Policy Taskforce: Who Supports and Helps Me

1. Introduction

This taskforce was convened to address the following principle:

The system should recognise that there is a range of important carers around each individual, and these carers (formal or informal) need empowerment and assistance from the system in order to provide this care.

The taskforce rejected the terminology of “formal” and “informal” carers and this report instead will refer to “carers”¹ and “the workforce”².

This report contains a set of workable policy proposals that we believe are in line with the public consultation. They are not fully worked up, nor do they cover every area encompassed by the taskforce remit or identified by the taskforce’s initial discussions, but, with one exception, they present a consensus view from the group on the areas requiring action, and we believe that they are all implementable. The exception is proposal 7, which Susanna White does not support because she has doubts about its achievability.

2. Working methods

The taskforce adopted an iterative process whereby discussions at meetings, interspersed with circulation of papers by members, enabled the gradual narrowing down of a range of issues to three main proposals, one of which incorporates four sub-proposals. Comments were sought from DH colleagues at each stage so as to ensure that the development of ideas took account of work already in hand. The group’s work was further informed by regular updates from the public consultation. A template format (Annex 2) was used for written proposals, which were then tested in plenary discussion against five questions: Are the ideas good? Are they comprehensive? Are they implementable? Do they reflect a consensus? Do they respond to the priorities coming through from the public consultation?

Not all members of the taskforce were able to attend meetings or comment on proposals. Those from whom this report reflects input are listed at Annex 1.

3. Problems to be addressed

At its first meeting, the taskforce identified the following priority areas:

• The needs of carers: recognition of their contribution, information, skills and training, practical and emotional support, a life outside caring
• Communication, trust and balance of power between carer(s), workforce member(s) and the individual in receipt of care
• The need for interlinked health & social care training and career development
• Low public awareness of how to access and navigate the system
• Capacity needs of non-statutory organisations providing services.

The specific needs of children as recipients of care were not clearly identified as an issue for this group until late in the process. At this point, a proposal was put forward which the group did not have time to discuss in detail. The taskforce recommends that this is an important area which needs to be addressed by the White Paper team, but it is not in a position to make recommendations.

¹ A carer is a person who provides care to another person and is neither paid for providing that care nor provides that care as a volunteer placed into the caring role by a voluntary organisation (definition from Carers UK)
² This encompasses the statutory, commercial and voluntary sectors, and includes volunteers.
4. Proposals

A. Carers

Proposal 1: A new, cross-government offer to carers that values their work, recognises them as people in their own right, and delivers on the following promises:

- We will look after your health and well-being
- We will recognise your role as an active citizen and we will mitigate the potential disadvantages you face
- We will actively support you by providing breaks, money, training, by the use of personalised budgets, and for those of working age we will keep you in touch with the world of work
- Professionals in the health and social care field will properly recognise your role as partners in the delivery of care.
- We will give access to the information you need in a holistic way at both a national and local level.

How will it work?
To implement this holistic approach, we recommend that:

- the new offer is published by a stated date, and publicised to carers
- a senior champion for carers’ issues is identified in the DH.
- a ministerial led, cross government Task force is established
- processes are put in place to ensure that all relevant policies are checked for their impact on carers
- a renewed national strategy for carers, building on the 1998 strategy, is developed that both targets support at current carers (segmenting to ensure responsiveness to diverse needs) and addresses the future challenges posed by demographic changes.

Additionally, it will need to be recognised that as more care has shifted from hospitals to the community, carers are doing more than ever before, and there needs to be a resource shift to mirror and support this.

How will it address the need?
- There are about 6 million carers. Over 1.25 million of them work over 35 hours a week. This is a workforce equivalent to that in the NHS. We must support, develop and grow numbers of carers to meet service users’ needs into the future and to avoid a negative longer term financial impact.
- Relative to the general population, poverty, ill health and social isolation among carers rise in proportion to hours per day and number of years spent caring. This proposal addresses aspects of that problem judged to be particularly significant.
- The proposal will drive co-operation and co-ordination of support to users to ensure multiple benefits from development of carers and the paid workforce.

