

Halton Joint Strategic Needs Assessment 2015/16

Adult and Young Carers



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Description	The document describes the policy context, estimated prevalence, risk factors and sub-groups of need, current service provision and national best practice in relation to those who provide unpaid care (carers) in Halton.
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Related documents	Halton Carers Strategy 2015-2018

Please quote the JSNA

We would like to know when and how the JSNA is being used. One way, is to ask people who use the JSNA when developing strategies, service reviews and other work to quote the JSNA as their source of information.

List of Abbreviations

ASCOF	Adult Social Care Outcomes Framework
CCG	Clinical Commissioning Group
GP	General Practitioner
HSCIC	Health and Social Care Information Centre
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LE	Life expectancy
LSOA	Lower super output areas
NHS	National Health Service
NEET	Not in education, employment or training
NICE	National Institute for Health and Clinical Excellence
ONS	Office for National Statistics
PUC	Providing unpaid care
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
SWEMWBS	Short Warrick-Edinburgh Mental Wellbeing Scale
TAF	Team around the family
UCE	Unpaid care expectancy
VOICES	Views of informal carers for the evaluation of services

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Key Findings

- Unpaid carers make up a significant 'workforce' at 15,010. This will probably continue to rise
- 'Caring' has traditionally been seen as a female role. Whilst there are a higher proportion of carers who are female, the split is not so significantly skewed towards women, with 57% of carers being female and 43% are male. Whilst a higher percentage of carers aged 25-49 are women a higher proportion of those aged 65+ are male
- The health and wellbeing of carers tends to be poorer than their non-carer peers. Levels of poor health amongst carers increases as the number of hours of care per week increases, with those providing 50 hours of more care per week having the poorest health. Halton has the 4th highest percentage of carers providing 50 or more hours care a week and also some of the highest levels of ill health and disability. Yet, national research shows carers often feel they do not have enough time to look after their own health. Plans need to be developed locally, in collaboration with carers, on how best to support the health of carers
- The mental wellbeing of Halton carers is poorer than that of the general population of the borough
- Only 10% of carers in Halton are known to their GP. Proactive identification is needed to increase this figure
- Only 44.9% of people identified as carers on GP records received their annual influenza vaccination in 2014/15. This means that only about 5% of all carers receive an annual vaccination against influenza. At a GP practice level uptake varied from 26.7% to 68.3% so no practice achieved the national target of 75%. Greater awareness of the benefits and risks is needed both within the carer population and amongst professionals to increase uptake
- Both nationally and locally, most people who provide unpaid care are in employment. Yet national research indicates many carers have to give up work as they are unable to meet of dual needs of their employed work and their caring role. This not only puts the carer in financial hardship but means employers are losing skilled and experienced staff that could have been retained by supportive workplace policies
- In terms of outcomes of being a carer, data for 2014/15, for those carers known to adult social care, shows Halton carers experience is similar to that seen across the North West and England. For example similar proportions stated they have about as much time as they wish and have as much social contact as they want as comparator areas
- Of known carers, a lower proportion of Halton carers provide help with physical care but more provide emotional support than comparator areas. This reflects the higher proportion who stated they cared for a person with mental health problems. However, the percentages are high across all areas of care showing unpaid carers provide multiple roles
- Census data shows that 14% of carers reported a long-term health problem/disability, which limited their day-to-day activities a lot. A further 17% stated they had a disability that limited their daily lives a little. These proportions were higher than for North West and England carers
- Halton has a higher proportion of people with long-term conditions, including multiple conditions, than the national average. These numbers are projected to rise, especially older people with 3 or more conditions. Together with efforts to support more people to remain living in their own homes, there will be an increased need for unpaid carers

Key priorities for commissioning

- To close the gap between the number of carers currently known to services and the number identified through the 2011 Census
- To identify more individuals who are caring for 50+ hours per week, and those carers with a long term disability that limits their day to day activities
- To increase the number of carers registered with their GP
- To improve the uptake of flu vaccinations by carers
- To improve information sharing between social care, NHS services and the voluntary sector to support integrated, personalised care
- Reduce financial hardship through improved access to welfare rights advice
- To raise awareness of carers issues amongst local employers and the need for supportive policies to help carers remain in employment. This will support efforts to reduce financial hardship as well as improve life satisfaction/ reduce social isolation amongst carers.
- To improve carers levels of satisfaction with social care services
- To ensure the implementation of NICE guidance, particularly with regards to; mental health; drugs and alcohol; the transition between inpatient hospital settings and community or care home settings for adults with social care needs; dementia - supporting people with dementia and their carers in health and social care; older people with social care needs and multiple long-term conditions; and end of life care
- To ensure that carers receive the support that is appropriate to them maintaining and/or improving their physical and mental health
- To ensure that carers receive advice and information regarding home equipment and assistive technology services
- To ensure the implementation of the 'triangle of care' for mental health

1. Introduction

Carers play an important role in society and have particular challenges that they have to overcome. An enormous amount of personal and community care is provided by family and friends, and social care and health services should be seen in this context. Estimates of how much the equivalent cost of this informal support would be if carers' input had to be replaced run as high as £87 billion per year, which is nearly as much as total spending on the NHS. Indeed at 1.25 million people providing 50 hours of more care per week, this is a greater full-time workforce than the whole NHS.^[1] This is without including the numbers who provide between 1-49 hours of care per week which is the majority.

Where services are needed to support people with illnesses, disabilities or addictions, the needs of informal carers should not be neglected, as they are closely linked, and often have a very important bearing on the effectiveness of the interventions for the cared for person.

For some people, having a caring responsibility may only last for a few months at a time and be intermittent; however, for others it may be continuous and last many years. For example, as people born with learning disabilities or with complex health conditions are living longer, it is possible for someone to become a carer in their twenties and remain a carer for most or the rest of their lives.

The provision of unpaid care can be seen as a social good where people give support to family and friends suffering from health conditions or impairments which disable them. Yet, a key finding of the interim report from the independent commission on the future of health and social care in England^[2] suggested the current system of means tested social care was a lottery, leading to inequity and a reliance on unpaid care, compared with health care which is free at the point of use. However, there are clearly funding implications for meeting social care needs in the future as the population ages. This will be compounded by the significant budget cuts facing local authorities.

The pressures on carers are such that that over time the effect on their health, social and financial wellbeing can be significant. Carers need support to continue to care - otherwise care can break down, with considerable cost to the individuals and to the health and social care system. For example, the 2011 Census showed the prevalence of unpaid care rose in England between 2001 and 2011 and that this care has disproportionately fallen on women between the ages of 50 and 64. An ageing population increases the risk of becoming an informal carer, especially during working ages. Such care provision has been shown to affect women's participation in the labour market more noticeably than men's.^{[3][4]}

2. Policy Context

National policy, strategy and legislation on carers have changed significantly over the last few years. The most significant change in the 2014 Care Act, which sets out a number of set duties on local authorities and other public sector organisations.

2.1. National Policy

The Care Act (2014)

Under the Care Act, local authorities take on new functions. This is to make sure that people who live in their areas:

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
- Can get the information and advice they need to make good decisions about care and support
- Have a range of providers offering a choice of high quality, appropriate services.

Importantly, the Act strengthens the rights and recognition of carers in the social care system, including, for the first time, giving carers a right to receive services. These strengthen significantly the rights of carers and sets out clear duties for Local Authorities and other public sector organisations.

Carers Strategy England 2008-2018 (2010)

The Carers' Strategy has five objectives for carers to be achieved by 2018, so that carers will be:

1. Recognised and supported as an expert care partner
2. Enjoying a life outside caring
3. Not financially disadvantaged
4. Mentally and physically well, treated with dignity
5. Children will be thriving, protected from inappropriate caring roles.

The Coalition Government refreshed this strategy in 2010 retaining these aims but inserting four priority areas:

- Supporting early self-identification and involvement in local care planning 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.

Carers Strategy: The Second National Action Plan (2014-2016)

This update to the national carers' strategy provided an overview of achievements since the last update in 2010 and sets out key actions for the next two years. Major progress in identifying and supporting carers is being brought about by the Care Act and the Children and Families Act and the update encourages a refresh of their local carer strategies to ensure all partners are signed up to the latest developments.

The Children and Families Act (2013)

In 2013, the Government tabled an amendment to the Children and Families Bill resulting in young carers being protected by law for the first time. This means that when a child is identified as a young carer, the needs of everyone in the family will be considered. This will trigger both children's and adult's support services into action – assessing why a child is caring, what needs to change and what would help the family to prevent children from taking on this responsibility in the first place.

NHS England Commitment to Carers Policy (2014)

This policy sets out how NHS England will support the NHS to deliver what carers have said is important to them. The document sets out a series of commitments to carers based on what carers outlined is important to them:

- *“Recognise me as a carer”*
- *“Information is shared with me and other professionals”*
- *“Signpost information for me and help link professionals together”*
- *“Care is flexible and is available when it suits me and the person for whom I care”*
- *“Recognise that I may need help both in my caring role and in maintaining my own health and well-being”*
- *“Respect, involve and treat me as an expert in care”*
- *“Treat me with dignity and compassion”.*

NHS Five Year Forward View (2014)

The NHS Five Year Forward View recognises that, with an ageing population, increased long term conditions, and funding for health that is not keeping pace with demand, promoting well-being and preventing ill-health will become even more important to the capacity and financial viability of the NHS. Providing better support for carers is therefore critical to the future of the NHS. This follows on from NHS England's Commitment to Carers Policy.

‘We will find new ways to support carers, building on the new rights created by the Care Act This will include working with voluntary organisations and GP practices to identify them and provide better support.’

2.2 Impact of the Care Act (2014) on local authority

Under the Care Act, local authorities have taken on new functions. This is to make sure that people receive services that prevent their care needs from becoming more serious, or delay the impact of their needs.

People can get the information and advice they need to make good decisions about care and support and have a range of providers offering a choice of high quality, appropriate services.

Importantly, the Act strengthens the rights and recognition of carers in the social care system, including, for the first time giving carers a clear right to an assessment of their support needs and to receive funded services.

The change in carers' rights will have an impact on the way services are provided locally and a significant demand on local authorities resources to undertake timely assessments and provide appropriate support.

There is likely to be significant impact on local authorities in terms of how the needs of all carers are going to be met. However, the contribution of informal carers to the health and well-being of the population of Knowsley is hugely significant.

In addition, there are challenges in the following areas;

- To continue to identify adult and young carers and provide them with the information they need
- Identifying unmet needs – whilst adult social care and the third sector carers organisation have contact with a significant number of carers, the challenge is to reach out to those carers who are not in touch with services or who are not even aware that they are carers
- Keeping carers as informed as they wish in relation to the upcoming changes in relation to Transforming Adult Social Care.
- Ensuring that carers are as informed and involved as they wish in the commissioning, delivery and monitoring of appropriate carers support services
- To have an understanding of the impact on carers of any proposed changes to local authority charges and/or changes to adult social care funding criteria
- Welfare reform impact– Reforms to welfare are likely to continue to have a significant impact on carers, many of whom are already struggling financially because of their caring role. Carers UK have continually recommended that an assessment of impact on carers is undertaken

2.3. National Outcome Frameworks

Carers are a priority for Social Care, Public Health and the NHS. This is reflected in all three outcome frameworks, especially the Social Care Outcome Framework.

2.3.1 Social Care Outcome Framework:

- 3B: Overall satisfaction of carers with social services
- 3C: The proportion of carers who report that they have been included or consulted in discussions about the person they care for.
- 3D: The proportion of people who use services and carers who find it easy to find information about support

Also, inextricably linked to a number of other social care outcomes including:

- Permanent admissions to residential and nursing care homes per 100,000 population.

2.3.2. Shared Outcome between the NHS and Adult Social Care Framework:

- Carer-related quality of life

2.3.3. Shared Outcome between the Public Health and Adult Social Care Framework:

- Proportion of people who use services and their carers, who reported that they had as much social contact as they would like.
- Proportion of adults with a learning disability who live in their own home or with their family.
- Proportion of adults in contact with secondary mental health services living independently with or without support.

These outcomes will measure the success of services in supporting carers and will provide an indication of how the NHS, Public Health and Social Care are working together to support carers locally.

2.4. Local Policy

2.4.1. One Halton

One Halton has emerged following the production of the Strategy for General Practice Services in which a new care model was set out focusing on integrated health and social care services working in the community. The goal of One Halton is to create a health care system that:

- works around each individual's needs
- supports people to stay well, and
- provides the very best in care, now and for the future

The objectives that have been developed for One Halton are:

- To work better together regardless of discipline
- To find or identify those 'hidden' people who don't access care
- To treat and care for people at the right time, in the right place by the right people
- To help people stay healthy and keep generally well
- To provide the very best in care, now and in the future

In moving One Halton forward, five areas of focus have been agreed. They are:

- Older people
- People with Long Term Conditions
- People with mental health conditions
- Families and children, and
- The generally healthy

Service for carers will form an important part of delivering the first three of these areas of focus.

