at risk of having to give up work in order to care. We need to note in interpreting this data, however, that the large variations between authorities almost certainly reflect differences in reporting procedures and in the interpretation of official guidance, and that it is probably unwise to use them to judge the

Table 4.15 Carers Assessments and Services 1st April 2005 - 31st March 2006

Source: Community Care Statistics 2005-06: Referrals, assessments and packages of care for adults, England, The Health and Social Care Information Centre.

Notes: * <6, ** estimated from available data, *** missing data, columns may not sum due to rounding of the data.

We share the concerns of some of the local authorities included in this study about the comparability and reliability of these data, as there appear to be some differences in the interpretation of official guidance on how to prepare their returns, both in terms of what should be included/excluded and in terms of the time period for which data should be included. The figures given here are taken from official, published sources.

	Hertfordshire	Leeds	Sandwell	Sheffield	Southark	West Sussex	England
Total number of carers recorded in 2001 Census	95,740	70,199	30,086	55,940	18,367	73,338	4,854,731
Total number of carers assessed and reviewed	3,950	1,410	1,340	2,870	2,310	5,210	388,000
Carers assessed or reviewed separately	980	630	1,110	480	2,310	500	91,000
Carers assessed or reviewed jointly with client	2,270	460	220	2,370	0	4,540	247,000
Carers who declined assessment	700	320	10	10	0	180	49,000
Number of carers' assessments and reviews undertaken by age - ALL	3,250	1,090	1,330	2,860	2,310	5,030	339,000
<18	10	0	10	0	140	10	4,100
18-64	1,500	370	480	1680	1,560	1,350	169,000
65-74	690	220	130	580	360	560	66,000
75+	1,050	500	390	600	250	3,110	100,000
Age unknown	0	0	320	0	0	0	0
Number of carers receiving services after assessment or review	3,250	1,090	760	1,760	2,120	1,610	284,000
Receiving breaks/ carers specific services	1,750	860	520	1,750	900	1,290	142,000
Receiving advice and information only	1,460	220	250	10	1,210	330	142,000
Number of carers receiving services after assessment or review by age	3,250	1,090	760	1,760	2,120	1,610	284,000
<18	10	0	*	0	110	*	3,700
18-64	1,500	370	380	1,080	1,420	460	141,000
65-74	690	220	70	350	360	160	55,000
75+	1,050	520	130	320	230	1,000	84,000
Age unknown	0	0	80	0	0	0	0

relative performance of the authorities included in the CES study. The fact remains, however, that in the year 2005-6, the numbers of assessments of carers of working age were very small indeed (169,000 in the whole of England) (Table 4.15).

The official data for England also show that, following their Carers Assessment, 84% of carers received 'services'. However this category includes those who were given advice and information only, and in fact (following their assessment) only about a third of carers assessed in 2005-6 received a carer's break or specific service (142,000 out of 388,000, or 37%). Almost all of the English authorities in the CES study show a better performance than the English average on this measure, with Sheffield and Leeds both reporting that they provided a specific service or break to over 60% of the carers they assessed.

Data for carers' assessments and their outcomes is also available showing the client group of the person cared for. Again, although we are using officially published sources here, we have concerns about the comparability and reliability of these data, which were shared by some of the local authorities concerned. This shows that in England about two-thirds of assessments were of carers supporting people with a physical disability, frailty or sensory impairment, (38% of whom received a service). Of those assessed in 2005-6, about half of the 48,000 carers in England supporting someone with mental health needs and a similar proportion of the 31,000 carers supporting someone with a learning disability, received a specific break or service following their assessment (Table 4.16). For our selected localities, Tables 4.17-4.19 show details of domiciliary care, community-based services and direct payments arranged through local authorities in England, Wales and Scotland. These tables show the volume of home services, the number of clients being supported in different ways, and show recent, short-term, trends (but do not include services provided to children).

Table 4.17 shows that, in England as a whole, only about 25% of contact hours are supplied directly by the local authority. We can also see that only about 30% of all English households receiving home services get them directly from their local authority. This is in line with general trends towards outsourcing of these to independent service providers[42]. The picture nevertheless varies greatly between authorities – with Southwark at one extreme no longer providing any such services in this way, and Leeds at the other (in our sample) still doing so for 75% of households. Overall, Welsh authorities supplied 50% of contact hours directly through local authorities, and this was the figure in Swansea, one of our selected localities. However in Anglesey, our other Welsh authority, 95% of contact hours are provided by the local authority (Table 4.18). Parallel data are not available for Scotland.

In England, the number of *contact hours* of home help and home care per 10,000 households rose by 5% between 2005 and 2006; again there was variation between the CES authorities (Table 4.17). In Leeds this figure was 11%, while in one authority (West Sussex) it fell by 13%.[43] This compares with overall growth on 3% in Scotland, but with both our selected Scottish localities showing much higher increases (Table 4.19). (Comparable figures not available for Wales.)

By contrast, the number of *households* (per 10,000 households) receiving such help in the period 2005-6 fell slightly in England (-2%), but varied between the selected localities, from -12% in Leeds, to +7% in Southwark (Table 4.17). Comparable data is not available for Wales and Scotland.

In 2005-6, almost 40,000 people (37,000 in England, 907 in Wales and 1,829 in Scotland) were receiving Direct Payments. Users of Direct Payments are thus a very small proportion of all service users. In our ten selected localities, in 2005-6, Sheffield had the highest number of Direct Payments clients (730) and Anglesey the lowest (3), as shown in Tables 4.17-4.19.

