Supporting Carers:
The Case for Change

The Princess Royal Trust
for Carers

CROSS
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a positive partnership between The Princess Royal Trust for Carers and Crossroads Care

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1 Executive summary

1.1 The moral argument for supporting carers is clear and irrefutable. People who may be sacrificing their own hopes and dreams to care for a friend or relative deserve our support.

1.2 The three party leaders all echoed this sentiment in the televised debates during the General Election 2010. The Coalition Government has made commitments to improve support for carers, including £400m over four years through the NHS. The same moral arguments appear to have had less effect, however, at local level, where previous financial allocations for carers were, in many cases, used for other purposes.[1]

1.3 This report takes the argument beyond that of morality, but also demonstrates how using these allocations to increase support for carers also benefits the people being cared for, primary care trusts (PCTs), health commissioners, general practitioners (GPs) and councils. We provide evidence from randomised controlled trials (RCTs) and peer reviewed journals to show that increasing support for carers:

- ➔ improves health and wellbeing outcomes for patients and recipients of care;
- ➔ improves health and wellbeing outcomes for carers, who suffer disproportionately high levels of ill-health;
- ➔ reduces unwanted admissions, readmissions and delayed discharges in hospital settings;
- ➔ reduces unwanted residential care admissions and length of stays.

1.4 These are overwhelming reasons why budget holders in PCTs (and future health commissioners), who are focussing on Quality, Innovation, Productivity and Prevention (QIPP), and councils should increase allocations to support carers.

1.5 Furthermore, spending more on breaks, training, information, advice and emotional support for carers reduces overall spending on care by more than £1bn per annum, as a result of reductions in unwanted (re)admissions, delayed discharges and residential care stays.

1.6 We give examples of services – breaks, counselling, and training – that have shown success in helping carers to maintain their health and quality of life and that of the person they care for. These examples are mainly taken from The Carers' Hub (www.carershub.org), created by The Princess Royal Trust for Carers and Crossroads Care, which helps commissioners to audit, plan and facilitate a range of services for carers.

[1] Conochie, G (2010), 'Tough breaks for carers'. London: The Princess Royal Trust for Carers and Crossroads Care.

2 Government commitment to carers

2.1 In November 2010, the Government published 'Recognised, valued and supported: Next steps for the Carers' Strategy' which focuses on improving health and social care support for carers in England. Four priority areas for improvement were identified:

- ➔ supporting early self-identification and involvement in local and individual care planning;
- ➔ enabling carers to fulfil their educational and employment potential;
- ➔ personalised support for carers and those receiving care;
- ➔ support carers to remain healthy.

2.2 In the Strategy, the Government announced that £400m over four years (2011-15) would be included in allocations made to PCTs (and any subsequent commissioning bodies) to improve support for carers, including young carers.[2] It is not ring-fenced, but to encourage greater use of the money to support carers, the Government implemented three of the recommendations[3] that we made in previous reports:[4]

- ➔ PCTs must formulate plans and budgets with local authorities (LAs) and local carers' organisations;
- ➔ these plans and budgets must be made available to local people;
- ➔ the NHS Outcomes Framework has carers as an improvement area and the self-reported quality of life of carers will be monitored in each PCT area.

2.3 The Department of Health's (DH) social care grant to councils in England, the Carers' Grant, amounted to £256m in 2010/11. It was not ring-fenced, but the amount received by each council was published. The Government has confirmed that this grant will rise in line with inflation from 2011-15, but it will now go to councils through the general local government formula grant and amounts for each council will not be specified.[5]

2.4 The Government's commitment and guidance is welcomed, but comes at a time when the NHS is receiving, historically, low levels of financial growth and LAs are facing cuts in their overall budgets.

2.5 In such circumstances, the moral arguments and the clear Government direction may still not prove enough to ensure that local implementation will follow national intention. The following sections provide evidence of the beneficial impact of supporting carers to persuade local decision-makers that allocations made available to improve support for carers should be used for this purpose.

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[2]HM Government (2010), 'Recognised, valued and supported: Next Steps for the Carers' Strategy'. London: Centre of Information.

[3]Department of Health (2010), 'The Operating Framework for the NHS in England 2011/12'. London: Centre of Information. Department of Health (2010), 'The NHS Outcomes Framework 2011/12'. London: Centre of Information.

[4]See: Conochie, G (2010), 'Tough breaks for carers' & (2009) 'No breaks for carers' both London: The Princess Royal Trust for Carers and Crossroads Care.

[5]See Hansard 21st December 2010, Column 1296W. Paul Burstow MP, Minister of State for Care Services replying to a question from Tony Baldry MP.

3 Improve health outcomes for patients and people with care and support needs

3.1 Carers often provide the majority of care that would otherwise be the responsibility of health or social care professionals. Such carers need the appropriate knowledge and skills to care safely and in a way that promotes wellbeing for the care recipient. Carers, therefore, must be included in care plans and receive support to help them provide care, such as training.

3.2 There have been some studies looking at the impact of supporting carers on patient wellbeing, mainly within the area of stroke care. One RCT found that support for the family of stroke patients is linked with reduced depression amongst stroke patients (17% – 27%) and a reduced need for physiotherapy.[6]

3.3 Another RCT assessed the effectiveness of providing three to five sessions of personal care training to carers, each lasting 30-45 minutes. It resulted in a higher proportion of stroke patients achieving independence at an earlier stage, and reduced the need for physiotherapy and occupational therapy. There were also significant reductions in carer burden and improvements in mood and quality of life for carers and care recipients.[7]

3.4 As hospitals will no longer be reimbursed for emergency readmissions within 30 days of discharge following an elective admission, focus on re-ablement has grown. Evaluations of four re-ablement programmes in England found that carers play a crucial role and involving and supporting them can improve chances of long-term patient re-ablement.[8]

[6]Mant, J et al (2000) 'Family support for stroke: a randomised controlled trial'. The Lancet, 356, 808-813.

[7]Kalra, L et al (2004) 'Training carers of stroke patients: randomised controlled trial'. BMJ, 328, 1099-1101.
Patel, A et al (2004) 'Training care givers of stroke patients: economic evaluation'. BMJ, 328, 1102-1107.

[8]Care Services Efficiency Delivery Programme. Homecare re-ablement Workstream (2007), 'Homecare re-ablement retrospective longitudinal study'. London: Care Services Efficiency Delivery.