Proposals 2-5: four specific new policy developments to make the offer tangible

- Proposal 2: A cross-government strategy to promote health and well-being among carers, to enable them to stay healthy and minimise the costs (both to carers and to the economy) of carers being unable to continue with caring and/or to return to work after caring.
• **Proposal 3:** Increased and improved practical and emotional support for carers, designed around the needs of the individual, accompanied by clearer and more formalised expressions of what support is on offer to carers and how to access it. This may not be cost-neutral.

• **Proposal 4:** Recognition of carers’ role and contribution, through training modules for all relevant health and social care staff on working in partnership with carers, for example by involving them in team based assessments.

• **Proposal 5:** A national independent information service covering health, social care, employment, benefits, housing, tax credits etc, to relieve the burden on carers of having to go from source to source gathering the information they need.

**How will they work and how will they address the need?**

Proposals 2-5 are described in detail, together with explanations of how they will address need, in Annex 3. Proposal 2 is on page 10, Proposal 3 on page 12, Proposal 4 on page 13 and Proposal 5 on page 14.

**B. The workforce**

The next two proposals reflect the need for the workforce to be highly responsive to user and carer needs if it is to deliver high quality, user-led health and social care. Success in this endeavour will depend on a long term plan for sustaining the workforce by increasing its value, status and pay. This is particularly important in the context of the predicted expansion of need for carers over the next 10-12 years.

**Proposal 6: create interlinked career pathways in health and social care**

We recognised that work is already underway in this area (eg Options for Excellence, sector skills council responsibilities) but want to propose that it is a priority to develop an interlinked workforce strategy which:

• ensures that workforce development and training include modules on liaising/working with carers

• facilitates the movement of carers in and out of the workforce

• provides proper policies to support carers who are also in the workforce

• delivers an interlinked qualifications framework, to enable movement between health and social care and between different provider sectors

• covers attitudes, values and models of care as well as competences

• is based on dedicated funding arrangements

• is adequate for the complexity of the task, given that the workforce ranges from qualified professionals to unqualified support staff

• takes account of the new type of workers needed to deliver the new agenda

• builds on existing philosophies (person-centred care and a patient-led NHS) and enhances existing attitudes and skills to promote more inclusive models of team working with patients and carers

• considers if the child workforce developments signpost a possible way forward

**How will it work?**

The main output will be a shared curriculum for practitioners in health and social care, in pre- and post-qualifying education and training, with shared competences and, when appropriate, qualifications across current streams and an interlinked career pathway that takes account of carers and enables movement between jobs and sectors.

**How will it address the need?**

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3 both in health and social care through the work of Skills for Health and Skills for Care
• It will address the lack of flexibility that currently exists, created by the division between health and social care services.
• It will help create a public service career framework to improve staff management and retention across the public sector. This is particularly important in a tight labour market.
• A more appropriate model for workforce development, education, training and CPD will allow for closer attention to issues of humanity and dignity.
• At service user level, continuity of care for the individual will be enhanced and a shared language of care, responsive to users’ needs, will be developed.
• The skills and experience of carers will be optimised by their being enabled easily to move in and out of the workforce, where appropriate.

Proposal 7: drive the development of an appropriately skilled, trained workforce through better service commissioning informed by the engagement of local communities in the planning, design and delivery of local services

If we are to deliver truly responsive health and social care services, the needs of the community must determine the core competencies of the local workforce. The community should be actively and positively engaged in identifying its needs and the services to meet these. This will help to achieve healthy communities as well as healthy individuals. In the most deprived areas, special efforts will be needed to engage service users and carers in this process.