2.4.2. Adult Social Care: People and Economy Directorate, Business Plan 2016 – 19

The Transformation Programme is a joint approach between Adult Social Care and the NHS to deliver personalisation and innovative approaches to support self-care, building on the work that has already been progressed in the borough. The 3 objectives of the programme are prevention, early intervention and managing complex care and care closer to home.

Carers' services will potentially have a key role within the following work areas:

- Social care in practice
- Active ageing
- Telecare and telehealth
- Mental health service re-design
- Integrated hospital discharge teams
- Community Multi-disciplinary teams (MDTs)
- End of life services

3. Level of need in the population

3.1. Overall provision of unpaid care

In the 2011 Census, 15,010 Halton residents described themselves as unpaid carers. This represents 12% of the Borough’s population and is higher than the national and regional figures (10.2% and 11.1% respectively). This is an increase of 1,482 since the 2001 Census with the percentage increase being similar to the national rate.

Table 1: Total numbers of unpaid carers, 2001 and 2011 Census, Halt on and comparators

	2001		2011		2001 to 2011 change	
	Number	Percentage of total population	Number	Percentage of total population	Number	% change
Halton	13,528	11%	15,010	12%	1482	11%
North West	722,119	10.9	781,972	11.1	59,853	8%
England	4,854,731	10%	5,430,016	10%	575,285	12%

Source: 2001 and 2011 Census, ONS

Whilst the overall proportion of unpaid care increased by 11% , the percentage increase amongst those providing between 1 and 19 hours of care per week increased by less than 1% compared to significant increases in the proportion of people providing 20-49 hours & 50 or more hours of unpaid care per week over this period. This is a similar pattern to that of the North West and England, including local authorities within Merseyside.

Table 2: Hours of unpaid care provided per carer a week in Halton, 2001 to 2011 Census

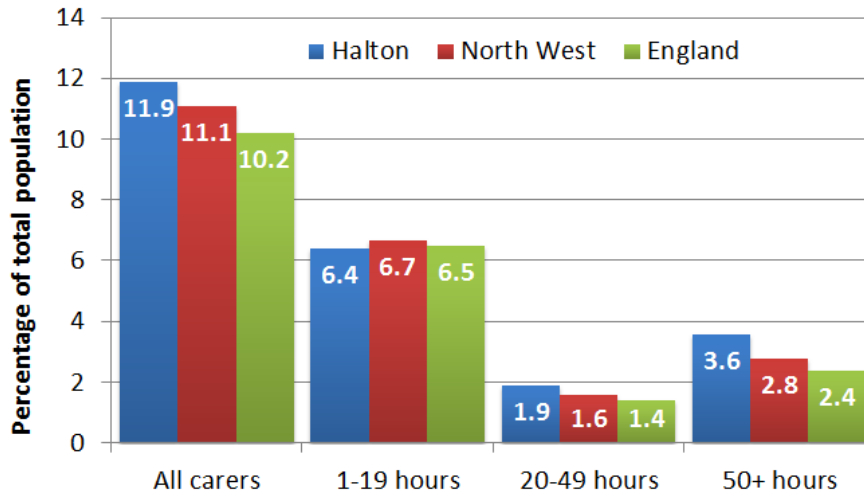
	2001		2011		2001 to 2011 change	
	Number	Percentage of unpaid care	Number	Percentage of total population	Number	% change
Provides care: total	13528	11.4% (% of total population)	15,010	12% (% of total population)	1,482	11.0%
Provides 1 to 19 hours care a week	7942	58.7%	8,004	53.3%	62	0.8%
Provides 20 to 49 hours care a week	1887	13.9%	2,439	16.2%	552	29.3%
Provides 50 or more hours care a week	3699	27.3%	4,567	30.4%	868	23.5%

Source: 2001 and 2011 Census, ONS

Halton had one of the highest percentage increases between the 2001 and 2011 Census in the proportion of its population providing 50 or more hours unpaid care one of highest levels of 50+ hours of care provision, placed 4th in the country behind East Lindsey, Knowsley and St Helens.^[5]

The amount and type of care that carers provide varies considerably. A carer might provide a few hours of care a week, perhaps shopping for a friend or relative, or they may care around the clock. Providing care can range from helping with household tasks on a regular basis to providing continuous care.

Figure 1: Percentage of total population who are carers, by hours of care provided, Halton and comparators, 2011 Census



Source: Table QS301UK, 2011 Census via Nomis

In the annual Personal Social Services Survey of Adult Carers in England 2014/15, carers are asked how many hours of care they provide and also how long they have been a carer for. The survey is administered by councils and sent to those known to be a carer. It thus represents only those known to adult social care as carers and may or may not be representative of carers as a whole. The survey nevertheless provides useful insights into the nature and type of unpaid caring provision locally and also the health and wellbeing of carers. However, it shows a significantly higher percentage of carers known to adult social care providing 50 or more hours of care per week, over 44% compared to Census data which indicates 19.7% of Halton carers provide this level of unpaid care (see Figure 2 in section 3.2.1.).

Table 3: Annual Carers Survey 2014/15 Q19 - About how long do you spend each week looking after or helping the person you care for? – Halton and comparator results

	0-9 hours	10-19 hours	20-34 hours	35-49 hours	50-74 hours	75-99 hours	100 or more hours	Varies - Under 20 hours	Varies - 20 hours or more	Other
Halton	4.6	8.3	8.0	8.9	8.0	7.6	37.0	4.9	5.8	7.0
North West	5.8	7.3	8.8	9.2	6.7	7.9	35.5	2.8	6.6	9.5
England	6.1	7.4	7.6	7.5	6.4	7.5	38.1	3.0	6.6	9.7

Source: HSCIC

Data for 2014/15 shows that 52.6% said they provided at least 50 or more hours of care per week. This is a greater proportion than the North West (50.1%) and England (52%) averages and much higher than the 2011 Census indicated. It may be that it is those who provide more hours of care who are more likely to request a carers assessment to help them manage their caring role.

Table 4: Annual Carers Survey 2014/15 Q19 - About how long have you been looking after or helping the person you care for? - Halton and comparator results

	Less than 6 months	Over 6 months but less than a year	Over 1 year but less than 3 years	Over 3 years but less than 5 years	Over 5 years but less than 10 years	Over 10 years but less than 15 years	Over 15 years but less than 20 years	20 years or more
Halton	0.3	3.3	14.7	19.2	22.2	12.0	8.1	20.1
North West	0.6	2.7	15.7	17.0	23.5	11.6	7.7	21.1
England	0.6	2.7	15.3	17.9	23.6	12.0	7.7	20.1

Source: HSCIC

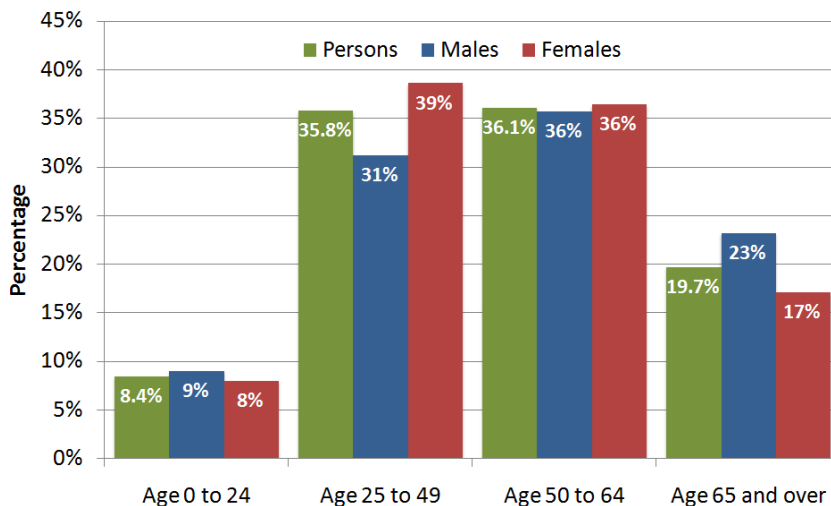
The number of years Halton carers had been a carer for at the time of the 2014/15 survey was broadly similar to the North West and Halton averages. Relatively few carers had been a carer for less than a year, and more than half (62.4%) had been a carer for over 5 years and 8 out of 10 (81.6%) had been a carer for 3 years or more. It may be that at the early stages of a person’s caring role they feel able to cope independently but as either their caring role changes or their own health and wellbeing is impacted upon unpaid carers feel the need for formal support.

3.2 Characteristics of Carers

3.2.1 Gender and age

Of the 15,010 unpaid carers in Halton, 8,584 are female and 6,426 are male, making the gender split 57.2% female and 42.8% males. This is a similar proportion seen regionally and nationally.

Figure 2: The proportion of unpaid carers by sex and age in Halton, 2011



Source: LC3301EW, 2011 Census via Nomis

The 2011 Census shows that Halton had 1259 young carers (aged 0-24), a percentage than nationally - 8.4% compared to 7.5% across England as a whole. In Halton, 2,960 people who provide unpaid care were aged 65 and over, which equates to 19.7% of all unpaid carers. This is lower than both the regional figure of 21.4% and the national figure of 22%. It can be assumed that those aged over 65 are likely to need some additional support from the council to support them in their caring role.

In Halton, the highest proportion of unpaid carers are women and 20 to 49 providing 1 to 19 hours of care (40.9%). More men provide 50 or more hours in unpaid care, 799 men compared to 739 women. For males providing 50 or more hours of unpaid care a week, 40.7% are aged 65 and over. For females providing 50 or more hours the largest proportion are of a younger age, 25 to 49.

Table 5: Number and percentages of unpaid care, hours of care per week, by gender age, Halton 2011

Males	All categories: Age	Age 0 to 24	Age 25 to 49	Age 50 to 64	Age 65 and over
Provides unpaid care: Total	6,426	576 (9%)	2067 (32.2%)	2291 (35.7%)	1492 (23.2%)
Provides 1 to 19 hours unpaid care a week	3,403	417 (12.3%)	1194 (35.1%)	1326 (39%)	466 (13.7%)
Provides 20 to 49 hours unpaid care a week	1,059	109 (10.3%)	384 (36.3%)	339 (32%)	227 (21.4%)
Provides 50 or more hours unpaid care a week	1,964	50 (2.5%)	489 (24.9%)	626 (31.9%)	799 (40.7%)
Females	All categories: Age	Age 0 to 24	Age 25 to 49	Age 50 to 64	Age 65 and over
Provides unpaid care: Total	8,584	683 (8%)	3310 (38.6%)	3123 (36.4%)	1468 (17.1%)
Provides 1 to 19 hours unpaid care a week	4,601	443 (9.6%)	1881 (40.9%)	1741 (37.8%)	536 (11.6%)
Provides 20 to 49 hours unpaid care a week	1,380	132 (9.6%)	525 (38%)	530 (38.4%)	193 (14%)
Provides 50 or more hours unpaid care a week	2,603	108 (4.2%)	904 (34.7%)	852 (32.7%)	739 (28.4%)

Source: LC3301EW, 2011 Census, via Nomis

NB: due to the composition & nature of the data-sets generating the overall information, each category is mutually exclusive; therefore the volumes of unpaid carers within each category must be regarded independently of the other.

3.2.3. Types of care provided

From the Annual Carers Survey an understanding of the nature of the care unpaid carers provide can be examined. It shows the type of support given by Halton carers is broadly similar to the North West and England (Table 6). There are higher proportions of adults aged 18-64 being cared for a lower levels of people aged 65+, with the difference being most marked in the 85+ age group, probably reflecting Halton's lower life expectancy (Table 7).

Table 6: Types of support carers have provided for the person they care for in the preceding 12 months, annual Carers Survey 2014/15

	Personal care	Physical help	Helping with dealing with care services and benefits	Helping with paperwork or financial matters	Other practical help	Keeping him/her company	Taking him/her out	Giving medicines	Keeping an eye on him/her to see he/she is all right	Giving emotional support	Other help
Halton	59.3	48.7	85.8	84.1	91.2	82.6	77.3	68.7	89.1	88.2	17.7
North West	66.7	58.1	85.5	84.5	92.6	83.1	78.0	74.9	91.1	84.6	21.7
England	68.6	58.8	86.4	86.4	93.0	83.5	76.4	76.4	91.3	85.1	20.3

Source: HSCIC

Table 7: Age of person cared for

	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Halton	4.5	9.0	10.2	9.9	13.5	17.1	21.3	14.7
North West	4.7	6.0	5.7	8.4	8.4	15.2	26.4	25.1
England	5.3	5.3	5.1	6.8	7.7	13.9	27.1	28.8

Source: HSCIC

A smaller proportion of people cared for by Halton carers have dementia, physical disability and sight or hearing loss, problems connected to ageing and terminal illness compared to the North West and England. Conversely a higher proportion have mental health problems, long-standing illness and alcohol or drug dependency.