Box 1: Stroke rehabilitation and carer respite

Crossroads Care Coventry and Warwickshire, NHS Coventry and Coventry City Council

When a stroke patient has completed the first part of treatment through a hospital, a meeting is arranged between a Crossroads Care support worker, the patient, the carer and a physiotherapist, to look at the goals and decide upon a rehabilitation plan.

The support worker, who has completed intensive training with the physiotherapy department, comes to the patient's home for a two/three hour period to help with exercises, thus giving the carer respite, during which Crossroads Care can help the carer access other services, such as support groups and activities.

http://www.carershub.org/content/stroke-rehabilitation-while-carers-have-break

3.5 The Government has highlighted carers as a group experiencing health inequalities within their plans to promote public health.[9] Evidence of comparative poor health of carers include:

- ➔ a four year study of 392 carers and 427 non-carers aged 66-92, which found that carers who were reporting feelings of strain had a 63% higher likelihood of death in that period than non-carers or carers not reporting strain;[10]
- ➔ carers providing high levels of care being associated with a 23% higher risk of stroke;[11]
- ➔ 52% of carers providing substantial care in one study being treated for stress-related disorders.[12] In another, over half the sample said they were in good health, but General Health Questionnaires (GHQs) indicated that 94% could be identified as having psychiatric disorders;[13]
- ➔ more than 80% of carers saying that their caring role has damaged their health;[14]
- ➔ carers providing more than 50 hours of care per week are twice as likely to report ill-health as those not providing care.[15]

[9]HM Government (2010), 'Healthy lives, healthy people: a strategy for public health in England'. London: The Stationery Office.

[10]Schulz, R & Beach, S, 'Caregiving as a Risk Factor for Mortality'. Journal of American Medical Association, Dec 1999, vol. 282 (23), 2215-2219.

[11]Haley, W et al (2010), 'Caregiving Strain and Estimated Risk for Stroke and Coronary Heart Disease Among Spouse Caregivers'. Stroke, 41:331-336.

[12]Henwood, M (1998), 'Ignored and Invisible: carers' experiences of the NHS'. Carers National Association.

[13]Unpublished 2002 research from Torbay Care Trust and Manchester PSSRU.

[14]General Household Survey, (2000). Office for National Statistics licensed under the Open Government Licence v.1.0.

[15]Census (2001). Office for National Statistics licensed under the Open Government Licence v.1.0.

Box 2. "Wraparound" support to maintain the carers' health

Belfast Carers' Centre, funded by Pfizer UK Foundation

The Wraparound Health Promotion Project offers health assessments and a package of support in carers' own homes, providing information on nutrition, exercise, emotional wellbeing, coping strategies and other health related issues. The service also offers emotional support and signposting to other services such as free health checks at a local pharmacist. The programme involves a weekly visit from a health promotion officer for the first six weeks.

http://www.carershub.org/node/30

3.6 That carers can, themselves, end up as patients or require care and support is clearly a negative outcome for PCTs, GPs and LAs. However, providing adequate support can enable carers to maintain their health whilst providing care:

- → 17% of carers who had taken a break of more than a few hours suffered mental ill-health compared to 36% of carers who did not have such a break since beginning their caring role;[16]
- → 35% of carers without good social support experienced ill-health compared to 15% of those with good support.[17]

3.7 More needs to be done to measure the impact of services on the wellbeing of carers. The Princess Royal Trust for Carers has recently published a tool that measures the impact of services on a carer's quality of life.[18] This has the potential to produce a new body of evidence. A further tool measures the impact of services on the wellbeing of young carers.[19]

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[16] Singleton, N et al (2002), 'Mental Health of Carers'. London: Office for National Statistics, The Stationery Office.

[17] Singleton, N et al (2002), 'Mental Health of Carers'. London: Office for National Statistics, The Stationery Office.

[18] Elwick, H et al (2010), 'Manual for the Adult Carer Quality of Life Questionnaire'. London: The Princess Royal Trust for Carers. Available for free download from http://static.carers.org/files/adult-carer-qol-published-version-5571.pdf.

[19] Joseph, S, Becker, F. Becker, S (2009), 'Manual for Measures of Caring Activities and Outcomes for Children and Young People'. London: The Princess Royal Trust for Carers. Available for free download from http://professionals.carers.org/young-carers/assessments,3063,PP.html.

4 Carers are key to independent living

4.1 The Government's 'Vision for Adult Social Care' requires LAs to provide personal budgets for everyone who is eligible for ongoing social care, preferably as a direct payment, by April 2013.[20] This is aimed at improving the outcomes and independence of people with care and support needs.

4.2 An evaluation of personal budgets[21] found that it is often carers who become the managers of the personal budget/direct payment and who are responsible for finding out about services, recruitment, managing personal assistants, finance and paperwork. The evaluation cited a study, which found that four-fifths of carers performing this role felt increased stress was placed on them.[22]

4.3 Carers need support to enable them and the person they care for to maximise the benefits of personalisation. Some carers reported that training helped them do this, and that information from social care professionals was unhelpful in this regard.[23] More recent work has reported that carers cite training and access to advice and support as important to the success of managing a personal budget.[24]

4.4 Personalisation in health and social care will only deliver the desired improvement in outcomes for recipients of a personalised budget if we give carers the support they need to assist the planning and management of it.

Box 3. Helping families make the most of personal budgets

Carers' Support Bexley, funded by The Princess Royal Trust for Carers

The scheme supports carers who are responsible for managing personal budgets on behalf of the person they care for, by offering ongoing support around managing budgets, accounting, insurance, and employing care staff. It also provides support for people who are self-funders. Importantly, control remains with the personal budget holder.

http://www.carershub.org/node/161

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[20] Department of Health (2010), 'A Vision for Adult Social Care: Capable Communities & Active Citizens'. London: Centre of Information.

[21] Glendinning, C et al (2009), 'The Individual Budgets Pilot Projects: Impact and Outcomes for Carers'. Universities of York & Kent. Commissioned by Department of Health.

[22] Glendinning, C et al (2009), 'The Individual Budgets Pilot Projects: Impact and Outcomes for Carers'. Universities of York & Kent. Commissioned by Department of Health.

[23] Glendinning, C et al (2009), 'The Individual Budgets Pilot Projects: Impact and Outcomes for Carers'. Universities of York & Kent. Commissioned by Department of Health.

[24] Newbronner, L et al (2011), 'Keeping Personal Budgets Personal: Learning from the experiences of older people, people with mental health problems and their carers'. London: Adults' Services Report, 40, Social Care Institute for Excellence.