Challenges facing local authorities

We asked our local authority interviewees to reflect on the challenges their organisations faced in continuing to develop and deliver services supporting carers. As well as their concerns about effective partnership working, notably with health authorities (an issue of particular concern in the English authorities), they identified four further areas, outlined below.

First, reaching carers, providing them with information and encouraging them to use (carers') services was still 'work-in-progress'. Currently,

Table 4.16 Carers Assessments and Services by client group 1st April 2005 – 31st March 2006

Source: Community Care Statistics 2005-06: Referrals, assessments and packages of care for adults, England, The Health and Social Care Information Centre.

Note: * <6, ** estimated from available data, *** missing data, columns may not sum due to rounding of the data.
See also note to Table 4.15 about data comparability and reliability.

	Hertfordshire	Leeds	Sandwell	Sheffield	Southark	West Sussex	England
Numbers of carers assessed and those receiving services or information, by client group of cared for person							
Physical disability, frailty and sensory impairment – Carers assessed	2,400	700	800	1,660	***	3,200	247,000
Receiving breaks or carers specific services	1,300	600	200	700	500	800	95,000
Receiving advice and information only	1,100	200	100	10	700	200	110,000
Mental Health – Carers assessed	500	300	430	330	***	310	48,000
Receiving breaks or carers specific services	300	200	300	300	300	200	23,000
Receiving advice and information only	200	40	20	0	400	0	18,000
Learning Disability – Carers assessed	170	30	40	700	***	430	31,000
Receiving breaks or carers specific services	200	30	10	700	30	100	16,000
Receiving advice and information only	0	10	0	10	50	40	10,000
Substance Misuse – Carers assessed	0	0	0	0	***	10	2,700
Receiving breaks or carers specific services	0	0	0	0	0	0	1,900
Receiving advice and information only	0	0	0	0	0	0	500
Vulnerable People – Carers assessed	130	70	70	50	***	1,100	10,900
Receiving breaks or carers specific services	30	50	20	10	30	200	6,100
Receiving advice and information only	90	20	10	0	30	70	3,000
% carers receiving services following assessment or review	100	100	57	62	92**	32	84

Table 4.17 Domiciliary Care, Community-Based services and Direct Payments – ENGLAND

* Community Care Statistics 2006, Home Care Services for Adults, England, The Health and Social Care Information Centre – Figures relate to survey week in September 2006, **Community Care Statistics 2005-06: Referrals, assessments and packages of care for adults, England, (1st April 2005-31st March 3006) The Health and Social Care Information Centre, *** Data either missing or zero in current or pervious year, ~ These figures may contain anomalies as the figure for home care delivered by the local authority includes services delivered to residents of supported housing, for example where a resident with a learning disability has their own tenancy.

	Hertfordshire	Leeds	Sandwell	Sheffield	Southark	West Sussex	England
HOME SERVICES FOR ADULTS*							
Contact hours provided and households receiving home help and home care, by provider							
Contact Hours All	74,040	43,030	22,705	50,375	22,595	34,695	3,738,500
Local Authority	23,530	23,480	11,060	16,375	0	7,870	920,060
Independent	50,530	19,550	9,315	34,000	22,595	26,830	2,818,440
Households provided with services**							
All	7,465	4,480	2,140	4,525	2,005	3,405	345,770
Local Authority	520	3,360	645	1,820	0	955	104,485
Independent	6,945	1,270	1,670	2,930	2,005	2,485	253,340
Number of clients	7,635	4,630	2,180	4,525	2,065	3,410	359,240
Households receiving intensive service**	1,625	1,095	680	1,535	720	1,560	100,130
Contact hours of home help and home care per 10,000 households (% change 2005-2006)							
All	1,760 (+4)	1,427 (+11)	1,957 (+1)	2,315 (+3)	2,135 (+6)	1,081 (-13)	1,828 (+5)
Local Authority~	559 ***	778 (+3)	283 (-21)	752 (-10)	0 ***	245 (-13)	450 (-3)
Independent	1,201 (-29)	648 (+22)	1,684 (+6)	1,562 (+11)	2,135 (+6)	836 (-13)	1,378 (+7)
Households receiving home help and home care per 10,000 households (% change 2005-2006)							
All	177 (-2)	149 (-12)	185 (-1)	208 (-1)	190 (+7)	106 (-6)	169 (-2)
Local Authority~	12 ***	111 (-16)	56 (-21)	84 (-17)	0 ***	30 (-19)	51 (-12)
Independent	165 (-8)	42 (-3)	145 (+5)	135 (+9)	190 ***	77 (-1)	124 (+1)
COMMUNITY-BASED SERVICES AND DIRECT PAYMENTS**							
No. of clients receiving community based services	19,280	21,980	8,350	14,810	6,870	21,170	1,494,000
No. of clients receiving community based services from ethnic minority groups	640	1,090	910	970	1,640	260	79,000
No. of clients receiving Direct Payments	490	170	190	730	210	310	37,000

Table 4.18 Domiciliary Care, Community-Based services and Direct Payments – WALES

*Source: *Volume of day and domiciliary adult services 2006 (from Local Government Data Unit – Wales, accessed 21/06/07)*
*** Adult homecare service intensity analysis 2005-06, *** Clients aged 18+ on the book to receive community-based services on the last day of the period 2005-2006 Note: Data on carer's assessments and services are not currently published for Wales.*