Table 8: Conditions cared for person has, 2014/15

	Dementia	Physical disability	Sight or hearing loss	Mental health problem	Problems connected to ageing	Learning disability or difficulty	Long-standing illness	Terminal illness	Alcohol or drug dependency
Halton	22.3	46.6	24.0	34.7	27.3	18.4	42.4	2.7	2.4
North West	31.5	53.5	31.2	22.0	37.0	17.9	41.4	4.8	2.1
England	34.6	55.4	32.5	19.5	38.8	18.1	40.1	5.6	1.5

Source: HSCIC

Living arrangements are similar albeit with a slightly higher proportion of Halton carers caring for a person who does not live with them than the North West and England averages.

Table 9: Living arrangements between carer and person cared for, 2014/15

	With me	Somewhere else
Halton	69.0	31.0
North West	71.5	28.5
England	73.0	27.0

Source: HSCIC

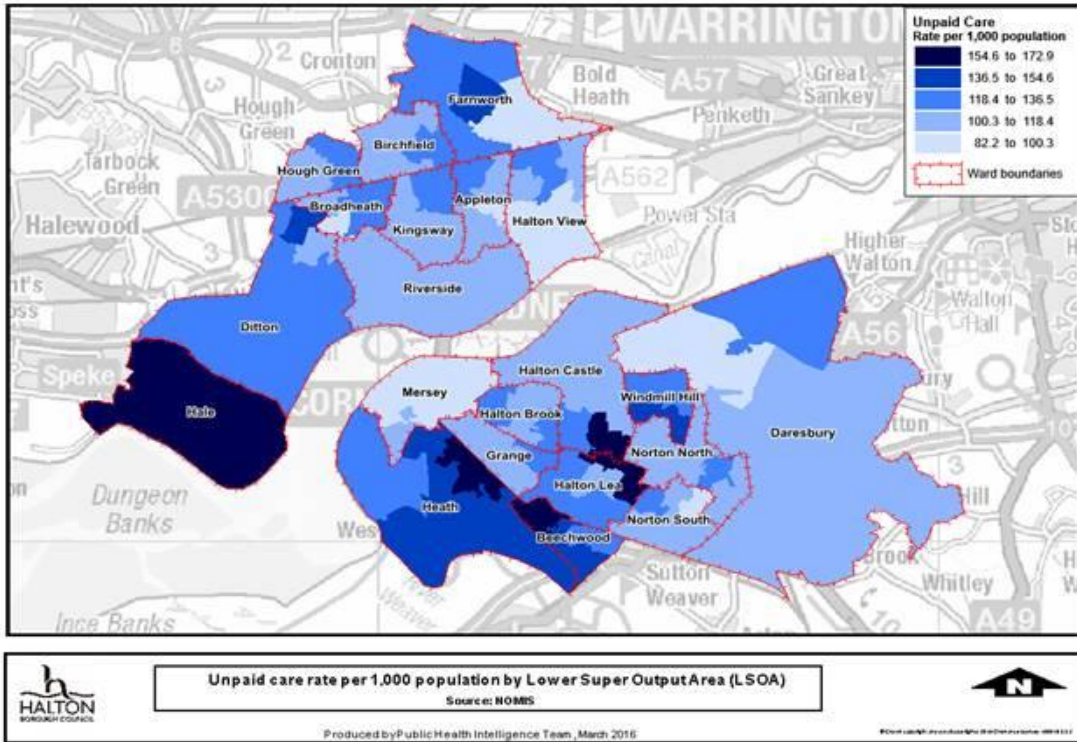
3.2.2 Location of carers - Where do carers live?

Data from the Census also enables the mapping of residents who identified themselves as carers as data is available at a lower super output area (LSOA)^[i] as well as ward. Figure x shows the location of residences for carers in Halton with the darker areas representing those locations where the proportion of residents who are carers is highest.

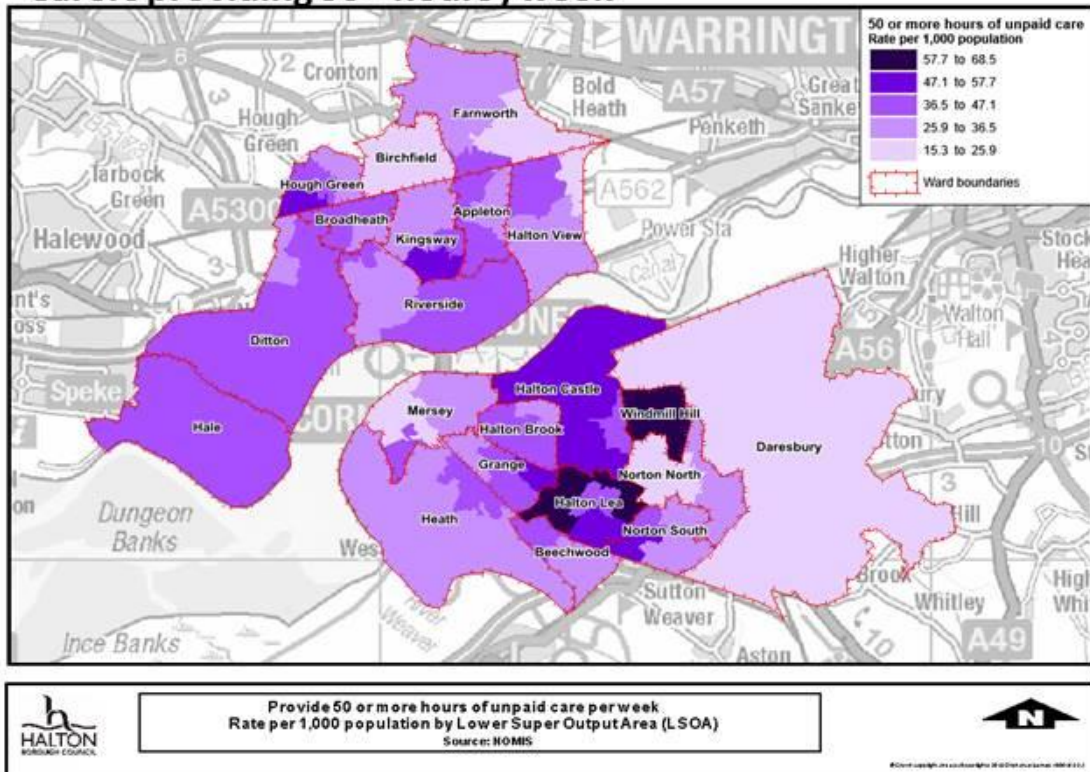
ⁱ LSOA is a small geographical area, smaller than an electoral ward, made up of approximately 1,500 households

Figure 3: Location of all carers and those providing 50 or more hours of care per week

All carers

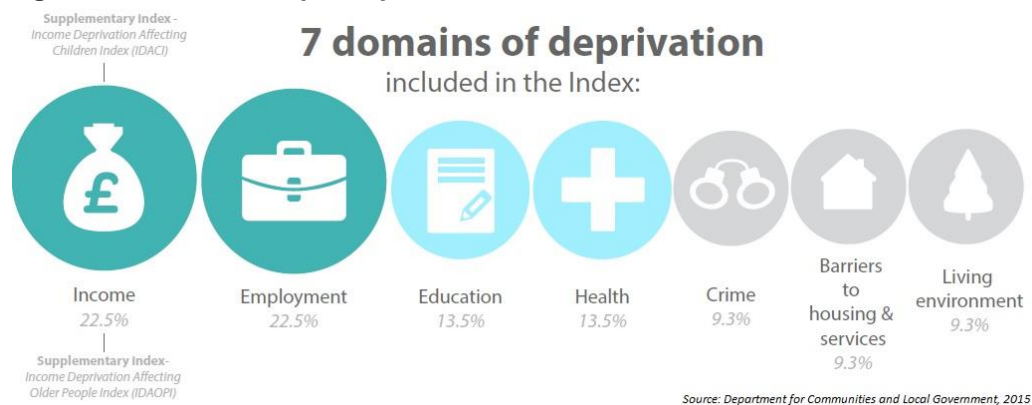


Carers providing 50+ hours /week



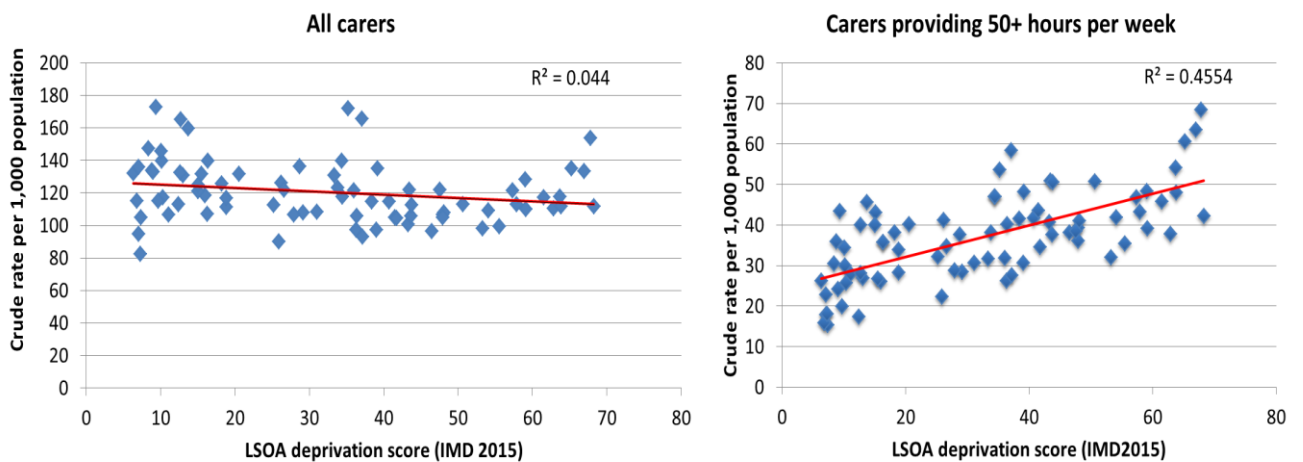
The English Indices of Multiple Deprivation (IMD) measure relative levels of deprivation in 32,844 small areas or neighbourhoods, called Lower-layer Super Output Areas, in England. Produced every couple of years the latest ones were released September 2015, with most of the indicator using 2012/13 data. The English Indices of Deprivation 2015 are based on 37 separate indicators, organised across seven distinct domains¹ of deprivation which are combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2015 (IMD 2015). This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower layer Super Output Area (LSOA), or neighbourhood, in England. Every such neighbourhood in England is ranked according to its level of deprivation relative to that of other areas.

Figure 4: Index of Multiple Deprivation Domains



As Census data on carers is also available at LSOA level it is possible to analyse the two data sets in a way that helps to see the extent to which geographical deprivation is related to being a carer. This is not to suggest that all carers living in a particular area will be deprived or not deprived as everyone’s situation is different and this is not the purpose of the IMD statistics. It shows that there is no correlation between being a carer providing any level of care and deprivation with only a weak-medium strength relationship between carers providing 50+ hours per week and geographical deprivation.

Figure 5: Correlation between carers locations and IMD 2015



Source: Table LC3304EW, 2011 Census, via Nomis

3.3 Economic Status of Carers

A UK report on the impact of caring on family finances^[6] found that families taking on caring responsibilities often face lasting financial pressure as a result of loss of earnings and rising household costs relating to the extra costs of ill-health or disability.

Carers UK (2013) found that:^[7]

- Four in 10 (44%) of carers surveyed have been in debt as a result of caring
- Nearly one in four (58%) carers spend at least 10% of their income on energy bills. Up from 54% in 2011/12
- 36% of carers are struggling to afford utility bills like electricity, gas, water or telephone bills
- 52% of carers say that financial concerns are affecting their health
- 41% of those struggling are cutting back on essentials like food and heating

Many carers struggle to combine work with caring responsibilities and, as a result, may have to leave work, reduce their hours or take lower paid or part-time jobs. Yet being in employment is beneficial for health and wellbeing and reduces social isolation.

Carers UK (2013) found that:

- Nearly two thirds (65%) of carers in work have used annual leave to care while, nearly half (47%) have done overtime to make up for taking time off to care
- One in seven (15%) have taken a less qualified job, turned down or not sought promotion because of caring responsibilities
- A further one in six (17%) continue to work the same hours but find their job is negatively affected by stress, tiredness or lateness. Over half (56%) of carers who gave up work to care spent or have spent over five years out of work as a result
- One in five carers is forced to give up work as a result of their caring responsibilities. This is significant given the importance of 'meaningful activity' (such as employment) to maintaining an individual's positive mental health. Such activity also reduces social isolation

There are multiple pieces of legislation which are relevant to the rights of carers in employment. The Employment Rights Act 1996, as amended by the **Employment Relations Act 1999**, gives carers rights to help them manage work and their caring responsibilities. People who are looking after someone who is elderly or disabled are now protected against direct discrimination or harassment because of their caring responsibilities under the **Equality Act 2010**.