5 Focus on carers to improve health and social care outcomes

5.1 The DH has advised that the NHS should recognise the vital role played by carers and make sure that carers remain in good health, and that their health-related quality of life does not deteriorate as a result of their caring responsibilities.[25] The 'NHS Outcomes Framework' includes a carers-specific improvement area measure:

- ➔ enhancing quality of life for carers measured by a health-related quality of life for carers' survey collected using the GP Patient Survey (EQ5D).

5.2 The evidence in paragraphs 3.2. to 3.4 shows that supporting carers is also relevant for PCTs to help achieve successful measures in other improvement areas such as:

- ➔ ensuring people feel supported to manage their condition;
- ➔ improving recovery from stroke;
- ➔ emproving the experience of care for people at the end of their lives.

See Appendix 1 for full details of relevant improvement areas and measurement indicators.

5.3 Similarly for LAs, there will be outcomes statements to measure performance against that specifically relate to carers:

- ➔ enhancing quality of life for carers;
- ➔ improving access to information about care and support;
- ➔ treating carers as equal partners.

5.4 PCTs and councils who want to perform well and serve their local populations, will have to make sure that carers can access information, advice, training, breaks, and emotional support.

Box 4. "Care Plus" at the end of life

Tower Hamlets Carers' Centre, NHS Tower Hamlets and London Borough of Tower Hamlets

Carers of people with end-stage heart failure are referred to a care coordinator to provide support. The care coordinator can fast-track access to services across health and social care, and has an emergency fund of up to £250 for equipment that makes the caring role easier. There has been a large reduction in hospital admissions (approximately 28 days fewer in hospital per patient than expected), an increase in people dying at home, and fewer carers needing bereavement services.

http://www.carershub.org/content/fast-track-care-and-support-end-life-heart-failure-patients-and-carers

[25] The Department of Health (2010), 'The NHS Outcomes Framework 2011/12'. London: Centre of Information.

6 Reducing hospital admissions and delayed transfers of care

6.1 Admission can be an indication of a breakdown in the caring relationship, because the carer is no longer able to care, often as a result of the strain of caring causing physical or mental ill-health.

6.2 There is evidence to suggest that a significant number of admissions are due to problems associated with the carer rather than the person admitted. One study found that problems associated with the carer contributed to readmission in 62% of cases. Carers of people readmitted were more likely than other carers to:[26]

- be experiencing ill-health, fatigue and interrupted sleep;
- be conducting at least one intimate task;
- and generally feel frustrated.

6.3 A whole systems study tracking a sample of people over 75 years old who had entered the health and social care system, found that 20% of those needing care were admitted to hospital because of the breakdown of a single carer on whom the person was mainly dependent.[27] A health professional advised that respiratory distress is often used to admit a patient, when the real reason is because the carer may be in hospital and it is thus unsafe to leave the other person at home.

6.4 The previously mentioned RCT (para 3.3) also found reduced hospital days of stroke patients contribute to lower annual treatment costs of £4,043 compared to the control group.[28] Another study looking at the impact of support for the family of stroke victims found it produced shorter length of hospital stays than in the control group.[29]

6.5 These studies substantiate the belief that social care services can impact upon demand for health services and the Government is encouraging closer working between the two.[30]

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[26]Williams, E, Fitton, F (1991), 'Survey of carers of elderly patients discharged from hospital'. British Journal of General Practice, 41, 105-108.

[27]Castleton, B (1998), Developing a whole system approach to the analysis and improvement of health and social care for older people and their carers: A pilot study in West Byfleet, Surrey. Unpublished. Referenced by Banks, P (1998) 'Carers: making the connections'. Managing Community Care, vol 6, issue 6.

[28]Kalra, L et al (2004), 'Training carers of stroke patients: randomised controlled trial'. BMJ, 328, 1099-1101.

Patel A, et al.(2004), 'Training care givers of stroke patients: economic evaluation'. BMJ, 328, 1102-1107.

[29]Dennis, M et al (1997), 'Evaluation of a stroke family care worker: results of a randomised controlled trial'. BMJ, 314, 1071-1076.

[30]Minister for Care Services, Paul Burstow MP, has advised he sees himself as "Minister for Integration" http://www.dh.gov.uk/en/Publicationsandstatistics/Bulletins/Chiefnursingofficerbulletin/July2010/DH_118136.

6.6 Measuring delayed transfers of care is a good indication of how well health and social care services are interfacing. The Government has included an outcome measure of this for councils to monitor progress.[31] The current figures show significant numbers of patients being delayed in the transfer of their care at considerable costs. Delayed transfers can also be bad for patients, threatening their independence and delaying or impeding rehabilitation.

6.7 In six months from August 2010 to January 2011, 27,555 patients experienced 660,942 days of delayed transfer of care in England. When annualised, this equates to additional costs of approximately £150m to the NHS. This discounts delayed transfers between NHS funded beds. For workings see Appendix 2.

6.8 Carers who do not feel prepared or sufficiently supported are one cause of delays in transfer of care. In 2010, The Princess Royal Trust for Carers published 'Out of Hospital' to help hospitals improve their discharge processes by involving carers.[32] This guide refers to lessons learnt from pilots in The Great Western Hospital, Swindon and Barnet and Chase Farm Hospital. Key recommendations are:

- ➔ include identification, recording and referral of carers in hospital discharge policy;
- ➔ collect clinical audit data on the numbers of carers identified and the impact of providing carer support on patients and hospital, e.g. improved patient experience of discharge, increased hospital efficiency;
- ➔ health commissioners should agree carers' standards as part of the contract with hospital trusts;
- ➔ health commissioners should actively participate in local strategic and developmental work on carers issues, e.g. local carers' strategy.

6.9 The evidence that increasing support for carers can reduce hospital and residential care admissions is important for PCTs and councils in relation to measuring performance against the NHS Outcomes Framework.

6.10 As well as the improvement areas and outcome indicators described above relating specifically to carers, PCTs and health commissioners should consider carers when looking to improve in the following areas of the NHS Outcomes Framework[33] (see Appendix 1 for a full description):

- ➔ helping people recover from episodes of ill-health or following injury;
- ➔ reducing time spent in hospital by people with long-term conditions;
- ➔ helping older people to recover their independence after illness or injury.

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[31] Department of Health (2011), 'Transparency in outcomes: a framework for quality for adult social care'. London. Centre of Information.