	Anglesey	Swansea	WALES
HOME CARE*			
Contact Hours All	318,793	675,268	12,800,417
Local Authority	301,581	336,826	6,386,373
Independent	17,212	338,442	6,414,044
% contact hours supplied by the LA	95	50	50
Number of clients receiving home care aged 18+ (in the survey week)**	698	1,830	25,161
Number of clients receiving 10+ hours of homecare per week + (in the survey week) ** (%)	177 (25%)	790 (43%)	7,390 (29%)
The rate of older people (aged 65+) help to live at home per 1,000 population aged 65+	66.82	56.46	85.54
The rate of older people (aged 65+) receiving homecare per 1,000 population aged 65+	47.96	29.47	40.71
COMMUNITY-BASED SERVICES AND DIRECT PAYMENTS***			
No. of clients receiving community based services	1,818	8,184	81,780
No. of clients receiving Direct Payments	3	50	907

Table 4.19 Domiciliary Care, Community-Based services and Direct Payments – SCOTLAND

*Source: * Home care Scotland, 2006, Statistical Release, Scottish Executive National Statistics Publication (accessed via the Scottish Executive website on 21/06/2007), ** Distribution of Home Care Hours Received, by Local Authority, 2006, *** Direct Payments Scotland 2006, Statistical Release, Scottish Executive National Statistics Publication (accessed via the Scottish Executive website on 21/06/2007).*

	East Ayrshire	Falkirk	Highlands	SCOTLAND
HOME CARE*				
Hours of service provided or purchased by the LA	22,593	19,364	15,875	604,081
Change since 2005	+19%	+34%	-1.4%	+3%
Number of clients receiving home care (in the week beginning 31st March 2006)**	1,859	2,325	2,633	70,657
Change since 2005	+6%	+7%	-5%	-0.6%
Number of clients receiving 10+ hours of homecare per week (in the survey week) ** (%)	749 (40%)	535 (23%)	435 (17%)	18,324 (26%)
No. of clients receiving Direct Payments***	36	58	194	1,829

the level and quality of Carers Assessments, as a gateway to services, was capturing only a small minority of local carers. Resolving the tension between supporting personal choice in a competitive marketplace of local services, on the one hand, and undertaking professional assessment of needs and risks in order to identify appropriate packages of care, on the other, was problematic. Carers Assessments are potentially a prime vehicle for identifying ways of improving the support available to working carers – not only, or even mainly, through identifying ways of supporting them directly (e.g. through respite and breaks), but also through delivering services to those they care for in more flexible, sensitive and situation-specific ways. One way of meeting this challenge could be for local authorities to reach out to local employers and to consider conducting assessments in the workplace or running information sessions about caring and Carers Assessments in co-operation with human resources departments.

Second, some local authorities were questioning how best to commission *culturally appropriate* services for small minorities. They felt caught between a historic approach which involved funding specialist, 'building-based' services to meet the needs of particular groups, and a modern emphasis on services delivered in the home which are sensitive to everyone's preferences. Most authorities are not providing a service which targets working carers among their local ethnic minority population groups, although there is now robust evidence of the greater likelihood among some ethnic minority groups of being a carer at younger ages and when in paid employment (as demonstrated in CES Report 3).

Third, many interviewees said that the employment agenda for carers was moving forward only very slowly, despite being underpinned by new legislation affecting carers in England and Wales in 2004 (see earlier in this report), and by changes to employment legislation dealing with flexible working. Although they were providing specialist benefits and employment rights advice, and courses to accredit caring skills and to support entry to employment and education, the challenge of reaching carers in work, beyond those working as local authority employees, has tended to be addressed only through pilots, special projects and short-term initiatives. Given the

growing importance of the working carers' agenda, it is crucial that all agencies with responsibility for supporting employers, employees and carers work together to find effective solutions and to help working carers to identify as carers, seek the support they need, avoid undue stress and damage to their health and careers, and obtain the flexible, tailored services they need to meet their own specific caring situation. There are emerging opportunities in the areas of local regeneration and local strategic planning[44] into which a focus on carers' employment could be inserted, as demonstrated by the Hertfordshire ACE project (described on page 37).

Fourth, our interviewees questioned the adequacy of resources. Carers Grant, and similar funding allocations had, in their view, been a very important and effective catalyst for service development, yet these funds represented a 'drop in the ocean' in achieving the transformation of services needed by working carers. Some were concerned about whether funding of this type would continue and about how to protect such funds as budgets specifically for carer support. Some argued that until a carers' perspective was adequately embedded in the thinking of all social care and health staff, core funding which supported services for users would not necessarily be allocated in ways which best support carers. But the real challenge related to the future and to the wider resources available to those working in social and other local services. This challenge arises from the need to provide a range of support and services needed to assist working carers and those they care for in the context of growing demand for care, among both older and younger people, as discussed in the opening section of this report.

Best practice and innovation in supporting working carers

We conclude this report with a selection of examples of new practices and models which the authorities taking part in this study had developed to support carers, and in particular those among them who are employed or trying to combine work and care.

Identifying and informing working carers

East Ayrshire Social Services have developed a new initiative to target information about carers' services to carers working for local large employers. Information provided by the local Carers' Centre will be included on individuals' payslips. This is seen as a good way of reaching all members of the workforce, as other communication channels can be exclusive – for example, communication via email does not reach a large number of employees in elementary and lower-skilled occupations who often do not have access to a computer at work. In the first instance information will be sent to employees of East Ayrshire Council, and to NHS Ayrshire and Arran.