How will it work?
• Analysis of workforce supply and demand across the public, commercial and non-profit sectors, recognising that a mixed economy of social care delivery already exists, and that proposals for encouraging a wider variety of health care providers are already being developed by DH
• Procurement approaches which value quality and the outcomes users want as well as cost factors
• Outcome based approaches which encourage new providers into the market and stimulate more flexible and innovative deployment of appropriately skilled, trained staff
• Local and regional actions by local authorities and government offices to encourage partnership, joint commissioning and shared provider development (eg training), using mechanisms such as Local Area Agreements.
• Studying existing models of community engagement and piloting some to determine what works and what is transferable to health and social care. For example:
  • the connected care pilot in Hartlepool (which brings together the PCT, Social Services, Regeneration and local community groups)
  • the recruitment of volunteer health counsellors from the local community in Slough to provide a health neighbourhood watch to identify undiagnosed diabetes.
  • the Skills for Care new types of worker pilots.

4 Already covered for London in recent King’s Fund care services inquiry “The Business of Caring”
5 The Skills for Care New Types of Workers pilots can give evidence of what works and suggest ways forward.
How will it address the need?
Better service commissioning will stimulate demand for a more appropriately skilled and remunerated workforce and will therefore improve recruitment, retention and development at the same time as delivering services that respond to users’ needs.

Health and social care services need to be bespoke to individual needs, if community concerns regarding existing service structures are to be directly addressed. Ensuring that commissioners engage with their local communities differently, and involve them in the planning, design and delivery of services, will respond directly to this need. It can also provide a pool of potential health and social care workers from the local community, if the community engagement programme provides accredited training for its participants. Community engagement will improve the organisation of the health and social care to better meet the needs of users.

Community engagement allows communities to have a direct say in both the services that need to be commissioned and the workforce that should be configured to meet those communities’ needs. It provides a capacity tool for individuals, groups and agencies and a sustainable infrastructure for working in concert with local communities.

5. **Priorities for action**
There is a case for starting work to deliver on all these proposals as quickly as possible. If we had to pick one area that has been neglected, it would be the carers proposal. We would also recommend early consideration of the long term plan for sustaining the workforce by increasing its value, status and pay.

Chair, National Strategic Partnership Forum
Chair, Who Supports and Helps Me Task Force
11th November 2005
Annex 1

This report reflects input from the following members of the taskforce:

Bob Abberley (Unison)  
Susanna White (ADSS)  
Imelda Redmond (Carers UK)  
Emily Holzhausen (Carers UK)  
Rebecca Rosen (King’s Fund)  
Maria Lagos (Skills for Care)  
Juliet Bouverie (Macmillan Cancer Relief)  
Fiona Street (UK Home Care Association)  
Colin Angel (UK Home Care Association)  
Peter Richardson (IDeA)  
Richard Kramer (Turning Point)  
Colin Beacock (RCN)  
Jo Butcher (National Children’s Bureau)  
Paul Ennals (National Children’s Bureau)  
Catherine Guelbert (South East London SHA)  

Rob Webster (DH – senior aide)  
Sarah Fisher (DH – secretariat)  

No RCN input took place after 2nd November due to their application for judicial review of Commissioning a Patient-Led NHS.
Annex 2

POLICY TASKFORCE: Who Supports and Helps Me

TEMPLATE FOR PROPOSALS

Common header information:
Sub group (carers, workforce and interfaces)
Name of proposal
Please number pages

Notes:
Papers do not need to be long or detailed – we would suggest a maximum of 4 sides.

Proposals
Include a short introduction covering:

- What is your proposal
- What problem is it addressing (include any evidence you are aware of) and why is it important that this is addressed
- How is it going to be implemented

As far as possible, you should also attempt to cover and quantify (it may not be possible to complete all of these for all proposals):

- Inputs – eg staff, IT, physical capacity
- Outputs – eg publications, events, systems
- Impact – what will happen as a result of your proposal being implemented
- Levers and incentives – what levers already exist to make your proposal happen, and what incentives might be needed in the system
- Possible targets or standards
- Trade offs and impacts on rest of health and social care system and wider systems
- The leadership challenge – a statement, encompassing both delivery and accountability, of the implications for leaders at every level if they and their teams are to achieve full implementation of the proposal.