[32] Newbrunner, L (2010), 'The Princess Royal Trust for Carers Out of Hospital Project – Learning from the Pilot Projects'. London: Acton Shapiro Ltd. Available at: http://professionals.carers.org/health/hospitals,806,PP.html.

[33] Department of Health (2010), 'The NHS Outcomes Framework for 2011/12'. London: Centre of Information.

Box 5. Support for families before discharge

Bristol and South Gloucestershire Carers' Centre, NHS South Gloucestershire

A Carers' Support Worker, based at Frenchay Hospital, supports carers through the hospital pathway and discharge process. Carers are offered emotional and practical support and services run by the Carers' Centre; training in providing care; emergency planning; and support groups. The Carers' Centre has worked with hospital staff to improve awareness of carers' issues and hospital practice. Ninety one families were supported in an 18-month period, saving 300 bed days.

http://www.prtcarerscentre.org.uk/

7 Reducing unwanted residential care admissions

7.1 The Government's 'Vision for Adult Social Care' has 'Prevention' as its first principle with the aim of maintaining people's independence. The Government declared that "carers are the first line of prevention" and as such need to be properly identified and supported.[34] Government recommends that councils should offer support to carers to prevent the escalation of demand on statutory services.

7.2 The Government advises that some councils are spending on residential care at disproportionately high levels, not due to local choices, but because adequate support for people to remain at home is not available or because people are discharged from hospital without a suitable care plan.[35]

7.3 The Government has created outcome measures to enable councils to monitor their progress against delivering services which prevent deterioration and delay dependency[36] (see Appendix 3 for full descriptions of all relevant outcome measures):

- ➔ the proportion of council spend on residential care;
- ➔ admissions to residential care homes, per 1,000 population.

7.4 A longitudinal study of 100 people with dementia and their main family carer found a 20-fold protective effect of having a co-resident carer when it comes to residential care admissions.[37] Further studies have confirmed that where there is no carer, the person receiving care is more likely to be admitted into residential care.[38]

7.5 Carer-related reasons for admission to nursing or residential care are common, with carer stress the reason for admission in 38% of cases.[39] This suggests that giving carers extra support to manage their caring role more effectively and maintain good health could reduce unwanted residential care admissions.

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[34]Department of Health (2010), 'A Vision for Adult Social Care: Capable Communities & Active Citizens'. London: Centre of Information.

[35]Department of Health (2010), 'A Vision for Adult Social Care: Capable Communities & Active Citizens'. London: Centre of Information.

[36]Department of Health (2010), 'Transparency in outcomes: a framework for adult social care'. London. Centre of Information.

[37]Banerjee, S et al (2003), 'Predictors of institutionalisation in people with dementia.' Journal of Neurology, Neurosurgery & Psychiatry 2003; 74:1315–1316.

[38]Davies, B and Fernández, J (2000), 'Equity and Efficiency Policy in Community Care'. Aldershot, Ashgate.

[39]Bebbington, A, Darton, A, Netten, A (2001), 'Care Homes for Older People: Volume 2. Admissions, needs and outcomes'. University of Kent, Personal Social Services Research Unit.

7.6 One RCT of 406 spousal carers of people with Alzheimer's disease (USA) over ten years found that those whose carers had received support, including six sessions of individual and family counselling, experienced a 28.3% reduction in rate of nursing home placement and were likely to stay at home for 557 days longer than those whose carers were not supported in this way.[40]

7.7 A study based in Australia showed that ten sessions of training, which focused on distress and isolation reduction, coping skills, fitness and diet, and social and leisure activities for carers of people with dementia, delayed residential care admission significantly.[41] An RCT that looked at a Dutch programme of day care-based respite, coupled with carer support and advice, found that the programme achieved significant delays in transfer to residential care.[42]

7.8 Councils should consider this evidence in relation to outcome measures of performance which will be affected by how well carers are supported:[43]

- ➔ helping older people to recover their independence;
- ➔ preventing deterioration and emergency admissions.

Box 6. Counselling for carers

CLASP the Carers' Centre, funded internally

Counselling is provided entirely by volunteers who are coordinated by a professional counsellor. The coordinator takes referrals, makes the original assessment, matches carers with counsellors and provides supervision and support. CLASP works with several higher education institutions which provide trainee counsellors as volunteers whose work at CLASP counts towards a counselling qualification. Carers are initially offered six sessions, which can be extended if necessary.

http://www.carershub.org/content/counselling-trainees-providing-support-carers

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[40]Mittelman M et al (1996), 'A Family Intervention to Delay Nursing Home Placement of Patients With Alzheimer Disease: A Randomized Controlled Trial'. Journal of the American Medical Association. Dec 4; 276(21): 1725-31.

See also: Mittleman, M et al (2006), 'Improving caregiver well-being delays nursing home placement of patients with Alzheimer disease'. Neurology, vol 67, no 9, pp 1592–1599.

[41]Brodaty H, Gresham M, Luscombe G (1997), 'The Prince Henry Hospital dementia caregivers' training programme'. International Journal of Geriatric Psychiatry, Dementia study, vol 12, pp 183–92.

[42]Dröes, R et al (2006), 'Effect of the Meeting Centres Support Program on informal carers of people with dementia: results from a multi-centre study'. Aging & Mental Health, 10(2), 112-124.

[43]Department of Health (2010), 'Transparency in outcomes: a framework for adult social care'. London. Centre of Information.

8 The economics of care at home

8.1 Focusing on meeting the needs and preferences of families, may also help councils to manage their reduced resources. Increasing support for carers can prevent or delay a need for residential care, and reduce the proportion of care in residential settings. Projecting such a scenario entails the consideration of three effects on resources:

- ➔ increased expenditure on support for carers;
- ➔ increased expenditure on supporting people at home rather than in residential care;
- ➔ reduced expenditure on residential care.

8.2 Our forecasting shows that an extra £119m spent to support carers and an extra £459m spent supporting people in their home rather than in residential care, would result in overall savings for residential care for councils in England of over £925m per annum. See Appendix 4 for full workings.

8.3 Although, the increase in spending on care at home is larger than the increased spending on carers, the former alone is not the cause of reduced residential care. Rather, increased spend on home care is an effect of carers being able to manage their caring role better, thus preventing residential care admissions. Therefore, it is the extra £119m spent on carers that causes the chain reaction that creates reductions in residential care and overall savings.

8.4 Calculations for each council in England, excluding four councils for whom NHS Information does not hold the required data, showing the potential saving for each is included in Appendix 5.