The payslip campaign has been underpinned by a number of additional practical forms of help for working carers: East Ayrshire Council has developed a 'Carers' Employment Pack' explaining carers' rights and entitlements. The Carers' Centre has worked closely with ten of the largest local employers to ensure that young carers progressing into employment are appropriately supported and that their situation is understood. Home visits and evening appointments with Carers' Centre staff can be arranged for carers in employment.

Using a similar approach, Swansea Carers' Week and Carers' Rights Day 2005 was publicised on **City and County of Swansea Council** payslips. The County Council has found that an effective way of raising awareness of carers' issues among its own staff has been to hold information events in its County Hall and Guildhall. The Swansea Carers' Centre has worked with one of the largest local employers, the DVLA, mounting an information display in the DVLA offices about carers' rights and entitlements, which staff have been encouraged to visit during their lunchtimes.

Employees of **Sandwell Metropolitan Borough Council** working in Adult and Community Services are offered the opportunity to join a Staff Carers' Group (mentioned earlier in this report). Open to all carers, employees' attendance is permitted during work time. The group meets on a quarterly basis to provide mutual support and offers a varied information programme which has included health improvement activities and updates on recent policy developments.

Promoting choice and control of services to working carers

West Sussex County Council has been leading a project, within the ACE partnership, targeting employed carers, and looking at the role which Direct Payments can play in enabling users and carers to purchase the services they want to suit the needs and routines of *both* their lives. This has been developed in partnership with the Independent Living Association. Services have included the development of brokerage to assist carers and users who are unable to take on the management of Direct Payments themselves, with training to help them think through the implications of independent living for the carer. On the supply side, co-operatives of care workers have been formed to provide cover for personal assistants at times when they are off sick or on holiday, thus enabling the user and carer to have continuous provision. Improved access and promotion of play-schemes for disabled children has also been undertaken to assist parents to sustain their employment or to consider training options.

More detailed information about this, and other aspects of West Sussex County Council's work through the ACE partnership, are given in CES Report 5, *Action for Carers and Employment: impact of the ACE partnership 2002-7*.

Involving working carers in commissioning and strategic planning processes

Sheffield City Council has recently developed an initiative supported by POPPS[45] to create a database of 'Expert Elders'. This offers a potential model which could be applied to working carers in the strategic and commissioning processes of Adults' Services.

Applications have been sought from individual service users and their carers aged 50 and over, to be listed as 'experts'. As part of the registration process, the local authority records ethnic background, skills and interests and the time commitment a person is willing to make. Training opportunities are promoted to enhance experts' skills if they so wish. Service teams across Health and Social Care have been encouraged to draw on those experts who have appropriate interests and knowledge when planning or reviewing service delivery:

We'll send out the pro forma saying – and what are the areas that you're interested in? So they can tick that they're interested in carers' issues – and funnily enough a lot of the carers have ticked different things for carers' issues, and a lot of the non-carers have ticked carers' issues. But they can tick whether they're interested in commissioning or evaluating contracts; whether they're interested in informed support, residential care. … We will then invite them to be part of steering groups or boards – or we'll send them paperwork. They can be involved as much or as little as they want to be, because not everybody wants to keep turning up to regular meetings – so it might be that we would send them a draft of something and say, 'what's your view on this'.

(Senior Manager, Sheffield City Council)

Practical support for carers wanting to work, or to change their employment arrangements

Hertfordshire County Council's project within the ACE partnership has developed tailored services for employed carers or carers wanting to work. A *Carers' Pre-Career Guidance Pack* was commissioned to help carers to explore all their options, including those they would not have considered (for example retraining or volunteering). Access was negotiated for carers to attend existing Back to Work courses run at local colleges. A Money Advice Unit is available to supply carers with calculations of their likely income, including the impact on benefits and the cost of additional services to replace them, on a case by case basis. Professional advice has been offered to carers in work who wished to make changes to their working arrangements. A Carer/Manager agreement form has been developed, with carers' input, which sets out the agreement reached, aiming to protect working carers from arbitrary changes owing to a change of manager.

Sandwell Metropolitan Borough Council funds the local Carers' Centre to run an Adult Guidance and Lifelong Learning Service. This service offers free, confidential guidance to carers on a one-to-one basis. Guidance can include leisure activities, job opportunities, training courses and careers advice. The service promotes opportunities to learn new skills, runs its own courses and holds information about locally run sessions, courses and events.

Delivering responsive respite care for working carers

Many of the CES authorities have prioritised the provision of respite services to allow carers to take short breaks from caring, in order to relax and also to pursue employment interests.

Since 2001, **Falkirk Council** has run a Short Breaks Bureau, with an annual budget of £273,000, to operate as a single co-ordination point for all short term respite care, incorporating at least one overnight stay for each client across the locality. Respite in Falkirk takes many forms, from residential overnight care, to sitting services, day trips and holidays. The bureau team book appropriate provision at the request of community care workers or individuals using Direct Payments, in much the same way as a travel agent might do. The advantage of a single service is that it maximises the use of all respite provision contracted by the local authority, and can be responsive to any regular or exceptional pattern of respite need:

All the respite breaks that are being arranged by the council, that people are getting financial assistance for, should come through us. What we've tried to do is to arrange flexible breaks for people, so that they can have the kind of respite break that they want. We do contract beds in care homes for people with physical disabilities, learning disabilities, mental health and older people and people with dementia. But we also spot purchase breaks and they can be any kind of break, providing it meets the needs as assessed by the community care worker, and that an appropriate risk assessment is done in relation to whether the person's needs are going to be safely met. Now that can be anything from somebody going over on holiday to Spain to going to a caravan, to going into a bed and breakfast accommodation, going on a bus tour. There's a whole variety of ways that we can arrange breaks. We've got a joint dementia initiative which is a council service as well, and they have recruited some family carers who will have people to stay with them to arrange a break in the carer's home. So there's a whole variety of different breaks that people can have.