You may also wish to consider:

- Sanctions and regulation
- Legal consequences
- Costs.
Annex 3

Policy Task Force: Who Supports and Helps Me

Carers proposals in detail

1. **Background**

The group focusing on carers took the approach that carers, (by whom we mean family and friends who provide support and care to sick and disabled friends and relatives in an unpaid capacity) must be at the heart of the legislation and implementation plan on out of hospital care. They currently provide the lion share of the care and without proper attention to this important group there will not be a feasible implementation plan.

1.1 **Facts About carers**

- One in eight (1 in 8) adults are carers... around six million people
- Over 3 million people juggle care with work
- The main carer's benefit is £45 for a minimum of 35 hours, equivalent to £1.26 per hour
- 1.45 million provide over 20 hours care per week
- 1.25 million people provide over 50 hours of care per week
- People providing high levels of care are twice as likely to be permanently sick or disabled
- Over 1 million people care for more than one person
- 58% of carers are women and 42% are men
- By 2037 the number of carers could have increased to 9 million
- Every year over 2.3 million people become carers and roughly the same number end their caring role

1.2 **Comparison with the workforce**

The combined health and social care workforce amounts to approximately three million. About 1:7 of this workforce will also be carers.

1.3 **The future role of carers**

As we state above there are currently almost six million people in the UK providing care, of whom nearly half are providing significant amounts of care. It is this three million who are at risk of falling out of the work, of being in poor health, of being socially isolated. They are likely to be in the poorest sections in our communities. It is the carers who are providing high levels of care over long periods such as parents of disabled children, parents of adults children with acquired disabilities or spouses with long term conditions such as MS or Parkinsons who are also most likely to go into old age in poverty and poor health.

The change in the demographic structure of the UK is well understood, so too is the changed role of women and family structure. There is no evidence that families will ‘care’ less for their vulnerable relatives, but it seems likely that the type of support they will be able to give will change, perhaps playing a bigger role in navigating and organising care.
There is already a fault line built into the system where there is a big drive for employment for those who can, an emphasis on saving for pensions, working longer. It is estimated that the country will need an additional 2 million people in the workforce within the next 10-12 years. At the same time we have an increased dependency rate of people potentially requiring care and those able to provide that care.

At present many carers tell us that that they spend much of their time fighting the system, going from one institution to another sorting out equipment, benefits, support in the home. This takes up a lot the time they would rather spend actually providing care. They are often left worn out and frustrated by the battles they continually fight. The group took the view that a cross government holistic approach was essential if we are to firstly, remove the barriers to families providing care, and secondly, provide the support that encourages and enables families to provide that care. Without this approach the implementation of the visions in the green paper on social care and the white paper on out of hospital care cannot be realised.

1.4 The main problems faced by carers
These are well documented, and are as follows:

- Access to quality reliable information
- Deterioration in their own health
- Social Isolation
- Lack of breaks and practical support
- Lack of recognition for their role and contribution
- Lack of opportunities to work
- Poverty and low level of benefits for those who can’t work

2. How the proposals are organised
The proposals are organised in a “hub and spoke” format, with an overarching proposal forming the “hub” and then four “spoke” proposals which are designed to make the “hub” proposal real.

3. The “hub” proposal: new cross-government offer to carers
This proposal provides an overarching recommendation on the approach to carers. It is then followed up by more detailed proposals under each relevant heading.

- We will give access to the information you need in a holistic way at both a national and local level
- We will look after your health and well being
- We will recognise your role as an active citizen and we will mitigate the potential disadvantages you face
- We will actively support you by providing breaks, money, training, by the use of personalised budgets, and for those of working age we will keep you in touch with the world of work
- We will support you to work by improving employment rights for carers, introducing tax credits, working with employers to promote carer friendly practices
- If you are out of work we will provide you with benefits that properly recognise and understand the role that you play in the delivery of health and social care
- Professionals in the health and social care field will properly recognise your role as partners in the delivery of care.
3.1 What Problem is it Addressing
a) From the individual carers perspective
The more years you provide care for and the longer the hours you provide that care, the more likely you are to be poor, iller, and more socially isolated than the general population. This proposal tackles the issue from a number of angles.

b) From a service providers point of view and broader societal view
The delivery of health and social care is predicated on the assumption that at least as many, if not more, people will provide the bulk of care into the future. Unless policies are put in place to remove the barriers and increase the recognition and support it is unlikely that this will happen.