Box 7. GPs prescribing breaks for carers

Crossroads Care Cambridgeshire, NHS Cambridgeshire and 22 GP practices

GPs can issue a carer with a free prescription to contact Crossroads Care who will visit the carer and help them access the support they need and want. If the carer wants a break, it can be booked directly through Crossroads Care and at no charge to the carer. There are also support group sessions that carers can sign up to for free. The number of carers identified increased by 80% in six months and GPs advised that 32% of prescriptions prevented a hospital admission.

http://www.crossroadscarecambridgeshire.org.uk/

8.5 There are very few carers who receive a personal budget that allows them to purchase weekly support. Rather, it is more common for carers to receive a one-off personal budget to spend. Council figures provided to the NHS Information Centre for the Community Care Statistics report found that 47,850 carers across England received one in 2009/10.

8.6 The Household Survey of Carers 2009/10 found that only 4% of carers had been assessed and of those 4% (which would equal about 240,000 carers In the UK):

- ➔ 4% reported getting a break in their own home (9,600);
- ➔ 8% reported getting a break away from home (19,200);
- ➔ 16% got a direct payment or personal budget (38,400).

8.7 Such low numbers of carers receiving support is not because of substantial funding being channelled to carers through grants to carers' charities rather than personal budgets. Of 29 councils who provided the NHS Information Centre with data, funding amounted to £11.6m in 2009/10. It is conceivable that those who did not reply, place a lower premium on supporting carers, hence the lack of data provided, and indeed 35 other councils that did respond advised they gave no funding at all to charities to support carers.[44] We hope this is incorrect information, but if not it is of great concern.

8.8 Even assuming the same level of funding to charities to support carers as the 29 councils that provided information for all councils in England, this would still only total £60,800,000, and is likely to be a great overestimate.

8.9 What these figures and our projections show is that a transformation in the level of support councils provide to carers is needed to increase the quality of life outcomes of carers and the people they care for, and to enable councils and PCTs to achieve the outcomes they desire.

[44]Niblett, P (2011), 'Personal Social Services Expenditure and Unit Costs England, 2009 –11 – Final Council Data'. London: The NHS Information Centre.

9 Conclusions

9.1 Councils and PCTs face immediate funding pressures, which may lead some to think that increasing spending on carers is not a realistic solution to the challenges they face. However, this report produces evidence that makes improving support for carers a vital element of any solution to the various challenges faced and key to meeting the QIPP challenge.

9.2 We cannot improve health and wellbeing outcomes and reduce dependency for many people with disabilities or illnesses without supporting carers through training and involving them in care support planning (paragraphs 3.1 – 3.4).

9.3 We cannot address health inequalities and the comparative ill-health of carers without providing breaks, emotional support/counselling, and advice on how to handle the strains associated with providing care (paras 3.5 – 3.7).

9.4 We cannot achieve the aims of people using personal budgets/direct payments to control the services they receive without giving carers information and advice on how to help find and manage services and personal budgets (paras 4.1 – 4.5).

9.5 PCTs and councils cannot hope to serve their communities and perform well against outcome measures without involving carers in care planning and ensuring carers can maintain a quality of life (paras 5.1 – 5.4).

9.6 We cannot reduce unnecessary demands on health and social care services without providing a range of these services for carers to help them provide care preventing demand arising in the first place. The Government is correct to say that "carers are the first line of prevention"[45] (sections 6 and 7).

9.7 This report provides evidence that improving support for carers can produce overall savings for councils of approximately £1bn per annum by enabling people to receive care at home for longer and reducing need for residential care. We have not projected cost savings to the NHS of reduced admissions and delayed transfers of care, but the evidence in this report shows that improving support for carers can reduce (re) admissions (paras 6.6 – 6.8 and section 8).

9.8 The evidence gathered in this report is clear in its message: not investing in improving support for carers now, will very quickly cost you more than is initially saved.

[45]Department of Health (2010), 'A vision for adult social care: Capable communities and active citizens'. London: Centre of Information.

Appendix 1: NHS Outcomes improvement areas and measurement indicators relevant to carers

Source: Department of Health (2010), 'The NHS Outcomes Framework 2011/12'. London: Centre of Information.

Improvement Area	Indicator measurement
Quality of life for carers.	A health-related quality of life for carers' survey collected using the GP Patient Survey (EQ5D).
People feel supported to manage their condition.	Proportion of people feeling supported to manage their condition.
Recovery from a stroke.	Indicator is to be confirmed.
Experience of care for people at the end of their lives.	Indicator to be developed based on survey of carers.
Recovery from episodes of ill-health or following injury.	Number of emergency admissions for acute conditions that should not usually require hospital admission and emergency readmissions within 28 days of discharge from hospital.
Time spent in hospital by people with long-term conditions.	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) and unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s.
Recovery of independence amongst older people after illness or injury.	Proportion of people aged 65+ who were still at home 91 days after discharge from hospital into rehabilitation services.

Appendix 2: Delayed transfer of care

NHS figures show that in the six months from August 2010 to January 2011, 27,555 patients experienced 660,942 days of delayed transfer of care in England.[46] At a cost £290.88 per acute bed day and £279.47 per non acute bed day, the direct costs of delayed transfers for this six month period is £188,639,601. Annualised this would amount to £377,279,201.

These figures are based on costs in Wales reported by the Wales Audit Office for 2006/07.[47] Costs for 2010/11 are calculated on an annual increase of 2.44% from 2006/07 figures as this was the increase from 2005/06.

Not all of these direct costs could be released in full as some transfers would be internal, possibly from an acute bed to a non-acute bed. The marginal cost of these bed days is more likely to be approximately £147,630,991 based on the same proportion as used in aforementioned Wales Audit Office report.

[46]Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AcuteandNon-AcuteDelayedTransfersofCare/index.htm.

[47]Wales Audit Office (2007), 'Tackling delayed transfers of care across the whole system'. Cardiff: Auditor General for Wales.

Appendix 3: Council outcome measures

Source: The Department of Health (2011), 'Transparency in outcomes: a framework for quality in adult social care'. London: Centre of Information.