A recent report on supporting working carers highlights the economic benefits of supporting carers to stay in work.^[8] Its recommendations include the importance of effective joint working between Local Authorities and care providers to support the development of services that meet carers' needs using Local Enterprise Partnerships and Health and Wellbeing Boards to promote this agenda. Carers UK and major businesses have set up Employers for Carers offering help to employers to retain the one in nine employees who are caring for a family member. Details can be found at:

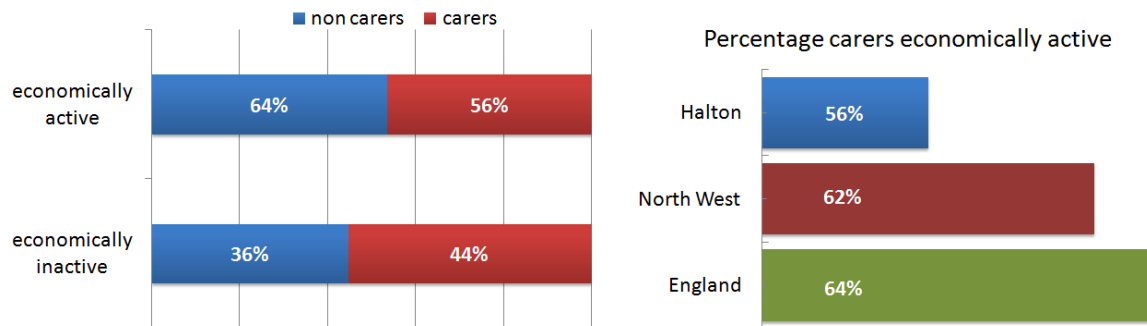
<https://www.employersforcarers.org/>

Levels of economic activity amongst carers

Economically active people are defined as those people who are in employment and those people who are unemployed and are available to work.

Economically inactive people are defined as those people who are not in employment or those people who are not available to work. This includes people who are retired, those looking after family, those who are long term sick and some students.

Figure 6: Economic status of unpaid carers compared to non-carers, Halton 2011



Source: LC6301EW, 2011 Census, via Nomis

Figure 6 shows that although a smaller proportion of carers are economically active than their non-carer peers, the majority of carers are economically active. However, in Halton a slightly smaller percentage of carers are economically active compared to the North West and England.

Table 10: Economic activity by main types, Halton carers compared to Halton non carers

Economic Activity	Halton		Carers only	
	Provides no unpaid care	Provides unpaid care	North West	England
Economically active: Total	64%	55.8%	62%	64%
Of those who are economically active:				
In employment: Total	58%	51.4%	57%	59%
Part-time	12.8%	14.6%	13%	13%
Full-time	38.0%	30.8%	34%	35%
Self-employed: Total	5.5%	4.9%	7%	9%
Full-time students	2%	1.0%	2%	2%
Unemployed: Total	6%	4.4%	5%	5%
Economically inactive: Total	36%	44.2%	38%	36%
Of those who are economically inactive:				
Retired	20%	25.3%	22%	21%
Looking after home or family	3%	8.9%	4%	4%
Long-term sick or disabled	7%	6.3%	5%	4%
Other	2%	1.9%	2%	2%

Source: LC6301EW, 2011 Census via Nomis

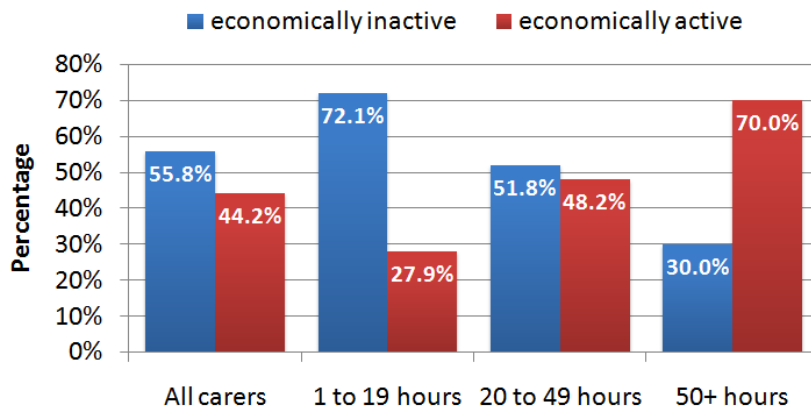
In Halton, 8,184 unpaid carers are economically active, which is equivalent to 55.8% of all unpaid carers. This is lower than the regional average of 56.8% and the national average of 57.9%. Of the economically active unpaid carers in Halton, 7,538 unpaid carers are in employment, which is equivalent to 51.4% of all unpaid carers.

30.8% of Halton unpaid carers are in full time employment. This is a lower proportion than the regional average of 34.1% and the national average of 46.9%.

Assuming that carers who also have a full time job, are in full time education or are economically inactive due to illness or disability are more likely to need support to fulfil their caring role, this equates to 5,633 carers in Halton fitting into this category.

Figure 3 shows that those providing 50 or more hours of unpaid care are much less likely to be economically active, compared to all carers, less than one in three. Conversely more than two out of every three carers providing 1 to 19 hours of care per week are economically active.

Figure 7: Economic activity by hours of care provided



Source: LC6301EW, 2011 Census via Nomis

Carers known to adult social care are less likely to be in employment than all carers, although the percentages for Halton are higher than the North West and England. As seen in the previous sections, carers known to adult social care provide more hours of care than all carers, which is likely to explain this difference, at least in part. A greater proportion indicate they are retired than seen in the 2011 Census.

Table 11: Economic status of carers responding to the 2014/15 Personal Social Services Annual Carers Survey

	Retired	Employed full-time	Employed part-time (working 30 hours or less)	Self-employed full-time	Self-employed part-time	Not in paid work	Doing voluntary work	Other
Halton	44.5	17.3	9.3	1.5	0.6	22.7	4.5	7.8
North West	54.8	9.8	11.5	1.9	2.4	19.0	5.6	7.1
England	58.0	9.1	10.8	1.9	3.0	18.3	5.3	6.1

Source: HSCIC

Carers known to adult social care were also asked about the level of support they received from their employers and if this was adequate. Of those in employment more felt supported than didn't feel supported. 8.1% felt they did not need support from their employer. Despite these small percentages, it may be worth working with employers locally to ensure good practice in supporting those who have a caring role. Especially as this represents only a small proportion of the 51.4% of carers who are employees.

Table 12: Support from employers

	I am in paid employment and I feel supported by my employer	I am in paid employment but I don't feel supported by my employer	I do not need any support from my employer to combine work and caring	I am not in paid employment because of my caring responsibilities	I am not in paid employment for other reasons	I am self-employed or retired
Halton	13.0	8.8	8.1	26.4	11.3	32.4
North West	12.7	5.4	5.8	22.1	12.4	41.6
England	11.9	4.6	5.6	20.5	11.3	46.1

Source: HSCIC

Table 13 shows that of those providing 50 or more hours of unpaid care, most are in employment with unemployment rates in this group being below that of all carers and indeed non-carers who are economically active. A higher proportion of those providing 50 or more hours of unpaid care are retired or unable to work due to illness or disability than carers overall and non-carers.

Table 13: Economic activity by number of hours of caring

Economic Activity	All categories: Provision of unpaid care		Provides no unpaid care		Provides unpaid care							
	Number	% of all economic activity	Number	% of all economic activity	Provides unpaid care: Total		Provides 1 to 19 hours unpaid care a week		Provides 20 to 49 hours unpaid care a week		Provides 50 or more hours unpaid care a week	
	Number	% of all economic activity	Number	% of all economic activity	Number	% of all economic activity	Number	% of all economic activity	Number	% of all economic activity	Number	% of all economic activity
All categories: Economic activity	100,819	100%	86,149	100%	14,670	100%	7,742	100%	2,387	100%	4,541	100%
Economically active: Total	63,611	63.1%	55,427	64.3%	8,184	55.8%	5,583	72.1%	1,237	51.8%	1,364	30.0%
In employment: Total	57,771	57.3%	50,233	58.3%	7,538	51.4%	5,200	67.2%	1,112	46.6%	1,226	27.0%
Employee: Total	50,469	50.1%	43,799	50.8%	6,670	45.5%	4,588	59.3%	984	41.2%	1,098	24.2%
Part-time	13,175	13.1%	11,030	12.8%	2,145	14.6%	1,344	17.4%	357	15.0%	444	9.8%
Full-time	37,294	37.0%	32,769	38.0%	4,525	30.8%	3,244	41.9%	627	26.3%	654	14.4%
Self-employed: Total	5,466	5.4%	4,743	5.5%	723	4.9%	503	6.5%	102	4.3%	118	2.6%
Part-time	1,447	1.4%	1,213	1.4%	234	1.6%	160	2.1%	36	1.5%	38	0.8%
Full-time	4,019	4.0%	3,530	4.1%	489	3.3%	343	4.4%	66	2.8%	80	1.8%
Full-time students	1,836	1.8%	1,691	2.0%	145	1.0%	109	1.4%	26	1.1%	10	0.2%
Unemployed: Total	5,840	5.8%	5,194	6.0%	646	4.4%	383	4.9%	125	5.2%	138	3.0%
Unemployed (excluding full-time students)	5,157	5.1%	4,551	5.3%	606	4.1%	355	4.6%	116	4.9%	135	3.0%
Full-time students	683	0.7%	643	0.7%	40	0.3%	28	0.4%	9	0.4%	3	0.1%
Economically inactive: Total	37,208	36.9%	30,722	35.7%	6,486	44.2%	2,159	27.9%	1,150	48.2%	3,177	70.0%
Retired	20,782	20.6%	17,068	19.8%	3,714	25.3%	1,363	17.6%	573	24.0%	1,778	39.2%
Student (including full-time students)	3,884	3.9%	3,619	4.2%	265	1.8%	176	2.3%	53	2.2%	36	0.8%
Looking after home or family	3,921	3.9%	2,615	3.0%	1,306	8.9%	260	3.4%	279	11.7%	767	16.9%
Long-term sick or disabled	6,689	6.6%	5,766	6.7%	923	6.3%	277	3.6%	174	7.3%	472	10.4%
Other	1,932	1.9%	1,654	1.9%	278	1.9%	83	1.1%	71	3.0%	124	2.7%

Source: Table LC6301EW 2011 Census, via Nomis

A small proportion of carers may be entitled to and claiming Carers Allowance. This is a taxable benefit and although not means tested, eligibility is dependent on the amount a person earns from other sources. Eligibility depends on a number of factors:

- being 16 years of age or over
- spending at least 35 hours a week caring for someone
- having been in England, Scotland or Wales for at least 2 of the last 3 years
- normally living in England, Scotland or Wales, or living abroad as a member of the armed forces
- not being full-time education or studying for 21 hours a week or more
- earning no more than £110 a week (after taxes, care costs while at work and 50% of personal pension contributions)
- being in receipt of a range of other state benefits including state pension, out-of-work benefits, universal credit and other allowances may affect eligibility. However, having underlying entitlement to carers allowance may increase some of these benefit amounts payable but it may also decrease some benefit amounts
- The person you care for must already be in receipt of one of the following benefits:
 - Personal Independence Payment (PIP) daily living component
 - Disability Living Allowance (DLA) - the middle or highest care rate
 - Attendance Allowance
 - Constant Attendance Allowance at or above the normal maximum rate with an Industrial Injuries Disablement Benefit, or basic (full day) rate with a War Disablement Pension
 - Armed Forces Independence Payment

Table 14: Number of Halton carers receiving Carer Allowance payments, as at May 2015

Age	Male	Female	Total
aged under 18	10	10	10
aged 18-24	50	90	150
aged 25-29	40	130	170
aged 30-34	60	210	270
aged 35-39	70	190	260
aged 40-44	90	240	330
aged 45-49	100	200	310
aged 50-54	120	220	340
aged 55-59	90	210	300
aged 60-64	130	120	250
aged 65 and over	~	30	40
unknown age	~	~	~
Column Total	770	1,650	2,420

Source: Department for Work and Pensions, via Nomis

3.5 Health of Carers

3.5.1. Health risks associated with being a carer

Carers' needs are complex and vary dependent upon the individual's personal circumstances, including the amount and type of caring needs of the person they care for, their individual living and working conditions, their age and family set up amongst other things. Indeed, some carers are at a greater risk of being disadvantaged or becoming ill themselves than other carers. It is therefore important to recognise and respond to those that are at greatest risk whilst at the same time there are general support needs that are applicable to all carers.

There are significant risks associated with caring and maintaining good health and positive wellbeing. These include risks to physical health (strain, injury, exhaustion and lack of sleep), mental health (stress, anxiety, worry and depression) and financial pressures (loss of income from paid employment). Many carers also experience social isolation and find it difficult to maintain relationships and social networks due to the impact of caring for someone. Carers can also receive inadequate support from services to help them with their caring role, resulting in illness and limited support to help them recover.