3.2 How is it going to be implemented?
This holistic approach is the only way we will remove the barriers to people providing care. We would recommend that:

• a senior champion for carers issues is identified in the DH.
• That a ministerial led, cross government Task force is established
• That processes are put in place to ensure that all relevant policies are checked for their impact on carers
• We recommend that a national strategy, building on the earlier strategy developed in 1998 is developed. This strategy should not only focus support current carers but also looks at removing the barriers for carers is in the future. Without this it is difficult to imagine how we can respond to the demographic changes and the increase in dependency ratios.
  o Specific strands to be developed which would make the offer tangible under each and across each of the offer areas.

4. The “spoke” proposals: making the offer real

4.1. Carers' health and well-being (proposal 2, page 2)

"We will look after your health and well-being"

What is the proposal?
To produce a co-ordinated strategy to promote health and well being amongst carers. This strategy would build on existing government programmes e.g. Choosing Health, Work and Well-Being, PSAs and LAAs
A key element of this strategy would be cross Government working.

What problem would this be addressing?
Poor health amongst carers, particularly those that provide high levels of care is well documented. The 2001 Census identified carers as being twice as likely to be in poor health as the general population. This difference is even more marked among carers in the younger age groups.

The main types of health problems carers face are:-
• Depression and other mental health problems
• Injury, particularly back and joints
• Stress related problems

Carers also find it hard to look after their own health. They frequently put off health care appointments and surgery. They are unable to recuperate properly after illness or surgery, this leads to long term problems.
The way health care is currently delivered means that it is not flexible enough to meet carers needs, for example policies on appointments and home visits may reduce carers opportunities to get the help they need. If you have little or no respite it is impossible for you to attend the GP surgery if are looking after a terminally ill relative or a mother with Alzheimer's.

When a carer’s health breaks down they are unable to continue providing the care for their relative, this responsibilities falls back on NHS or SS. Many carers who have been providing intensive care over long periods can end up with a multitude of health problems when their caring responsibility comes to an end. The peak age for caring is 45-59. In theory these people have many years of work ahead of them, but too often their health is so poor that they cannot return to work.

All this brings significant cost to the economy and to health and social care budgets, on top of the personal cost to the carer.

How is it going to be implemented?

- Current government initiatives that are looking at health and well being should give specific consideration to carers
- The cross Government strategy including the offer to carers would include a health promotion strand.
- This would consider
  - Health promotion for carers, how Primary Care can help, support and maintain carers’ health
  - Promotion of the right to a flu jab aimed at carers
  - What Primary Care should do with the register of carers they are building
  - Analysis all government health care initiatives to see what impact this will have on carers and provide support to mitigate the negative impact e.g. early hospital discharge

Outputs

- Health promotion materials
- Guidance on appointments and home visits
- Specific health promotion clinics for carers, with proper tie in with local breaks service
- Training programme for carers expected to deliver often medical procedures at home. Eg tube feeding, medication administration, also training in lifting and handling

Impact

- Less negative health impact for carers
- their ability to continue to provide care is not unnecessarily impeded
- greater awareness of the role and contribution amongst health care professionals
- greater recognition for the role and contribution that carers make

Levers and Incentives

- Well being agenda
- Health of the nation
- Work agenda
- The need for families to continue the care, without the contribution of carers the state costs will rise

Possible targets and Standards

- Health improvement targets
• Standards in information giving

Trade Offs
• Cost impact of carers not providing the bulk of health and social care.