(Senior Manager Falkirk Council)

Anglesey County Council has a similar objective, but a different delivery model as – unlike Scottish authorities – Welsh authorities have been in receipt of designated carers' funding to support carers' respite. Since the introduction of the Carers Special Grant, the Council has established a Flexible Purchasing Budget. This is used to commission a range of flexible support services to meet the specific assessed needs of carers from providers in the statutory, voluntary and independent sectors. This has enabled the Carers' Assessment and Reviewing Officer, who works alongside Social Workers from the specialist teams, to respond in an innovative and flexible manner: to agree Care Plans and services that provide emergency respite care; to give carers a meaningful break from caring and an opportunity to pursue their own social and leisure activities; to support them in their caring role; to provide evening and weekend breaks from caring; and to enable carers to attend education and training activities or remain in work.

Over the last 5 years, there has been a fourfold increase in expenditure on the Flexible Purchasing Budget and a substantial increase in the number of carers who receive support services. The provision of residential respite care specifically to support carers in the caring role and to provide them with overnight, weekend or 7-day breaks has increased fivefold. A small but increasing number of carers have been supported to attend training programmes provided by local further education colleges to promote confidence and develop skills related to their interests or to equip them to pursue formal education or return to the labour market.

Developing a strategic approach to supporting working carers, in partnership with key stakeholders

Hertfordshire County Council has led a substantial project within ACE 2, one part of which has been designed to improve the awareness and knowledge within the social care workforce of the *Carers (Equal Opportunities) Act 2004*. Case study examples of carers' circumstances were identified and embedded into a training programme which was supported by a specially developed DVD, *Working for Carers*. The DVD was produced using clips of carers speaking about what makes a difference to them. Most assessment and care management teams were trained by the project. New training packages for homecare and other private and voluntary sector staff have also been delivered.

Another important aspect of the Hertfordshire project has been improving inter-agency working and putting carers' employment into other partners' agendas. For example, under a new multi-agency strategy, work has been undertaken to:

• Make work-focused interviews through Jobcentre Plus more carer-friendly.

• Produce a *Guide for Care Managers* to help them signpost carers to other agencies who can provide employment services or access to training opportunities.

• Broaden the use of a next step *Carers' Pre-Career Guidance Pack* among voluntary sector partners, community based learning providers and libraries.

• Examine the opportunities to raise carers' employment issues with Primary Care Trusts, through the use of a Local Area Agreement target.

• Incorporate carers and employment targets into the East of England Regional Assembly's Social (Inclusion) Strategy Action Plan 2007-2010.

• Promote carers' access to adult learning through collaboration with the Learning and Skills Council.

Also as part of the ACE partnership, **Carers Scotland**, in partnership with a range of stakeholders from the public, private and voluntary sectors in Scotland, has developed a National Framework for Carers and Employment. This was produced to coincide with the implementation of the *Work and Families Act 2006*, which gives carers the right to request flexible working. The purpose of the document is to provide a resource which will help employers implement the new legislation, and to promote the development of alternative care solutions to enable carers to remain in or return to paid employment. Strong partnerships have been developed with individual employers, employers' organisations, and with health and social work services to disseminate the information and to implement change. The Framework has been complemented by the production of a powerful case study on DVD, which can be used as an awareness raising or training tool for health and social work professionals as well as HR Managers within commerce, business and the voluntary sector.

(More details of the work of Hertfordshire County Council and of Carers Scotland within the ACE partnership are presented in CES Report No. 5, *Action for Carers and Employment: impact of the ACE Partnership, 2002-7*).

Conclusion

In *Carers Employment and Services in their Local Context* our main focus has been on the services available to support carers of working age, and in particular those who combine unpaid caring with paid work. The importance of recognising that carers of working age want and need better services is underscored in our other CES Reports, which provide very detailed information based on a large sample of carers. It has also been highlighted in other recent research[46] and emphasised in the 2007 report of the *Commission for Social Care Inspection*, relating to the whole of England. This noted a gap between national policy aims and people's experiences, and drew attention to the fact that the services needed to provide good support for carers and users are patchy and limited, with most only getting help when they are in crisis[47].

We began the report by outlining the wider socio-economic and demographic context in which these issues need to be understood, summarising key policy developments in this field in England, Wales and Scotland, noting that some significant differences have emerged in the three nations since the introduction of devolved government.

Using evidence from interviews with 'key actors' in ten local authorities in England, Wales and Scotland, and from the CES survey of carers (contextualised in analysis of the 2001 Census and other data from official sources), the report has shown that significant new attention has been given to carers' issues in recent years by local authorities, often working closely with their partners in the voluntary sector. All the authorities studied had developed a local Carers Strategy, and most had developed new projects and services to support carers. Despite this, in general the progress in their work to support carers of working age, especially those combining work and care or wishing to do so, had been rather slow.