Outcome measure	Indicator
People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs.	1C: Proportion of people using social care who receive self-directed support, and those receiving direct payments.
Carers can balance their caring roles and maintain their desired quality of life.	1D: Carer-reported quality of life.
People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.	1G: Proportion of adults with learning disabilities who live in their own home or with their family.
Delaying and reducing the need for care and support.	2A (overarching measure): Permanent admissions to residential and nursing care homes, per 1,000 population.
Earlier diagnosis, intervention and re-ablement means that people and their carers are less dependent on intensive services.	2B: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/ rehabilitation services.
When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.	2C: Delayed transfers of care from hospital, and those which are attributable to adult social care.
People who use social care and their carers are satisfied with their experience of care and support services.	3B: Overall satisfaction of carers with social services.
Carers feel that they are respected as equal partners throughout the care process.	3C: The proportion of carers who report that they have been included or consulted in discussion about the person they care for.
People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.	3D: The proportion of people who use services and carers who find it easy to find information about services.

Appendix 4: Savings to councils

We have based our financial projections assuming the following:

- ➔ either 15%, 20% or 25% reduction in residential care weeks depending on current proportion of care set in residential care;
- ➔ costs of providing care at home to people rather than in residential care is 25% above average because needs are likely to be greater than average;
- ➔ £50 allocated to support carers for every week transferred from residential care to care at home. This would be sufficient to pay for a mixture of training in things like first aid, counselling and breaks.

It is reasonable to assume that there is less scope for reductions in councils which already provide relatively low levels of care in residential settings. In England, the average percentage of residential care weeks as a percentage of care at home weeks is 81.23%.

We have based our projections in residential care reductions on the following:

- ➔ 15% reductions for councils with residential care weeks as a proportion of home care weeks under 70%;
- ➔ 20% reductions for councils with residential care weeks as a proportion of home care weeks between 70.01% and 95%;
- ➔ 25% reductions for councils with residential care weeks as a proportion of home care weeks over 95.01%.

Increased expenditure on carers	Increased expenditure on care at home	Decreased expenditure on residential care	Overall savings
£118,941,852	£458,499,818	£1,505,446,050	£928,004,378

Four councils were excluded because sufficient data was not available to allow calculations. These figures are based on figures returned by councils for the year 2009/10 and published by The NHS Information Centre (2011), 'Personal Social Services expenditure and unit costs: England – 2009-10 – Final Council Data'.

Appendix 5: Savings by individual council

Based on 2009/10 figures published by The NHS Information Centre (2011) 'Personal Social Services expenditure and unit costs: England – 2009-10 – Final Council Data'.

Council	Increased expenditure on carers	Increased expenditure on care at home	Decreased expenditure on residential care	Overall savings
Barking and Dagenham	£442,775.00	£3,300,345.48	£5,543,750.00	£1,800,629.52
Barnet	£463,687.50	£1,904,886.52	£7,167,150.00	£4,798,575.98
Barnsley	£472,297.50	£1,759,610.94	£4,831,350.00	£2,599,441.56
Bath and Somerset UA	£560,362.50	£2,998,958.52	£8,052,750.00	£4,493,428.98
Bedford UA	£480,412.50	£1,657,687.09	£5,939,500.00	£3,801,400.41
Bexley	£401,690.00	£1,545,516.61	£5,751,600.00	£3,804,393.39
Birmingham	£3,202,050.00	£23,013,572.53	£48,639,250.00	£22,423,627.47
Blackburn with Darwen UA	£379,240.00	£2,855,850.88	£4,234,800.00	£999,709.12
Blackpool UA	£516,000.00	£1,684,109.64	£4,128,200.00	£1,928,090.36
Bolton	£374,872.50	£1,454,735.32	£3,602,400.00	£1,772,792.18
Bournemouth UA	£573,075.00	£2,686,969.75	£6,506,500.00	£3,246,455.25
Bracknell Forest UA	£159,127.50	£674,909.87	£2,624,850.00	£1,790,812.63
Bradford	£893,085.00	£2,803,073.86	£10,653,750.00	£6,957,591.14
Brent	£315,862.50	£1,192,459.45	£5,982,150.00	£4,473,828.05
Brighton and Hove UA	£727,880.00	£3,509,347.37	£10,925,200.00	£6,687,972.63
Bristol UA	£1,083,190.00	£4,768,851.33	£16,342,200.00	£10,490,158.67
Bromley	£432,345.00	£1,369,715.30	£6,235,500.00	£4,433,439.70
Buckinghamshire	£721,837.50	£3,624,021.15	£11,558,550.00	£7,212,691.35
Bury	£567,050.00	£1,856,716.85	£6,037,000.00	£3,613,233.15
Calderdale	£341,542.50	£1,421,078.62	£3,462,750.00	£1,700,128.88

Council	Increased expenditure on carers	Increased expenditure on care at home	Decreased expenditure on residential care	Overall savings
Cambridgeshire	£847,372.50	£3,023,295.32	£11,045,400.00	£7,174,732.18
Camden	£328,080.00	£880,620.99	£5,623,200.00	£4,414,499.01
Central Bedfordshire UA	£671,337.50	£2,710,439.90	£9,841,500.00	£6,459,722.60
Cheshire East UA	£926,020.00	£3,766,612.18	£8,634,200.00	£3,941,567.82
Cheshire West and Chester	£617,550.00	£2,808,278.14	£6,869,850.00	£3,444,021.86
City of London	Data not available	Data not available	Data not available	Data not available
Cornwall UA	£1,246,520.00	£5,411,879.53	£14,930,000.00	£8,271,600.47
Coventry	£449,355.00	£2,452,281.22	£5,553,900.00	£2,652,263.78
Croydon	£723,010.00	£1,669,533.98	£12,594,200.00	£10,201,656.02
Cumbria	£1,614,860.00	£7,110,844.93	£18,166,400.00	£9,440,695.07
Darlington UA	£338,080.00	£1,310,310.06	£3,277,200.00	£1,628,809.94
Derby UA	£655,920.00	£2,064,478.63	£6,819,600.00	£4,099,201.37
Derbyshire	£1,415,407.50	£4,109,176.47	£17,543,100.00	£12,018,516.03
Devon	£2,349,410.00	£5,783,526.34	£28,870,600.00	£20,737,663.66
Doncaster	£866,760.00	£3,308,075.51	£9,332,200.00	£5,157,364.49
Dorset	£1,085,312.50	£5,008,210.42	£16,628,250.00	£10,534,727.08
Dudley	£768,160.00	£2,679,504.53	£9,980,400.00	£6,532,735.47
Durham UA	£1,270,050.00	£3,940,722.67	£14,868,150.00	£9,657,377.33
Ealing	£452,917.50	£1,078,008.47	£6,768,300.00	£5,237,374.03
East Riding of Yorkshire UA	£1,757,762.50	£6,398,999.62	£16,074,000.00	£7,917,237.88
East Sussex	Data excluded due to other incomplete data	Data not available	Data not available	Data not available
Enfield	£417,090.00	£2,286,083.32	£5,922,900.00	£3,219,726.68
Essex	£3,446,010.00	£21,299,981.94	£47,860,000.00	£23,114,008.06
Gateshead	£678,340.00	£2,718,869.69	£9,800,800.00	£6,403,590.31