It is estimated that the unpaid work and support that carers give save the UK purse £119 billion a year. This means that the cost of a single carer having to stop caring could result in additional residential care home costs of over £13,000 per year for each person previously cared for.^[9]

Carers UK found that 84% of carers surveyed said that caring has a negative impact on health. Nine out of ten (92%) carers said that their mental health has been affected by caring with only 1% saying that caring has improved their mental health. 67% of carers said their GP is aware of their caring responsibilities but gives them no extra help.^[10] Yet data shows only 10% of carers are registered as being carers on GP records. Carers not receiving respite are more likely to have mental health problems (36%), compared with those in receipt of respite (17%).^[11]

The health of carers deteriorates more quickly than that of non-carers due to the lack of support (often due to a lack of awareness of support available). 64% reported a lack of practical support and 50% a lack of financial support.^[12]

The Royal College of General Practitioners (RCGP)^[13] have identified (from various sources) that:

- Carers tend to neglect their own health. The impact on a carer's own physical and mental health is worsened if they are unable to attend their own health-related appointments. They may fail to notice their own health deteriorating and miss routine appointments or check-ups with doctors or dentists. Information from Carers UK shows that two in five carers postpone their own treatments due to lack of support. Care and support is also relied on to take the cared for to appointments if the carer works.
- Caring can limit carers' ability to take exercise
- 40% of carers experience psychological distress or depression, with those caring for people with behavioural problems experiencing the highest levels of distress
- 33% of those providing more than 50 hours of care a week report depression and disturbed sleep

- Those providing more than 20 hours of care a week over an extended period have double the risk of psychological distress over a two year period compared to non-carers. Risk increases progressively as the time spent caring each week increases
- 44% of carers suffer verbal or emotional abuse; 28% endure physical aggression or violence from the person they care for
- Older carers who report 'strain' have a 63% higher likelihood of death in a four year period
- Providing high levels of care is associated with a 23% higher risk of stroke

3.5.1.1. Which Carers are at Greatest Risk of Ill Health?

National evidence suggests certain types of carers are more at risk of ill health than others due to their caring responsibilities. Using the 'at risk' determinants of: economic activity, health, age and 50+ hours of unpaid care provided per week, the following 'sub-set' of unpaid carers has been identified as being potentially 'at risk' and therefore likely to need additional health and wellbeing support in their caring role.

Table 15: Number of Halton carers at increased risk of ill health

Type of carer at increased risk	Number
Economically active (full-time employment)	4525
Economically inactive (long-term sick/ disabled)	932
Bad/Very bad health	1454
Long-term disability which limits daily life a lot	2147
Providing 50 or more hours of care per week	4567
aged 65 and over	2960

Source: 2011 Census, ONS

3.5.2. Levels of health

The 2011 Census includes a question asking about the respondent's general health, within a number of categories. People were asked to assess whether their health was very good, good, fair, bad or very bad. This assessment is not based on a person's health over any specified period of time.

In Halton most people who provide unpaid care report being in good or very good health – 10,123 out of 15,010 or 67%. Of the remainder 3,433 reported fair health and 1,454 bad or very bad health.

However, the percentage reporting good or very good health was lower than the regional and national levels. Conversely the proportion reporting bad or very bad health was higher than these comparators, as Figure 5 shows.

Figure 8: Health status of unpaid carers, Halton and comparators, 2011

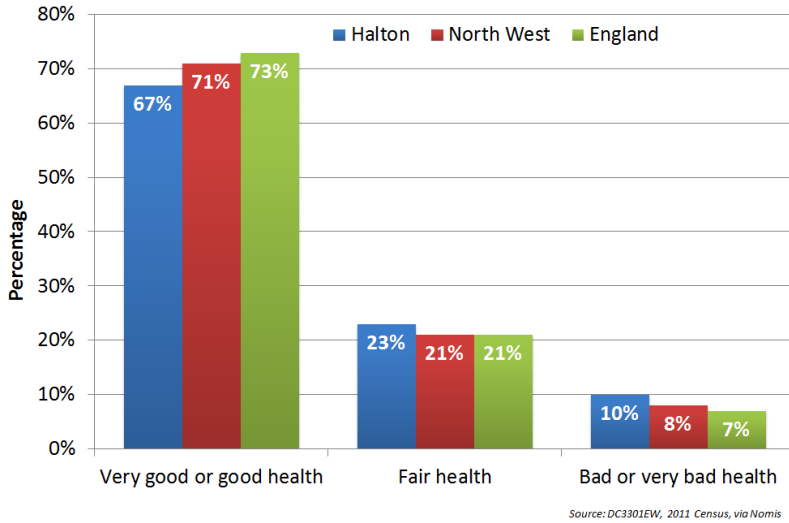
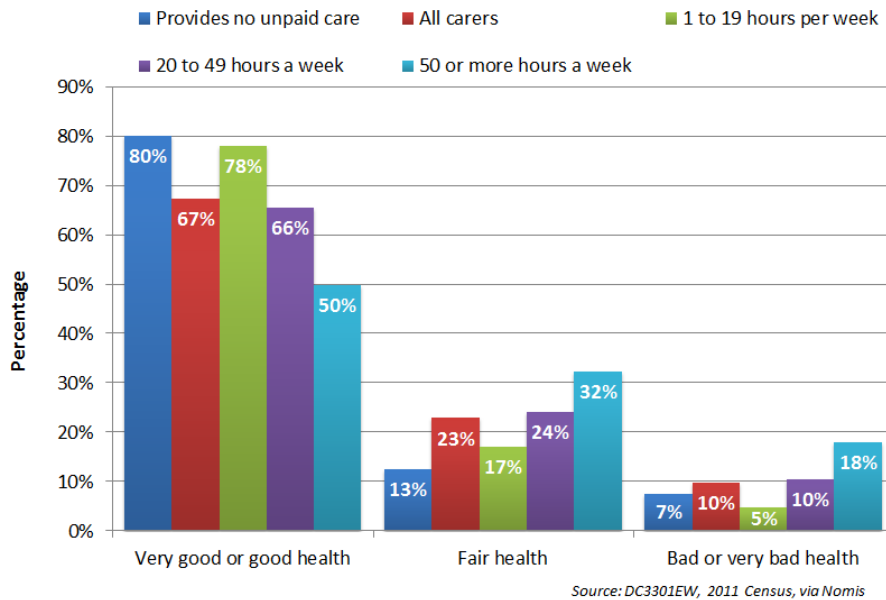


Figure 5 shows that the proportions of those in good or bad health varies by the amount of care provided, with those providing the highest number of hours having disproportionately poorer health. This may partly be an effect of age – those over the age of 65 are more likely to provide 50 or more hours of care a week and are also more likely to find their health worsening. All carers have poorer health than non carers, although for those providing 1 to 19 hours of care a week, the difference between them and non-carers is marginal.

Figure 9: Number of hours of unpaid care provided weekly, by general health of Halton carers



Carers who report bad or very bad health are themselves more likely to need additional support in their caring role and/or are accessing support to address their own health and wellbeing needs. In Halton there are 1,454 carers who report having bad or very bad health and of this group over half, 818, are providing 50 or more hours care per week. Nearly half of these are over age 65.

Table 16: Number and percentage of Halton carers with bad or very bad health, by age

	All carers		Age 0 to 24		Age 25 to 49		Age 50 to 64		Age 65 and over	
	Number	%	Number	%	Number	%	Number	%	Number	%
Provides no unpaid care	8139	7%	329	4%	1642	20%	2797	34%	3371	41%
All Carers	1454	10%	14	1%	267	18%	600	41%	573	39%
1 to 19 hours a week	382	5%	4	1%	92	24%	187	49%	99	26%
20 to 49 hours a week	254	10%	3	1%	58	23%	115	45%	78	31%
50 or more hours a week	818	18%	7	1%	117	14%	298	36%	396	48%

Source: DC3301EW, 2011 Census, via Nomis

Table 17: General health of Halton carers, by number of hours of unpaid care provided and gender

	Males			Females		
	Very good or good health	Fair health	Bad or very bad health	Very good or good health	Fair health	Bad or very bad health
Provides no unpaid care	81%	12%	7%	79%	13%	8%
All Carers	66%	23%	11%	69%	22%	9%
1 to 19 hours a week	77%	17%	5%	79%	17%	4%
20 to 49 hours a week	65%	23%	12%	66%	25%	9%
50 or more hours a week	46%	34%	20%	53%	31%	16%

Source: DC3301EW, 2011 Census, via Nomis

Whilst nearly twice the proportion of carers providing 50 or more hours of care have bad or very bad health compared to all carers (and more than double the proportion compared to those who do not provide unpaid care), a slightly higher percentage of male carers in this category suffer from poor health compared to the proportion of female carers. In terms of number though there are slightly more females providing 50 or more hours care who are in bad or very bad health than males, 426 compared to 392.

3.5.3. Unpaid Care Expectancy (UCE)

UCE is a new type of analysis by the Office for National Statistics (ONS) using data from the 2011 Census to estimate the average lifespan spent occupying an unpaid carer role. It is useful as a guide to unmet social care need and can be used to assess whether unpaid care is influenced by the relative prevalence of disability between areas.^[14]

For this analysis, those who respond to any duration of care per week were classified as a carer for calculation of UCE. These estimates divide expected lifespan into time spent in two distinct states, providing unpaid care and not providing unpaid care. The figures represent a snapshot of the mortality and carer status of the entire specified area population (in this case NHS England Clinical Commissioning Groups) in a given time period. They are not, therefore, the number of years that a person in an area will actually expect to live as a carer or non-carer. This is because:

- mortality rates are susceptible to change in the future
- unpaid carer rates may change because of changes to the criteria for accessing social care
- the impacts of new health care treatments to offset the disabling effects of health conditions
- cultural factors that influence the willingness to provide unpaid care
- the intermittent nature of unpaid care provision for some carers

- migration into and out of a given area which means people will live in a different area for part of their lives

UCEs have been calculated at three selected ages, shown to be significant milestones in unpaid care provision:

- at age 15
- at age 50
- and at age 65

National findings

Males at age 15 can expect to spend on average 7.1 years of their remaining life providing unpaid care, compared with 9.3 years for females. Although males at age 15 have shorter life expectancies than females, they still spend a smaller proportion of their lives providing unpaid care at 11.0% compared with 13.6% for females. Such figures point to females dedicating longer durations of their life providing care than males. It is at age 50 that both genders have the highest proportion of lives providing unpaid care; 15.7% for men and 17.1% for women.

While these estimates show a marked gender inequality in unpaid care provision at younger ages, this reverses at age 65. Men at this age were providing unpaid care for a similar number of years to women, but because of their shorter life expectancy, have a greater proportion of their remaining years of life providing unpaid care. At age 65 men are expected to spend on average 2.7 years of their remaining 18.6 years of life providing unpaid care while for women it is 2.6 years. This reversal at age 65 is likely to be partly explained by men's later retirement age after which men have greater freedom to take up caring responsibilities.

Table 18 shows that levels of UCE are higher in Halton than for England as a whole and the difference is statistically higher, life expectancy is lower indicating a higher level of ill health; thus the proportion of life spent providing unpaid care (PUC) is also higher than England.

Males in Halton at age 15 can expect to spend on average 8.0 years of their remaining life providing unpaid care, compared with 10.1 years for females. Although males at age 15 have shorter life expectancies than females, they still spend a smaller proportion of their lives providing unpaid care at 12.8.0% compared with 15.4% for females. Such figures point to females dedicating longer durations of their life providing care than males. It is at age 50 that both genders have the highest PUCs; 18.1% for men and 18.4% for women, with the gender gap being narrowest at this age.

While these estimates show a marked gender inequality in unpaid care provision at younger ages, this reverses at age 65. Men at this age were providing unpaid care for a similar number of years to women, but because of their shorter life expectancy, have a greater proportion of their remaining years of life providing unpaid care.

Table 18: Unpaid care expectancy (UCE), proportion of life providing unpaid care (PUC) and life expectancy (LE) at ages 15, 50 and 65, NHS Halton CCG compared to England, 2010/12

Age	Sex	UCE (Years)	Statistical significance compared to England	LE(Years)	PUC (%)	UCE Rank	LE Rank
England							
At age15	Females	9.3		68.4	13.6		
	Males	7.1		64.7	11.0		
At age 50	Females	5.9		34.4	17.1		
	Males	4.9		31.3	15.7		
At age 65	Females	2.6		21.1	12.4		
	Males	2.7		18.6	14.8		
Halton							
At age15	Females	10.1	*	65.9	15.4	20	203
	Males	8.0	*	62.6	12.8	10	193
At age 50	Females	5.9		32.2	18.4	102	201
	Males	5.3	*	29.4	18.1	25	197
At age 65	Females	2.7		19.3	13.8	79	201
	Males	3.0	*	17.0	17.9	10	200

* = statistically higher than England; blank = not statistically different

Source: Office of National Statistics, 2014

3.5.4. Carers with Long-Term Disabilities

Unlike the previous section which only asks if a person thinks their health is good or bad, the Census also contains questions asking about long-term ill health or disability. This data may include people who answered that their health was good or bad but the questions take it further by quantifying both the period of time that is considered 'long' (has lasted, or is expected to last, at least 12 months) and also the whether the condition(s) limit the respondent's daily life. This includes problems that are related to old age.