Leadership Challenge
• The NHS is not use to seeing carers as partners in the delivery of care. There is little or no recognition of the role that carers play. The challenge from the top would be to recognise carers contribution, to provide them with the right training and support

4.2. Practical and emotional support (proposal 3, page 3)
• "We will recognise your role as an active citizen and we will mitigate the potential disadvantages you face
• We will actively support you by providing breaks, money, training, by the use of personalised budgets, and for those of working age we will keep you in touch with the world of work"

What is the proposal?
There would be clearer and more formalised expressions of what support is on offer to carers, a clearer understanding of what they can expect, how it is accessed and funded

There would an increase in the total amount of support that is available that would be designed around the need of the individual rather than the service.

The increase in the sorts of services available would include:-
• emotional support, particularly when someone is caring for a terminally ill person. There is a lot of evidence to show that carers, particularly those who have been caring intensively need the support to continue when the person they care for dies. The emotional and health impact continues post caring.
• Return to work training
• Help in the house
• Free travel passes
• Access to leisure and Adult Education
• More flexible breaks services
• Training in accepts of providing care, e.g medication, feeding, lifting and handling
• Emergency plans would be put in place so that a carer will know what will happen to the person they look after should they become ill, get involved in a road accident etc.

What Problem is it addressing
Carers are currently not properly respected for their role and contribution. The lack of support and, sometimes, the inappropriate types of support, has a negative impact on carers own health and increases social isolation. We need carers to be healthy if they are to continue to provide the lion share of the care

It is really important that services are designed around the needs of the individual family. At present a lot of local services can be focused on support groups which have a limited appeal to many carers, in particular people who trying to combine work with care and to men. Attached is a report setting out the demographic profile of carers called We Care Do You?
How is it going to be operated?
Through local authorities, through voluntary organisations, with the use of individualised budgets and direct payments and also self funding
If the service user refused services their individualised budget could be passed to the carer for them to use on services to support the family
If someone is coming out of hospital and the care plan works on the assumption that a carer will provide the support. Proper resources will be put into support the carer. This is particularly true for mental health service users

Inputs
- Staff time
- Additional resources
- Changes to current policy and practice

Outputs
- New services
- Better quality information (ties back to proposal 2 above)

Impact
- Carers better supported,
- Improved health
- Likelihood of people continuing to provide support increases

Levers and incentives
- We need carers to provide care
- We need more people to provide care into the future

4.3. Recognition of carers’ role and contribution (proposal 4, page 3)

"Professionals in the health and social care field will properly recognise your role as partners in the delivery of care."

What is the proposal
Training modules should be developed for all relevant health and social care staff on working in partnership with carers. There is a great deal of evidence that team working producing better results. We would like carers to be involved in team based assessments.

What is the problem this would address
Carers consistently report that the lack of recognition of their role and contribution undermines their self esteem. They spend a lot of time fighting the system when they would like to work with the professionals in a constructive way. Lack of recognition contributes to depression and poor health. Often there are policies that act against the interest of the carer continuing to provide care. There is an enormous amount of duplication of effort.

How would it be implemented
Professional training bodies would include carer awareness in their curriculum. There would be Carers As Partners training delivered as part of CPD
All relevant policies produced by the DH would be checked for the impact they have on carers e.g. hospital discharge, social care eligibility criteria, and many more. Senior champions within the relevant parts of the DH would be identified. They would lead work on Cross Government Working

**Inputs**
- Developing of training modules (these already exist – would need to be tailored)
- Staff Resources to impact check policies
- Staff resources in identifying champions
- Relevant training bodies to take on board the issue and build it into their syllabus

**Outputs/impact**
- Carers would feel better recognised
- There is likely to be health improvements
- There would be less duplication of effort

### 4.4. National Independent Information Service (proposal 5, page 3)

“We will give access to the information you need in a holistic way at both a national and local level.”

The National Strategy for Carers published in January 1999 dedicates a chapter to the importance of information provision. The DWP Five Year Plan - Opportunity, Security Throughout Life - also emphasises the importance of quality information provision, so too do the guidance on the Carers (Recognition and Services) Act, Carers and Disabled Children Act, and the Carers (Equal Opportunities) Act. The National Service Frameworks for Mental Health, Older People and Long-Term Conditions all emphasise the importance of information.