Council	Increased expenditure on carers	Increased expenditure on care at home	Decreased expenditure on residential care	Overall savings
Gloucestershire	£1,454,080.00	£7,032,946.57	£16,759,000.00	£8,271,973.43
Greenwich	£342,682.50	£1,280,419.05	£5,181,300.00	£3,558,198.45
Hackney	£305,655.00	£1,400,848.77	£5,397,300.00	£3,690,796.23
Halton UA	£153,855.00	£436,711.50	£1,335,450.00	£744,883.50
Hammersmith and Fulham	£285,105.00	£1,056,519.68	£4,055,100.00	£2,713,475.32
Hampshire	£2,201,310.00	£7,724,632.06	£29,042,250.00	£19,116,307.94
Haringey	£675,775.00	£2,863,817.13	£11,541,000.00	£8,001,407.87
Harrow	£275,557.50	£682,633.32	£4,675,350.00	£3,717,159.18
Hartlepool UA	£425,462.50	£1,435,280.13	£4,084,000.00	£2,223,257.37
Havering	£365,722.50	£1,207,816.03	£5,490,000.00	£3,916,461.47
Herefordshire UA	£459,740.00	£1,785,407.87	£5,754,600.00	£3,509,452.13
Hertfordshire	£1,998,877.50	£4,586,360.46	£28,080,900.00	£21,495,662.04
Hillingdon	£534,470.00	£2,196,731.38	£8,790,200.00	£6,058,998.62
Hounslow	£262,650.00	£837,317.66	£4,667,700.00	£3,567,732.34
Isle of Wight UA	£392,190.00	£1,133,151.88	£4,296,450.00	£2,771,108.12
Isles of Scilly UA	£7,537.50	£26,091.35	£87,750.00	£54,121.15
Islington	£307,335.00	£971,084.59	£4,004,700.00	£2,726,280.41
Kensington and Chelsea	£189,712.50	£581,989.82	£3,486,900.00	£2,715,197.68
Kent	£2,752,500.00	£6,096,209.15	£35,244,000.00	£26,395,290.85
Kingston upon Hull UA	£1,256,975.00	£4,057,109.10	£14,784,750.00	£9,470,665.90
Kingston upon Thames	£433,337.50	£1,501,932.91	£7,114,000.00	£5,178,729.59
Kirklees	£713,737.50	£1,982,548.20	£8,105,250.00	£5,408,964.30
Knowsley	£365,257.50	£1,957,826.87	£3,896,850.00	£1,573,765.63
Lambeth	£670,280.00	£2,137,135.05	£12,641,800.00	£9,834,384.95
Lancashire	£2,222,782.50	£7,738,573.22	£22,255,500.00	£12,294,144.28
Leeds	£1,688,960.00	£8,807,954.04	£20,880,400.00	£10,383,485.96

Council	Increased expenditure on carers	Increased expenditure on care at home	Decreased expenditure on residential care	Overall savings
Leicester UA	£609,727.50	£1,309,438.28	£6,612,300.00	£4,693,134.22
Leicestershire	£1,102,042.50	£2,828,364.87	£11,024,850.00	£7,094,442.63
Lewisham	£421,192.50	£1,355,007.96	£6,121,650.00	£4,345,449.54
Lincolnshire	£2,114,790.00	£8,013,784.43	£21,286,400.00	£11,157,825.57
Liverpool	£1,271,860.00	£3,002,667.73	£13,676,000.00	£9,401,472.27
Luton UA	£356,130.00	£1,532,002.70	£5,081,200.00	£3,193,067.30
Manchester	Data not available	Data not available	Data not available	Data not available
Medway Towns UA	£572,820.00	£1,752,809.49	£8,504,200.00	£6,178,570.51
Merton	£334,710.00	£2,306,355.87	£4,945,600.00	£2,304,534.13
Middlesbrough UA	£466,180.00	£2,073,690.96	£5,468,200.00	£2,928,329.04
Milton Keynes UA	Data not available	Data not available	Data not available	Data not available
Newcastle upon Tyne	£585,180.00	£2,868,781.59	£6,159,900.00	£2,705,938.41
Newham	£327,772.50	£901,677.93	£4,903,500.00	£3,674,049.57
Norfolk	£2,739,640.00	£6,538,710.71	£28,627,600.00	£19,349,249.29
North East Lincolnshire UA	£369,082.50	£685,702.19	£4,590,900.00	£3,536,115.31
North Lincolnshire UA	£611,687.50	£3,052,477.47	£6,240,000.00	£2,575,835.03
North Somerset UA	£854,400.00	£2,760,095.38	£9,877,500.00	£6,263,004.62
North Tyneside	£653,990.00	£1,545,611.61	£7,699,000.00	£5,499,398.39
North Yorkshire	£1,146,555.00	£2,292,545.00	£12,722,100.00	£9,283,000.00
Northamptonshire	£2,017,737.50	£5,173,446.37	£24,287,000.00	£17,095,816.13
Northumberland UA	£1,104,830.00	£4,883,220.32	£12,620,800.00	£6,632,749.68
Nottingham UA	£824,470.00	£2,412,170.78	£9,587,600.00	£6,350,959.22
Nottinghamshire	£2,767,550.00	£7,348,540.30	£32,062,000.00	£21,945,909.70