Table 19 shows the proportion of unpaid carers reporting a long-term disability, which limits their day-to-day activities either a lot or a little. Whilst 81% of people who did not provide care reported that they did not have a long-term health problem/disability (limiting their day-to-day activities), only 68% of carers reported being disability-free, whereas 14% reported a long-term health problem/disability, which limited their day-to-day activities a lot. A further 17% stated they had a disability that limited their daily lives a little. These proportions were higher than for North West and England carers.

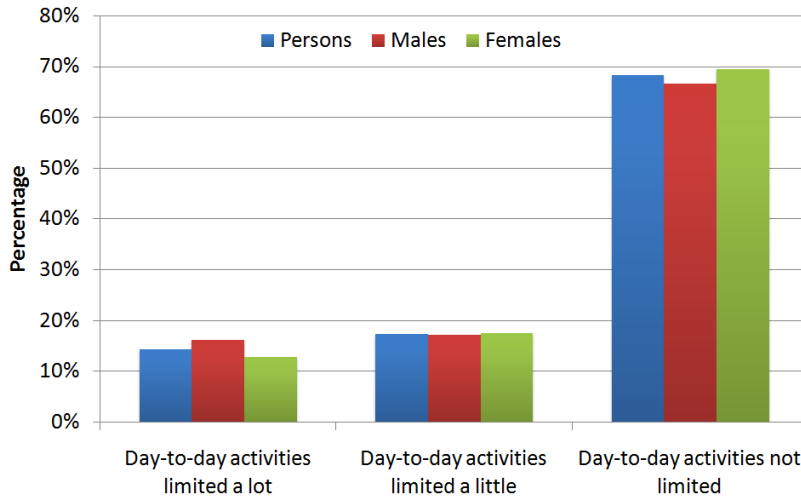
Table 19: Proportion of unpaid carers with long term disabilities

	Halton		North West		England	
	no unpaid care	provides care	no unpaid care	provides care	no unpaid care	provides care
Day-to-day activities limited a lot	11%	14%	10%	12%	8%	10%
Day-to-day activities limited a little	9%	17%	9%	17%	8%	17%
Day-to-day activities not limited	81%	68%	81%	71%	84%	73%

Source: Table LC3305EW, 2011 Census via Nomis

There is a slightly higher percentage of males carers reporting having a long-term health problem or disability that limits their daily lives a lot. This is likely to reflect the older age structure of male carers.

Figure 10: Proportion of Halton carers with long term disabilities, by gender



Source: LC3305EW, 2011 Census via Nomis

Of those carers known to adult social care who responded to the 2014/15 annual carers survey a greater proportion of Halton carers have physical impairment or disabilities, mental health problems or long-standing illnesses than the North West or England averages. A lower percentage have no health problems. This supports the findings from the 2011 Census and underlines the additional disease burden locally.

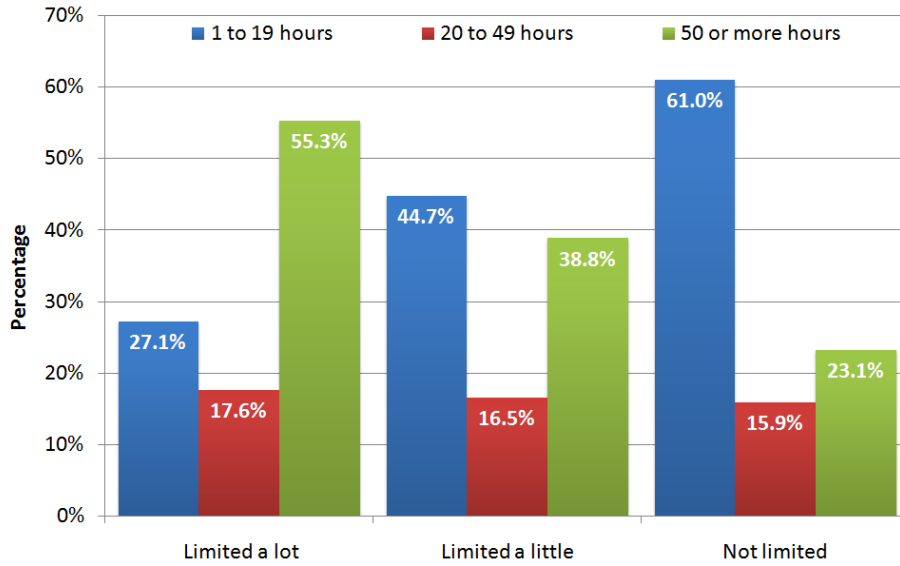
Table 20: Health problems of carers responding to the 2014/15 annual Carers Survey

	A physical impairment or disability	Sight or hearing loss	A mental health problem or illness	A learning disability or difficulty	A long-standing illness	Other	None of the above
Halton	21.8	12.8	11.5	3.1	29.0	14.6	37.4
North West	19.5	15.7	8.5	2.2	26.0	12.7	42.0
England	19.9	16.0	7.5	2.4	24.2	13.7	42.8

Source: HSCIC

Figure 8 shows that the proportion of carers reporting a long-term health problem or disability that limits their lives a lot increases as the number of hours unpaid care they provide increases. This in part will reflect that a high proportion of people providing 50 or more hours unpaid care are older. However, it is also likely to reflect that carers often report not having enough time to look after their own health and the strain, both physical and emotion, of their caring role. As a result, these carers are more likely to need additional health and social care support to maintain their caring role. Conversely, the majority of unpaid carers whose day-to-day activities are not limited by long-term illness/disability are those who provide 1 to 19 hours of unpaid care per week.

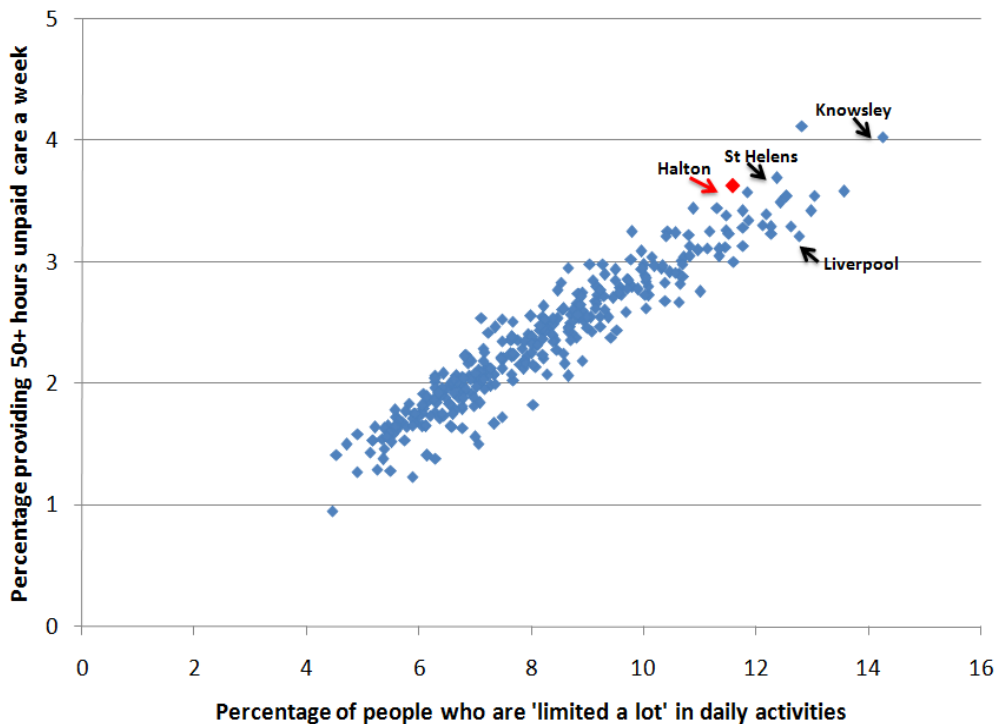
Figure 11: Proportion of Halton unpaid carers with long term disabilities against amount of unpaid care a week provided



Source: LC3305EW, 2011 Census via Nomis

As care is often related to health problems and disabilities which limited daily activities, it is expected that unpaid care would be higher in those authorities with the highest prevalence of people who are 'limited a lot' in daily activities and have older age structures. Figure 9 plots the percentage of an authority's usual residents who provide 50 hours or more care per week against its percentage of people who are 'limited a lot' in daily activities.

Figure 12: Percentage 'limited a lot' and percentage providing 50 hours or more unpaid care, by local authority in England in 2011



Source: 2011 Census, ONS

It shows a consistent increase in the highest levels of care provided (that is 50 or more hours per week) with increases in activity limitation. While this is to be expected, there is clearly an additional burden on relatives, friends and other informal carers in authorities with higher prevalence of activity limitations, such as Halton and, therefore, greater reliance on unpaid carers to support the social care needs of its residents.

The 2011 Census information on whether those providing unpaid care had a health problem or disability which limited their normal day-to-day activities either a lot, a little or not at all is useful in examining the relationship between an area's prevalence of people with pronounced disability and its prevalence of residents providing unpaid care at a level of 50 hours or more per week. Assuming that for those responding that their daily activities were limited a lot will have greater levels of dependency and need for social care than those who were limited a little or not at all, this helps to judge whether pronounced disability prevalence could predict unpaid care supply and whether it affects female supply more than male supply. Such information can provide clues as to whether unpaid care need depends on concentrations of dependency and poses questions as to why areas with similar concentrations of dependent residents have different supplies of unpaid care at this level.

There is a large difference in the prevalence of pronounced disability across CCG populations; those CCGs with a higher prevalence of pronounced disability generally have a higher proportion of residents providing unpaid care at 50 or more hours per week. The highest instances of unpaid care at this level are clustered in four NHS CCGs in Merseyside, some of which are among the most deprived authorities in England. Halton is one of these areas.

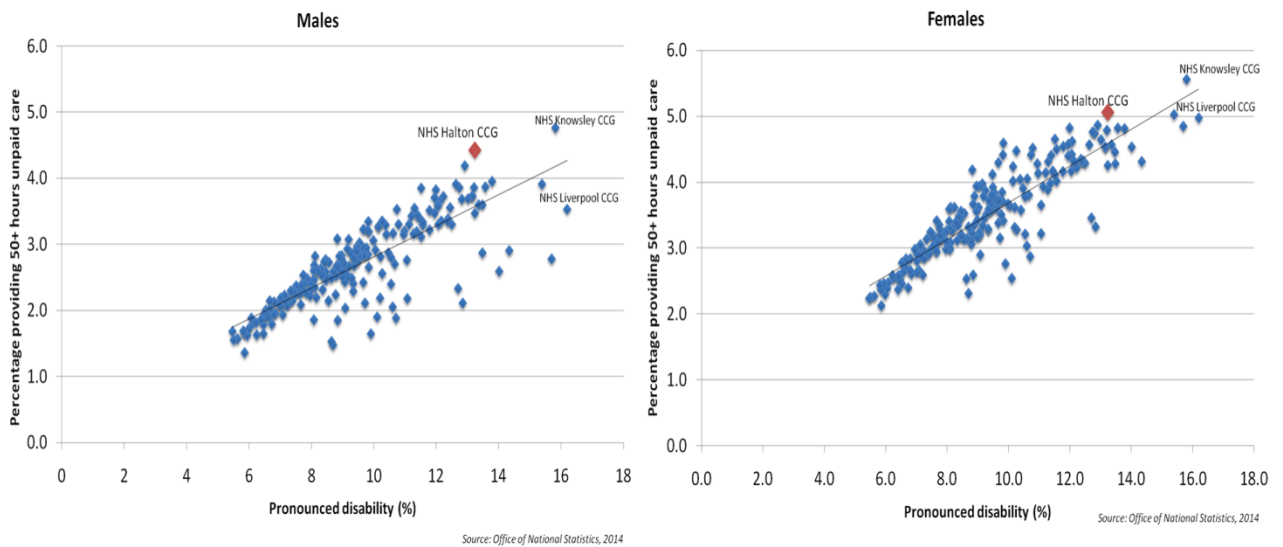
Table 21: CCGs with the highest (top 4) age-standardised prevalence (all persons aged 15 years or above) of unpaid care provision at 50 or more hours per week and the prevalence of people (all persons) with pronounced disability.