Their work had been affected by resource constraints and in some cases by difficulties in developing partnership approaches to carers with other agencies, but it also emerged that few authorities had turned their full attention to working carers, or had succeeded in identifying, consulting and supporting working carers, except in very small numbers. There was some evidence of authorities making assumptions about carers and work based not on listening to working carers, but on their experience of those carers, usually providing care in demanding situations and not currently in work, who were in touch with their services or with local voluntary organisations supporting carers. Few, if any, authorities had developed really effective strategies for identifying working carers across the whole spectrum of employment situations (as we show in CES Report 2 *Managing Caring and Employment*, carers work in all employment sectors, public, voluntary and private, many without accessing services), or for consulting with them about the

support and services they need to combine work and care.

Most of the authorities studied nevertheless developed new provision for carers which was valued, innovative and delivering real benefits for those carers involved. This included a range of new approaches, many of which offer models which other authorities may wish to develop. Some were developing new strategic approaches to supporting working carers, in partnership with other key stakeholders, while others had begun to involve working carers in their commissioning and strategic planning processes. In certain projects the key focus was on promoting choice in and control of services to working carers. We also found examples which were delivering responsive respite care for working carers, practical support for those carers wanting to return to work, and help for working carers wishing to change their employment arrangements using their new employment rights.

The report also presented evidence from official data about service provision and assessments of need, the 2001 Census and the CES survey of carers, conducted in 2006-7. Here our analysis highlights both the scale of carers' unmet needs and the insufficiency of available support. As also noted in the other CES reports, there is an urgent need to tackle this situation at both the local and the national level, with carers fully involved in identifying the changes needed, and addressing resource issues. The UK government's commitment to develop and implement a new National Carers Strategy from 2008, based on the 'experiences, aspirations and priorities of carers themselves[48]' is therefore an approach likely to meet with widespread support.

The detailed policy implications of the new evidence presented in the report, and a full set of recommendations, are presented in CES Report 6 *Carers, Employment and Services: time for a new social contract?* There we stress the need for radical new thinking, and significant developments in service provision, to enable carers, in their many different circumstances and situations, to integrate their caring roles with their everyday lives. As we have seen in this report, the contemporary 'carers and employment' policy agenda is a very compelling one, thanks to the particular combination

of demographic, labour market and technological developments which Britain faces. If in the future working carers are to sustain their caring roles and also to make their contributions in the workplace, while avoiding damage to their own health and wellbeing, it will be essential for strong emphasis to be placed on the development of better support and services which take full account of the realities of their working and caring lives.

Appendix 1 Research Methods

The Carers, Employment and Services (CES) study (2006-7) was directed by Prof. Sue Yeandle and based at the University of Leeds. Here we outline the methods used in collecting data for this report (CES Report No. 1). Fully described in CES Report No. 6, they included:

- A national survey of carers (1,909 responses), targeting carers of working age.
- In-depth interviews with carers in ten selected localities in England, Wales and Scotland.
- Interviews with 'key informants' in the selected localities.
- Documentary analysis of publicly available sources and other relevant materials.
- Detailed statistical analysis of the 2001 Census.

The CES Survey of carers and follow-up interviews

The survey questionnaire was specially designed for the project and tested in a range of pilots. It was distributed to respondents in two formats, a postal (paper) and an electronic version, and collected information about carers' personal/demographic characteristics, their caring responsibilities and the services they were accessing, their employment and financial situation, and their perceptions and attitudes. In the ten selected localities (which targeted both urban and rural carers, White and Ethnic Minority carers; and carers in affluent and deprived areas), the questionnaire was distributed via major employers, carers' organisations and other voluntary groups, social care and health services, and at relevant events such as conferences on carers' issues. The questionnaire was also made available on the websites of a number of relevant national organisations, and some employers distributed it electronically outside the target localities. Our aim was to access carers of working age, with a special focus on those who were in employment, wanting to work alongside their caring role, or had given up work to care. All questionnaire responses were entered in an electronic database and subjected to detailed analysis. Researchers selected 134 interviewees on the basis of information supplied in the questionnaires, and conducted face-to-face interviews with carers in a range of situations in each area. More details of these interviews are given in the methodological appendices of CES Reports 1-3.