Council	Increased expenditure on carers	Increased expenditure on care at home	Decreased expenditure on residential care	Overall savings
Oldham	£647,020.00	£2,083,835.25	£5,599,000.00	£2,868,144.75
Oxfordshire	£1,209,210.00	£4,399,780.14	£15,911,600.00	£10,302,609.86
Peterborough UA	£143,280.00	£531,820.90	£1,688,700.00	£1,013,599.10
Plymouth UA	£533,280.00	£1,822,673.05	£6,535,350.00	£4,179,396.95
Poole UA	£182,947.50	£862,399.02	£2,626,650.00	£1,581,303.48
Portsmouth UA	£420,250.00	£1,580,140.00	£6,385,400.00	£4,385,010.00
Reading UA	£221,857.50	£684,534.68	£3,672,000.00	£2,765,607.82
Redbridge	£382,027.50	£1,418,055.72	£5,646,750.00	£3,846,666.78
Redcar and Cleveland UA	£463,540.00	£1,897,568.43	£6,877,000.00	£4,515,891.57
Richmond upon Thames	£369,970.00	£1,365,897.88	£6,865,200.00	£5,129,332.12
Rochdale	£619,120.00	£2,475,760.59	£5,750,400.00	£2,655,519.41
Rotherham	£813,120.00	£2,691,979.81	£10,462,400.00	£6,957,300.19
Rutland UA	£56,535.00	£201,529.48	£578,850.00	£320,785.52
Salford	£470,272.50	£2,191,692.05	£5,063,700.00	£2,401,735.45
Sandwell	£804,820.00	£3,093,589.86	£10,063,400.00	£6,164,990.14
Sefton	£1,238,925.00	£6,401,751.78	£12,926,250.00	£5,285,573.22
Sheffield	£1,060,807.50	£3,486,962.69	£10,542,000.00	£5,994,229.81
Shropshire UA	£962,062.50	£3,568,577.21	£11,001,500.00	£6,470,860.29
Slough UA	£290,420.00	£993,683.20	£3,839,200.00	£2,555,096.80
Solihull	£318,277.50	£1,027,446.51	£4,507,950.00	£3,162,225.99
Somerset	£1,028,527.50	£4,693,843.48	£11,711,400.00	£5,989,029.02
South Gloucestershire UA	£699,562.50	£2,758,398.29	£11,703,250.00	£8,245,289.21
South Tyneside	£586,550.00	£2,076,057.56	£6,467,200.00	£3,804,592.44
Southampton UA	£374,902.50	£594,789.92	£4,699,650.00	£3,729,957.58
Southend-on-Sea UA	£771,612.50	£2,322,786.80	£8,404,250.00	£5,309,850.70

Council	Increased expenditure on carers	Increased expenditure on care at home	Decreased expenditure on residential care	Overall savings
Southwark	£439,762.50	£1,631,171.07	£9,449,400.00	£7,378,466.43
St. Helens	£408,920.00	£1,356,028.70	£4,209,800.00	£2,444,851.30
Staffordshire	£1,036,837.50	£4,145,575.75	£14,051,250.00	£8,868,836.75
Stockport	£481,605.00	£2,206,487.97	£4,594,650.00	£1,906,557.03
Stockton-on-Tees UA	£740,362.50	£1,727,193.45	£7,731,250.00	£5,263,694.05
Stoke-on-Trent UA	£957,150.00	£4,360,350.00	£10,225,750.00	£4,908,250.00
Suffolk	£1,653,410.00	£7,222,633.55	£23,397,400.00	£14,521,356.45
Sunderland	£764,920.00	£2,294,314.24	£9,363,000.00	£6,303,765.76
Surrey	£3,085,987.50	£12,779,661.19	£46,444,000.00	£30,578,351.31
Sutton	£418,160.00	£2,617,649.29	£6,914,600.00	£3,878,790.71
Swindon UA	£487,440.00	£1,610,991.66	£5,930,600.00	£3,832,168.34
Tameside	£464,287.50	£955,952.90	£4,058,850.00	£2,638,609.60
Telford and the Wrekin UA	£265,350.00	£1,088,970.09	£3,866,850.00	£2,512,529.91
Thurrock UA	£403,900.00	£2,130,324.27	£6,144,000.00	£3,609,775.73
Torbay UA	£723,112.50	£2,139,918.56	£6,601,750.00	£3,738,718.94
Tower Hamlets	£330,945.00	£1,482,904.97	£4,859,250.00	£3,045,400.03
Trafford	£583,862.50	£3,128,904.17	£6,792,500.00	£3,079,733.33
Wakefield	£816,110.00	£3,220,656.58	£8,557,800.00	£4,521,033.42
Walsall	£566,580.00	£1,182,818.29	£7,028,250.00	£5,278,851.71
Waltham Forest	£463,900.00	£1,490,433.60	£6,799,200.00	£4,844,866.40
Wandsworth	£691,460.00	£2,309,979.95	£10,273,600.00	£7,272,160.05
Warrington UA	£669,112.50	£4,279,416.55	£7,604,000.00	£2,655,470.95
Warwickshire	£783,862.50	£3,709,668.84	£10,209,300.00	£5,715,768.66
West Berkshire UA	£187,770.00	£852,492.61	£3,278,550.00	£2,238,287.39
West Sussex	£2,330,037.50	£12,889,861.49	£36,009,250.00	£20,789,351.01
Westminster	£423,292.50	£1,340,414.68	£6,873,600.00	£5,109,892.82
Wigan	£500,055.00	£3,246,222.43	£4,882,950.00	£1,136,672.57

Council	Increased expenditure on carers	Increased expenditure on care at home	Decreased expenditure on residential care	Overall savings
Wiltshire UA	£811,837.50	£2,823,778.48	£10,785,300.00	£7,149,684.02
Windsor and Maidenhead UA	£195,960.00	£661,741.85	£2,812,200.00	£1,954,498.15
Wirral	£1,174,687.50	£3,565,989.81	£15,400,000.00	£10,659,322.69
Wokingham UA	£316,737.50	£1,362,275.81	£6,040,000.00	£4,360,986.69
Wolverhampton	£921,100.00	£4,297,953.23	£10,995,250.00	£5,776,196.77
Worcestershire	£1,694,787.50	£7,395,588.59	£19,644,500.00	£10,554,123.91
York UA	£452,050.00	£1,707,640.02	£5,114,200.00	£2,954,509.98

The Princess Royal Trust for Carers
Unit 14 Bourne Court
Southend Road
Woodford Green
Essex IG8 8HD

Tel: 0844 800 4361
Fax: 0844 800 4362
Email: info@carers.org
Web: www.carers.org

Incorporated in Scotland as a non profit-making company limited by guarantee number 125046 Registered office:
7 West George Street, Glasgow G2 1BA

Charity number: SC015975
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Author: Gordon Conochie

Crossroads Care
Registered Office
10 Regent Place
Rugby
Warwickshire
CV21 2PN

Tel: 0845 450 0350 (local call charges)
Fax: 01788 565 498
Web: www.crossroads.org.uk

Crossroads Association
Charity registration no. 282102
A company limited by guarantee
Registered in England no. 1544708