	50+ hours/ week (%)	50+ hours/ week Rank	Pronounced disability (%)	Pronounced disability/Rank
NHS Knowsley	5.1	1	15.8	2
NHS Halton	4.7	2	13.2	13
NHS St Helens	4.5	3	12.9	18
NHS Liverpool	4.4	4	15.4	4

Source: 2011 Census, Office for National Statistics

ONS tested the relationship between the prevalence of unpaid care at 50 or more hours per week and the prevalence of residents with pronounced disability using correlations for males and females separately. Figure 10 shows a mainly linear relationship between the age-standardised prevalence of residents with pronounced disability and the prevalence of unpaid care at a level of 50 or more hours per week for males and females respectively across the 211 CCGs.

Figure 13: Prevalence of residents(all persons) with pronounced disability and prevalence of males and females providing 50 or more hours unpaid care per week by CCG.



Strong correlation coefficients of 0.82 and 0.88 were present for males and females respectively (as shown by the closeness of each data point to the best fit lines). This suggests the likelihood of providing care at this level is somewhat related to a CCG’s relative social care need based on pronounced disability prevalence.

This general relationship can be used alongside other data such as social care provision by the state to assess the likely effect on the prevalence of people providing unpaid care at 50 or more hours per week that a percentage rise in the prevalence of people with pronounced disability would have. For males, this shows that should an area experience a one percentage point rise in the number of people with pronounced disability, the percentage prevalence of care provision at 50 or more hours per week is likely to grow by 0.24 of a percentage point; for females it would be likely to grow by 0.28 of a percentage point. Such information is helpful in determining the impact of greater levels of dependency that may arise from population ageing in future years.

3.5.5. Mental and Social wellbeing of carers

Research indicates that many carers have poorer mental wellbeing than their non-carer peers and struggle to find time for themselves. A survey of over 2,000 carers^[15] conducted April to June 2015 found those surveyed had considerably lower wellbeing scores than the national average (18.9 versus 23.6 using the SWEMWBS^[ii] tool) and 20% considered themselves to have mental health problems. Yet many carers find it difficult to find time to focus on their own health needs, especially those undertaking 50 or more hours of unpaid caring a week.

Halton has recently introduced the SWEMWBS tool into its carers assessments. Comparing the percentage of carers with low, moderate and high mental wellbeing scores with the results of the 2013 Mental Wellbeing Survey^[16] which used the same tool, it can be seen that although, as with

ii) Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)

the overall percentages, the majority of carers rate their mental wellbeing as moderate, the percentage rating it as low was higher than the overall population score and the percentage rating it high was lower.

Table 22: Results of the 2013 Mental Wellbeing Survey of Halton adults and Halton carers assessments 2015

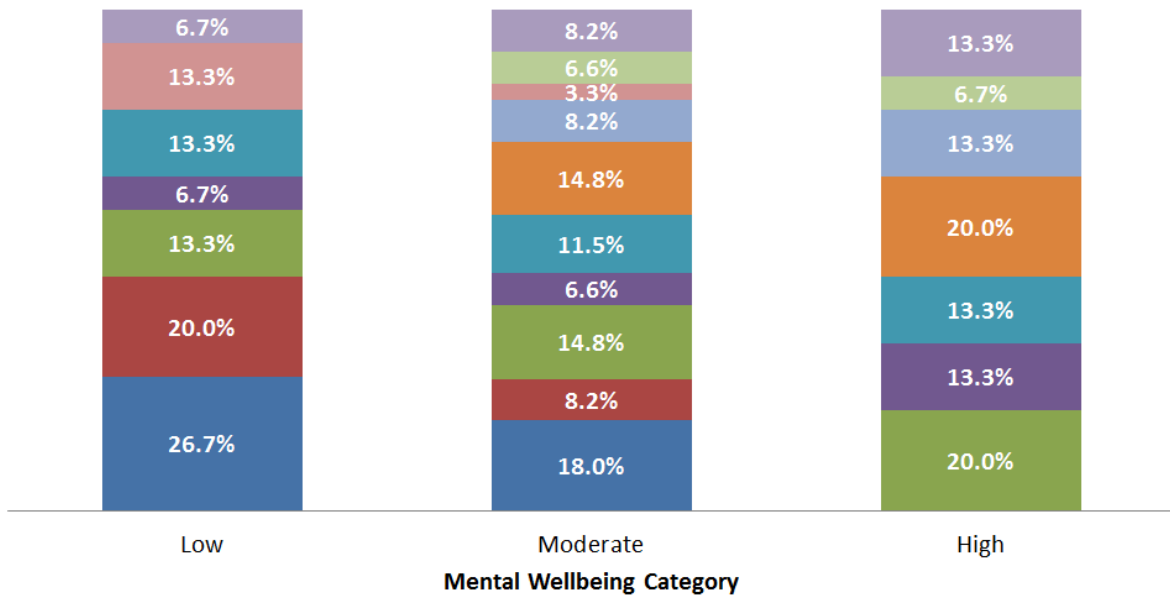
	Overall	Carers
Low	13.4%	17.0%
Moderate	62.8%	68.1%
High	23.9%	14.9%

Source: McHale, Hughes and Jones 2013 and HBC

Further analysis of the 2013 Mental Wellbeing Survey showed that there was a relationship with deprivation, with low scores being more prominent in the more deprived quintiles. Analysis of the Halton carers scores by deprivation decile shows a similar pattern, with 60% of carers with a low mental wellbeing score living in the 3 most deprived decile areas compared to 41% of those with a moderate score and 20% of those with a high score.

Figure 14: Mental Wellbeing score category by local deprivation decile, Halton carers 2015

deprivation decile 1 is the most deprived area, deprivation decile 10 the least deprived



NB: any deciles with 0% scores removed from chart

Source: HBC Carers assessments and Department for Local Government and Communities

8 out of 10 carers have felt lonely or isolated as a result of caring, with 55% of carers reporting they are not able to get out of the house much (rising to 64% for those providing 50 or more hours of care a week). 61% don't have time to participate in social activities, with nearly half (45%) not able to afford to. Over half (54%) struggle to pay household bills with 35% cutting back on essentials like

food and heating to make ends meet. 40% of carers say they rarely or never feel optimistic about the future, with parent carers especially worried about the future care of the children.

As seen in section 3.5.4., Table 20, a greater proportion of Halton carers have mental health problems than across the North West and England. However, in relation to feeling able to spend time doing things they want, having enough support and social contact, Halton carers known to social care rate similar or slightly better than these comparators.

Table 23: Responses to Q7 to 12, 2014/15 Annual Carers Survey

		Halton	North West	England
Which of the following statements best describes how you spend your time?	I'm able to spend my time as I want, doing things I value or enjoy	23.8	20.9	20.4
	I do some of the things I value or enjoy with my time but not enough	62.0	64.9	64.7
	I don't do anything I value or enjoy with my time	14.2	14.1	14.9
Which of the following statements best describes how much control you have over your daily life?	I have as much control over my daily life as I want	30.3	27.1	26.6
	I have some control over my daily life but not enough	59.1	61.8	60.6
	I have no control over my daily life	10.7	11.2	12.9
Thinking about how much time you have to look after yourself - in terms of getting enough sleep or eating well - which statement best describes your current	I look after myself	56.5	58.0	57.5
	Sometimes I can't look after myself well enough	28.2	27.1	27.6
	I feel I am neglecting myself	15.3	14.9	14.9
Thinking about your personal safety, which of the statements best describes your present situation?	I have no worries about my personal safety	86.8	85.7	84.9
	I have some worries about my personal safety	11.7	13.0	13.7
	I am extremely worried about my personal safety	1.5	1.3	1.4
Thinking about how much social contact you've had with people you like, which of the following statements best describes your social situation?	I have as much social contact as I want with people I like	39.2	39.5	38.5
	I have some social contact with people but not enough	47.8	47.1	47.0
	I have little social contact with people and feel socially isolated	13.1	13.4	14.5
Thinking about encouragement and support in your caring role, which of the following statements best describes your present situation?	I feel I have encouragement and support	45.2	40.7	39.7
	I feel I have some encouragement and support but not enough	42.7	42.6	43.3
	I feel I have no encouragement and support	12.1	16.7	17.0

Source: HSCIC

Table 24: The proportion of carers who reported that they had as much social contact as they would like - carers survey Q11

	Total	Males	Females	18-64	65+
Halton	39.2	37.9	39.8	34.3	44.5
North West	39.5	43.1	37.5	36.9	43.7
England	38.5	40.2	37.7	36.3	40.0

Source: ASCOF: 11(2) (Carers Survey Q11), HSCIC

A slightly higher percentage of females said they had as much social contact as they wanted. The percentage was greatest amongst older carers. This probably reflects the limited amount of free time working carers have for themselves.

Aggregating data from questions 7 to 12 of the carers survey, a quality of life score can be calculated. Data from 2014/15 (Table 24) shows that overall Halton rates were slightly higher than the North West and England. This includes higher scores for both men and women and for those aged over 65.

Table 25: Carer-reported quality of life score

	Total	Males	Females	18-64	65+
Halton	8.1	8.2	8.1	7.8	8.5
North West	8.0	8.2	7.8	7.8	8.3
England	7.9	8.1	7.8	7.6	8.1

Source: ASCOF 2014/15: 1D (based on Carers Survey Q7-12), HSCIC

3.5.6. Domestic Violence

There is very little research about domestic abuse against carers. Research by Queen's University in Belfast^[17] includes case studies from women who experienced domestic abuse from their husband for a number of years then, in later years, became the main carer for their abuser. This potential switch of control in the relationship can lead the carer to experience emotional conflicts such as anger versus feelings of love and sympathy for the abuser. If the abuse continues, this can cause further conflict for the carer between wanting to protect themselves, and any dependent children, versus knowing the abuser is dependent on them for day to day support.

Findings from a study focusing on older female carers^[18] supported the need for awareness that ageing caregivers can be placed at risk by verbally and physically abusive behaviours of the elders for whom they provide care.

Both these pieces of research indicate that carers need specialised support if they are in an abusive relationship as the emotional conflict they may experience about being the main, or sometimes only, care giver to their abusive spouse brings with it a raft of additional complexities. In such cases, it is imperative that services work together to support the carer and to ensure safeguarding of the vulnerable perpetrator.

In Halton, the issue of adult safeguarding is taken very seriously, and reports to the Adult Safeguarding Board already include the issue of domestic violence. However, the experiences of carers around domestic abuse have not, thus far, been considered and this may be necessary to ensure that processes and services for carers are delivering the best possible support. Local data on the number of carers subjected to domestic violence is not currently available.

3.5.7. Health and Wellbeing of Young Carers

A Young Carer is a young person (under the age of 18 years of age) who cares for or gives support to someone at home such as their parent, sister, brother, grandparent or a family friend. This care could include looking after someone who is unwell, disabled or has a mental health problem, or providing care for and support to a member of the family affected by drug or alcohol misuse.

Young carers are children and young people who often take on practical and/or emotional caring responsibilities that would normally be expected of an adult. The tasks undertaken can vary according to the nature of the illness or disability, the level and frequency of need for care and the structure of the family as a whole. A young carer may do some or all of the following:

- Practical tasks, such as cooking, housework and shopping
- Physical care, such as lifting, helping a parent on stairs or with physiotherapy

- Personal care, such as dressing, washing, helping with toileting needs
- Managing the family budget, collecting benefits and prescriptions
- Administering medication
- Looking after or “parenting” younger siblings
- Emotional support
- Interpreting, due to a hearing or speech impairment or because English is not the family’s first language

Some young carers may undertake high levels of care, whereas for others it may be frequent low levels of care. Either can impact heavily on a child or young person.

Nationally, in 2011, there were 177,918 young unpaid carers (5 to 17-years-old) in England and Wales. Of these, 54% were girls and 46% were boys. Within England, the North West had the highest proportion of young carers providing unpaid care at 2.3% (2.1% of males and 2.5% of females aged 5-17), whereas the South East had the lowest proportion at 1.9%.

An increase in the number of unpaid carers aged 5 to 17 was observed in all regions between 2001 and 2011. In England, the number of young unpaid carers increased by 19.5% during this period. In the North West the increase was 7.2%, a smaller increase but based on a higher baseline level in 2001.

Local authority level data from the 2011 Census is broken down only by broad age bands, 0-15 year olds and 16-24 year olds. It shows that Halton has a slightly higher level of young people who are carers than across the North West and England. This is the case for young carers under age 16 i.e. 0-15 years of age and young adults age 16-24 years of age (unfortunately this national dataset does not provide the ability to show the date by under 18 years of age).

Table 26: Provision of unpaid care by age band, 2011 Census

	All categories: Provision of unpaid care	Provides no unpaid care	Provides unpaid care: Total	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
Halton 0 to 15 year olds	24,927	24,579	348	267	53	28
Halton 16 to 24 year olds	14,493	13,579	914	596	188	130
Percentages						
Halton 0 to 15 year olds		98.6%	1.4%	1.1%	0.2%	0.1%
North West 0 to 15 year olds		98.8%	1.2%	1.0%	0.1%	0.1%
England 0 to 15 year olds		98.9%	1.1%	0.9%	0.1%	0.1%
Halton 16 to 24 year olds		93.7%	6.3%	4.1%	1.3%	0.9%
North West 16 to 24 year olds		94.6%	5.4%	3.8%	0.9%	0.7%
England 16 to 24 year olds		95.2%	4.8%	3.5%	0.8%	0.6%

Source: Nomis, 2014

Halton has a higher number of young carers aged 0-24 than nationally at 8.4% compared to 7.5% across England as a whole (the number of Halton young carers is 1259).