In-depth interviews with' key informants' in the ten localities

'Key informants' in each locality were approached for a one hour face-to-face interview. They included the local authority Carers Lead and also senior officers with a carers remit. The interview schedule was structured to capture officers' perceptions of the strategic development of carers' services within their organisations since the national strategies for carers had been launched. The interview also covered the processes of carers' assessment and engagement, and the local partnership structures and commissioning procedures which underpinned service delivery. Finally, officers were asked to reflect on what had worked well for employed carers and of the challenges which remained to be tackled. In addition, in some localities, a small number of interviews were undertaken by telephone and face-to-face, with local stakeholders who had played a prominent role in the development of their local carers strategy. The interview material was transcribed by the interviewer, using a template which focused on key issues relating to the project. Field-notes were included as well as verbatim quotations, and the completed templates were then subjected to a thematic analysis.
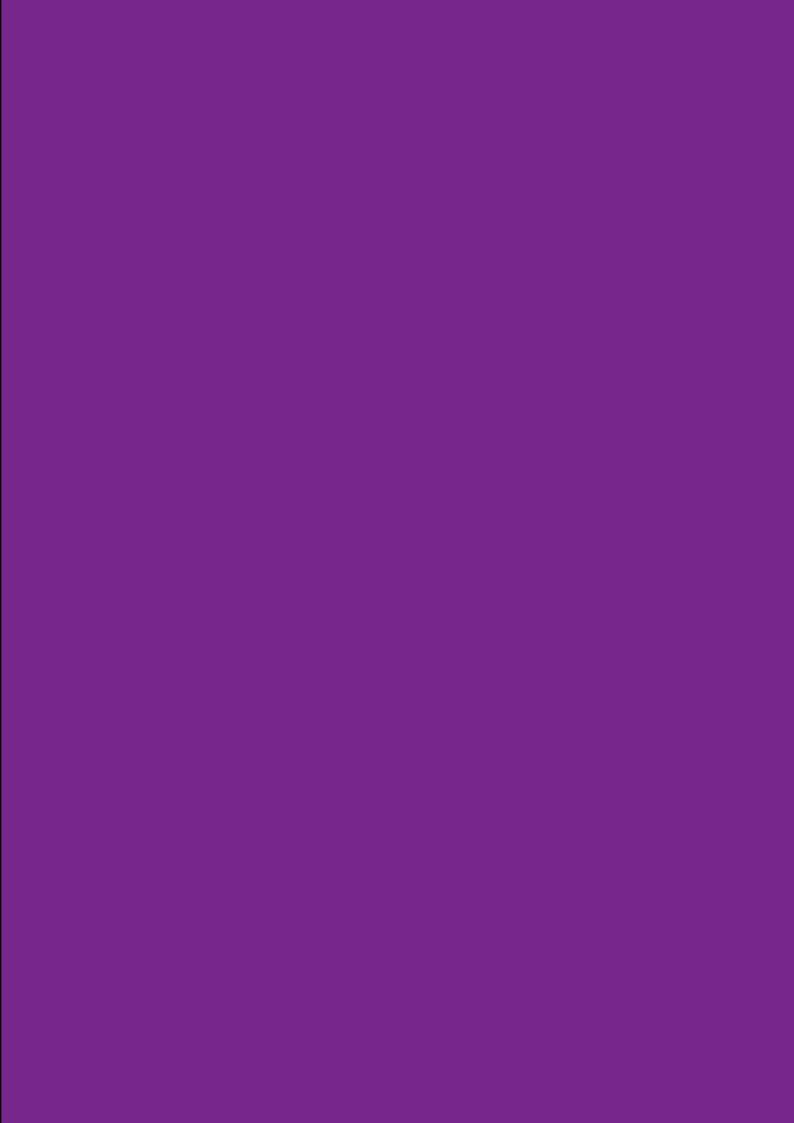
Notes

1. Many parent/carers of sick or disabled children nevertheless also have one or more dependent children who are unaffected by an illness or disability.

2. The *Carers (Equal Opportunities) Act 2004* refers to specific duties to support carers' employment, applied to statutory agencies in England and Wales. The *Community Care & Health (Scotland) Act 2002* guidance refers to employment being 'considered' during the assessment of carers providing a substantial amount of care on a regular basis: local agencies are thus under no statutory obligation to respond to carers' difficulties accessing or sustaining paid work and care.

3. More detailed information about carers and services in the ten localities considered in detail in the CES study is available in the *CES Locality Reports* which are part of the other output from this study.

4. A full description of the study methodology is available in CES Report No. 6 *Carers, Employment and Services: time for a new social contract?*. Appendix 1 to this report provides an outline of the main elements of the study relevant to the analysis presented here.

5. The 10 localities selected, all areas where a single local authority had responsibility for the provision of social care services, were: Hertfordshire; West Sussex; Southwark, Leeds, Sheffield, Sandwell, Falkirk, East Ayrshire, Anglesey and Swansea.

6. The question asked in the 2001 Census was: *'Do you look after or give any help or support to family members, friends or neighbours or others because of: long-term physical or mental ill-health or disability or problems related to old age?'*

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12. Buckner, L and Yeandle, S (2006) *Who Cares Wins: The Social and Business Benefits of Supporting Working Carers - Statistical Analysis: Working Carers: Evidence from the 2001 Census* London: Carers UK, page 11.

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[15] McCliment, B and Grove, K (2004) *Who Cares Now? An Updated Profile of the Independent Sector Home Care Workforce in England* London: UKHCA (United Kingdom Home Care Association) and Skills for Care.

Yeandle, S, Shipton, L and Buckner, L (2006) *Local Challenges in Meeting demand for Domiciliary Care – Synthesis Report*. Sheffield: Sheffield Hallam University.

[16] Yeandle, S, Bennett, C, Buckner, L, Shipton, L and Suokas, A (2006) *Who Cares Wins: The Social and Business Benefits of Supporting Working Carers*. London: Carers UK.

[17] *Carers UK* (formerly *Carers National Association*) has played a key role in lobbying for legislative/policy change, securing considerable all-party support. With other carers' organisations, such as *Contact a Family*, which has also engaged in lobbying and campaigning activities, and the *Princess Royal Trust for Carers* and *Crossroads (Caring for Carers)*, it has worked with local agencies and representatives of older, sick and disabled people and their carers, to raise the profile of carers and deliver appropriate information and services.

[18] Confederation of British Industry.

[19] The *Community Care and Health (Scotland) Act 2002*. In relation to new statutory rights for carers, guidance document CCD2/ 2003 states: *Carers are 'key' partners because they are different from other partners in the care-giving system in their status and their contribution. Carers are usually the main care-providers for the person they look after, but unlike other care-providers, they are not paid to provide that care. Carers generally have a close personal relationship with and commitment to the person they care for. For all these reasons carers play a unique role in the overall provision of care to the person they care for, and in care in the community as a whole.*

http://www.sehd.scot.nhs.uk/publications/CC2003_02full.pdf.