**What is the proposal?**
The proposal is for information to be provided at both a national and local level in a linked way that avoids duplication and is delivered to consistently high standards. This goes beyond the recommendation made in *Independence, Well-being and Choice* (the Green Paper on the future of social care), which recognises that quality information is important but recommends that this should be provided at a local level. It is our view that this proposition misses an opportunity.

**How is it going to be implemented?**
If we really want people to navigate around the system, whilst providing care and combining this with being active in the workforce we need an information service that operates in a fully integrated way covering health, social care, employment, benefits, housing, tax credits etc. If we fail to do this we increase the burden on the carer who has to go from source to source gathering the information they need. Many carers have told us that finding their way through the maze of rules and regulations is a full-time job. It can be the straw that breaks the camel's back, forcing people to give up work and go onto benefits, or to become ill through stress.

There is a clear distinction between the type of information that can be provided at a national level and then at a local level. A national service can be staffed by very experienced, highly trained people, the complimentary local level service can provide specific information on the services available in their locality, assistance with form filling...
for people who need that and act as sign posting referral agency to local support and services.

The national service would be delivered via telephone, email, website, the local service will be provided by phone, email, a linked website and face-to-face.

Carers are very clear that they want information to come from a source independent of any statutory provider. The information and advice required - for example on benefits, employment, tax credits etc. - is the same for someone living in Cornwall or Berwick-upon-Tweed.

Our view is that if you provide a national source of information and advice then local providers can focus their attention on providing up-to-date quality information on the services that are available locally.

What we believe is needed is a well-staffed national [UK-wide] helpline, housed in a call centre, with the support of a good database and website, and information leaflets. This call centre would employ staff operating at three levels.

**Level One** - would deal with less complex requests for information, answering standard questions.

**Level Two** - when a query cannot be dealt with at level one, a specialist, experienced and trained adviser would assist the family.

**Level Three** - a very small team, 1 or 2 lawyers who would provide advice and support to staff, not the public.

This service should be independently monitored annually and should achieve Community Legal Services Quality Mark for Helplines.

It is our view that the service should be run and managed by a UK-wide voluntary organisation, as the independence of advice is very important to carers.

The service would benefit from consistent branding that linked the national and local service

**Funding**

Detailed costings have not been worked out, but we estimate that the national service could cost in the region of £2.5 million a year, though of course depending on the size of need it is designed to meet this could be scaled up or down. At a local level current providers of service could either be reconfigured and rebranded, no estimate is available for this.

The service could be funded by means of a Government contract, where the funding is pulled together with contributions from the relevant departments. This would include Department of Health, Department of Trade and Industry, Home Office and The Treasury, Scottish Executive, Welsh Assembly and Northern Ireland Assembly.

**Inputs**

Depends on the size of the service. The project should aim to reach in the region of 1.5 million telephone contacts per year
Outputs
Range of leaflets on issues such as State second pension, accessing community care, care homes etc x 20 per year, numbers to be distributed, depends on the scale of the project and numbers targeted. A detailed database and website would have to be developed, all local sites would have to develop websites that mirrored the national site. An office base would have to be established

Impact
You would remove major barriers to people providing support to vulnerable relatives, this may free up their time and energy to spend more time on the care. More people will be able to combine work with care. There will be reduced pressure on local authority social services as people will be able to navigate the system and arrange their own care packages. There will be some equality for self funders.

Levers and Incentives
We need families to at least continue to provide the same level of care as today and indeed to increase this into the future if we are going to have an implementation plan for the White paper on Health and Social Care.

Possible Targets or Standards
A unified, recognisable service that operates at a local and national level. This service should be accredited through a national framework, perhaps Legal Services Quality Mark or similar.

Leadership challenge
The major leadership challenge will be to gain an understanding at a local and national level of the role that families play in the delivery of health and social care, and a commitment to removing the barriers for families who wish to provide that care. Getting buy in at a local level will present a challenge, many local authorities would consider that they already provide a good information service for carers and some do, but it is not universal and if you live in London and are trying to arrange care and support for a relative that lives in say Skipton it can be very difficult to do this.