[20] Thirteen Individual Budget pilots were set up in English authorities in 2006. These aim to give people greater control over their own social care budgets by choosing the services which suit them best http://www.dh.gov.uk/en/News/DH_4123522.

[21] Some carers who responded to the CES survey lived outside of our 10 target localities. We have allocated their responses to one of the three nations, England, Wales or Scotland, in all cases where they provided sufficient information for us to do so.

[22] The commonly held distinction between sitting services, respite services and carer's breaks is that the first two are centred on the user's needs and the latter is for the benefit of the carer. Sitting services take place in the home for a short time period; respite care is delivered in a setting away from the home and may involve an overnight stay; carer's breaks may take either of these forms but can also be a period of supported time when the carer and cared for person go on holiday together. Respondents applied their own definition to these terms as they answered the questionnaire.

[23] The ACE National partnership, led by Carers UK, is working to support the inclusion of carers in training and work, funded by the European Social Fund's Equal Community Programme Initiative.

[24] Beacon status is awarded to English local authorities, following competitive application, in recognition of excellence and a willingness to innovate in a specified service area. http://www.beacons.idea.gov.uk.

[25] This Appendix is available electronically as a pdf file: www.leeds.ac.uk/sociology/research/circle.

[26] In the interests of our interviewees' anonymity, the names, job designations and organisational affiliations of those who provided us with interviews are not used in this report.

[27] Government funding in England (Carers Grant) and Wales (Carers Grant Scheme); in Scotland (as part of Grant Aided Expenditure) an allocation to local authorities for carers' services, including respite.

28 Powers under the *Carers and Disabled Children's Act 2000* give local authorities the scope to offer direct payments to carers in lieu of services. These can be spent flexibly to meet the carer's specific need, for example on transport costs or to buy specialist guidance/ training.

29 In England, Local Area Agreements provide an opportunity for carers' employment needs to be highlighted as a distinct set of actions to increase economic growth and the population's prosperity.

30 See page 25, *Table 4.2 Designation of the Carers' Remit in CES authorities* for an explanation of the three 'types' identified.

31 Sheffield's and Swansea's latest Carers' Strategies were due to be published in July 2007 and September 2007 respectively, as the CES study was concluding.

32 In accordance with the duties placed upon them by the *Carers (Equal Opportunities) Act 2004*.

33 As outlined in the guidance for the *Carers (Equal Opportunities) Act 2004 (England and Wales)* issued by SCIE. www.scie.org.uk/publications/practiceguides/carersguidance/essential.asp

34 These designations describe the CES authorities in the period when the research was undertaken. Subsequently a change of responsibility may have occurred. In a number of cases the designation which has been chosen is the closest 'fit' rather than an exact match.

35 Equal Opportunities Commission (1997) *Mainstreaming Gender Equality in Local Government: A Framework*, EOC, Manchester.

36 Sir Peter Gershon was commissioned in 2003 by the Labour Government to undertake an independent review to assess how the public sector UK wide could exploit opportunities for efficiency savings, so that resources could be released for front-line public service delivery.

37 *Carers Week* celebrates the contribution carers make to society. Carers' Week was started by Carers UK, and is run by a partnership of seven charities, including the Princess Royal Trust for Carers, Rethink and the MS Society.

38 DIS – *Delivery and Improvement Statement*. This formal return is required from English local authorities with statutory responsibilities for adult social care services by CSCI.

39 This was not found to be the case in Scotland, possibly because the carers' centres there had developed independently of local authority and health board funding, which now currently fund approximately one fifth of their activities.

40 In 2006/07, the *Commission for Social Care Inspection* (CSCI) has introduced changes in the performance assessment process for English local authorities, replacing Delivery and Improvement Statements (DIS) with a Self-Assessment Survey (SAS - document no. 038/07, published Feb. 2007) in order to work 'towards a set of indicators that reflects outcomes for service user/carers' CSCI *Social Carer Performance 2004/05*.

41 Source: information supplied by *Carers Scotland*.

42 Yeandle, S, Buckner, L and Shipton, L (2006) *Local Challenges in Meeting Demand for Domiciliary Care: Synthesis Report* Sheffield: Centre for Social Inclusion, Sheffield Hallam University.

43 West Sussex, which shows a below average performance, has significantly improved this percentage since 2005/06 by addressing recording issues; specifically the ways in which it captures information relating to carers whilst continuing to provide a wide range of support through direct access schemes delivered by the voluntary sector.

44 In England these opportunities include *Local Area Agreements*, which outline the priorities for a local area and are agreed by central government and the local authority and its key partners, in some cases making up the local Strategic Partnership. In Scotland and Wales, JobCentre Plus is already working closely with the Local Economic Forums and with Community First Partners respectively to take forward a local employment agenda.

[45] *Partnerships for Older People's Projects* (POPPS) programme funded by the *Department of Health*, being piloted in Sheffield.

[46] Carers UK 2007 *Real change, not short change: time to deliver for carers* London: Carers UK.

[47] Commission for Social Care Inspection (2006) *The State of Social Care in England 2005-6* London: CSCI.

[48] Ivan Lewis, MP, Parliamentary Under Secretary of State for Care Services, speech to the conference *Cash in hand: choice and control in services delivery*, London, 24 May 2007.

Finding out more

Carers UK improves carers' lives through information provision, research and campaigning.

This research was commissioned by Carers UK on behalf of the ACE National partnership, and part-funded under the European Social Fund's EQUAL Community Initiative Programme. To find out more about Carers UK, contact:

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