Given that young carers are over twice as likely to live in households where at least one adult has a limiting disability^[19] and that there is a high level of limiting disability in the borough this may be an underestimate. Also, as the Census is completed by parents the figures reported may underestimate due to stigma and fear about the perceived consequences of revealing that their child is a carer. Children themselves may not wish to be recognised as a carer for fears of bullying, stigma or

embarrassment. These issues are seen in national surveys and also in the kind of feedback received from Halton young carers and their families. For example, a survey of secondary school children conducted by the BBC and the University of Nottingham found that 1 in 12 reported caring responsibilities.^[20] Applying this figure to the number of Halton residents aged 0-24 would give a figure of 3,276, just over 2.5 times as high as the census indicates.

In 2015/16, there were 520 young people and 0-18 years of age registered in contact with Halton Carers Centre. Data from 2013 showed 109 new young people have been registered as carers within the preceding year whilst 73 have been deregistered. (48% due to reaching their 18th birthday, 52% due to a change in their circumstances). 57% (number = 196) were female and 43% (number = 152) were males.

Table 27: Residence Location of Young Carers, 2013

Location	Number	Percentage
Runcorn	224	64.4%
Widnes	119	34.2%
Out of Borough*	5	1.4%

*Warrington, Helsby, Liverpool

Table 28: Age profile of Young Carers, 2013*

Age	Halton Number	Halton Percentage	National Percentage (2011 Census)
5-7yrs	8	2	6
8-9yrs	44	13	7
10-14yrs	149	44	41
15yrs	56	16	13
16-17yrs	85	25	33

* 6x DOBs not available at time of writing

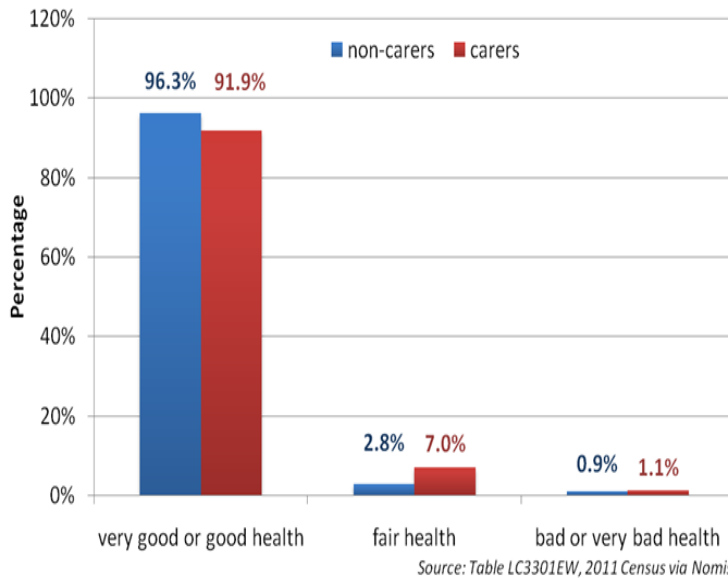
These figures put the rate as a percentage of the overall under-18 population of Halton at 1.2%. The 2011 Census is 1.4% of the 0-15 year old population.

Analysis of Census data also showed that young carers are likely to report that their health is not good compared to their non-carer peers. As the number of hours of unpaid care rose so did the level of self-reported 'not good' health.^[21] This is supported by the Longitudinal Survey of Young People in England found that young carers are 1.5 times more likely to have a disability, long-term illness or special educational needs, 1.5 times more likely to be from a black, Asian, or minority ethnic community and twice as likely to not speak English as their first language.^[22] Young carers are significantly more likely to grow up in poverty, with all the associated needs and risks this brings. Thus young carers may not only be at greater risk of poor health and risk-taking behaviours during childhood but this may continue into adulthood, further impacting on their lives even if their caring responsibilities change.

Analysis of 2011 Census data for Halton carers aged 0-24 substantiates these findings, although not to the same degree. Levels of good, fair and poor health amongst Halton carers aged 0-24 is broadly similar to that seen by carers aged 0-24 across the North West and England. The most clear disparity can be seen when considering the health of carers aged 0-24 providing different levels of care, with 92% of all Halton carers aged 0-24 having very good or good health compared to 87%

amongst those providing 50+ hours of care per week. Thus the Census data may be showing an under reporting not only of the number of young people providing unpaid care but of the health problems they face.

Figure 15: Health status of Halton residents aged 0-24 providing unpaid care, 2011 Census



	Very good or good health	Fair health	Very bad or bad health
Halton	91.9%	7.0%	1.1%
North West	91.8%	6.7%	1.5%
England	91.3%	7.0%	1.6%

Source: Table LC3301EW 2011 Census via Nomis

	very good or good health	fair health	bad or very bad health
All	96%	3%	1%
non-carer	96%	3%	1%
All carers	92%	7%	1%
1-19 hours	93%	7%	0%
20-49 hours	93%	6%	1%
50+ hours	87%	9%	4%

Source: Table LC3301EW 2011 Census via Nomis

Further impacts were revealed by a study of 15,000 pupils aged 13 and 14:^[23]

- Young carers are one and half times more likely to have a special educational need or a long-standing illness or disability
- One in 12 young carers is caring for more than 15 hours per week
- Around one in 20 miss school because of their caring responsibilities
- Young carers have significantly lower educational attainment at GCSE level - the equivalent to nine grades lower overall than their peers
- Young carers are more than one-and-a-half times as likely to be from black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language
- The average annual income for families with a young carer is £5,000 less than families who do not have a young carer
- Young carers are more likely than the national average to be 'not in education, employment or training' (NEET) between the ages of 16 and 19
- Young carers, especially those caring for adults with mental health or substance misuse issues, are likely to go on to become service users themselves. They are also more likely to become known to social care and to become a child in care
- Despite improved awareness of the needs of young carers, there is no strong evidence that young carers are any more likely than their peers to come into contact with support agencies and to become a child in care

Nationally, around a third of young carers are caring for a person with a mental illness. It is likely the actual number is higher and research has suggested that around a third of young carers are involved in inappropriate and excessive caring with consequent knock-on effects on schooling and other areas of their lives.

This information shows that caring responsibilities can place a great deal of pressure on the carer and this can be compounded when the carer is a child or young person. The risks include the risk of truancy, under-achievement, isolation, mental and physical ill health, poverty and stress.

Inappropriate caring tasks can represent a safeguarding concern. It could be inappropriate if a child or young person is undertaking personal care for an adult of the same or opposite gender. This risk is compounded if they are the only person having physical contact with that adult.

Locally, it is important to continue to raise awareness of young carer's identification and needs amongst key workers, together with an improved shared working practice between Adults and Children's services. This together with a proactive approach to 'early help' for the wider family when supporting adults would help embed safer preventative practice with vulnerable families. The Team Around the Family (TAF) division, through IWST, Family Work and Intensive Family Work teams are well positioned to explore such joint working initiatives.

For over a decade, there has been considerable consultation of the needs of young carers and their families. The messages have been very consistent: ^[24]

- They want time to have fun and socialise, getting breaks from caring.
- They want more help for the person they care for.
- They need to be less isolated and have people they can turn to.
- They need more money in their families.
- They need help at school with attendance, homework, course work and bullying.
- They need to be helped to get the best from learning and work towards an independent future.
- They need to be meaningfully involved in the planning for their cared for person, and given information and knowledge about the practicalities of caring.
- They need emotional support with worry, anxiety and low self-esteem
- They need help planning for and dealing with family crises.

3.5.8. The needs of carers of people with mental ill-health

Caring for someone with mental health needs presents different challenges for their carer compared with a physical illness or disability. These include: ^{[25][26][27][28][29][30]}

- The fluctuating nature of poor mental health. The need for, and levels of, support may therefore be unpredictable. Dependence on the carer can be really intense and prolonged at times yet minimal at others
- Poor mental health is not necessarily as evident as a physical health problem or disability, therefore may be less understanding or support forthcoming for the carer as there is with other health conditions
- Because of the stigma surrounding mental ill-health, carers may be less willing to seek support or share with family members and friends. This may mean they have less of a social network to draw on themselves with a resulting risk of poor mental health in the carer themselves
- Many people say dealing with the stigma surrounding mental health is worse than coping with the condition itself
- Carers play a key role in the recovery of people with poor mental health conditions. This is a significant level of responsibility
- Often mental ill-health is associated with other conditions, so this is not the only condition the carer is required to deal with

- There are a number of legal and ethical issues surrounding mental health that can make the role of caring even harder
- Carers need information, advice and support about carrying out their caring role, but also about understanding and coping with mental health conditions. Carers of people with poor mental health are dealing with taking on a caring role as well as learning how to respond to the behaviours and emotions associated with the condition

As a result of these issues, caring for someone with mental health needs may be even more emotionally draining than any other caring role. Family and friends bereaved by a suicide, or affected by those at risk of suicide, are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves. Keeping family and friends informed and providing the relevant advice and support in a timely manner can prevent this.^{[31][32]} Suicide prevention research and recommendations all cite the need to include, support, identify and listen to carers.^[33]

The Triangle of Care report^[34] emphasises the need for better involvement of carers and families in the care, planning and treatment of people with mental ill-health with the purpose of supporting recovery and sustaining wellbeing of both service user and carer. It was developed to address the clear evidence from carers that they need to be listened to and consulted more closely. The guide outlines key elements to achieving this as well as examples of good practice. Key elements include: The carers involved in patient care are identified as soon as possible.

- Professionals are ‘carer aware’ and equipped to involve carers effectively
- Protocols are in place regarding the sharing of information and confidentiality
- Specific professional roles are identified with carer responsibility
- Carers are able to meet with staff and are provided with information throughout the care and treatment pathway
- A range of support services are provided for carers

Fundamental to the Triangle of Care approach is the importance of understanding what carers need to carry out their role effectively: skills, information, advice, support, regular breaks. Not just focusing on the impact of the caring role, but the causes of the stresses in the first place. If the right information, advice, support and services are not available then a detrimental effect from the caring role will still ensue.

NICE guideline^[35] includes recommendations on the need for mental health services to offer carers of people with psychosis or schizophrenia an assessment of their own needs, provide information about the condition (including negotiation with service users about how their information will be shared), include carers in decision making if the service user agrees and, in addition, advise carers about their statutory right to a formal carer's assessment. The guidance recommends that all carers of people with psychosis and schizophrenia should be offered a carer-focused education and support programme, which may be part of a family intervention, as early as possible. It is likely that the same applies to people caring with other types of mental illness.

There is often a link between mental health and alcohol dependence. The NICE quality standard on alcohol dependence^[36] recommends that families and carers involved in supporting a person who misuses alcohol should have the opportunity to discuss concerns about the impact of alcohol misuse on themselves and other family members.

3.5.9. The needs of carers of people with dementia

One in three will care for a person with dementia in their lifetime. A report by the Carers Trust identified a number of critical points along the caring journey where information and support is most valued and needed by carers and what professionals can do to help at these times. It should be noted that these may be quite different to the critical points experienced by the person with dementia in their journey. The critical points for the carer are: ^[37]

- When dementia is diagnosed
- When the carer takes on an active caring role
- When the capacity of the person with dementia declines
- When the carer needs emotional support and/or a break from caring
- When the person with dementia loses their mobility
- When the person with dementia has other health problems
- When the carer has to cope with behaviour problems
- When the carer's own circumstances change
- When the person with dementia becomes incontinent
- When decisions about residential care and end of life have to be made

What is key at these points is that the carer knows where to go to for advice, knows what support is available, that the professionals they are in contact with are knowledgeable regarding dementia and that they engage with both the carer and the person with dementia and they understand the carers needs and issues not just those of the person with dementia. This research is being cited by Public Health England as a means of mapping the needs of carers of people with dementia

3.5.10. The needs of parent carers

Parent carers look after one or more children with a learning difficulty, a disability and/or an additional need. The role of parent carers blurs between being a parent and being a carer, as parents naturally 'care' for their children. However, parent carers are those that have children that need additional support 'to live ordinary lives' as a matter of course. Similar to other carers, parent carers are not always identified as they are parents first. This is especially true for parents of children that have additional needs who are not eligible for social care, short breaks or a statement of educational need. These are the carers that get the least support and often feel very alone. We do not know how many there are as they are usually unknown to services. However these parents can get support from the voluntary sector, especially parent support groups. 'Disabled children and their families have the same human rights as others, including the right to the same quality of life as those who do not live with disability.

A lack of support can result in parent carers having mental health issues, physical health issues, and relationship difficulties.

3.5.11. The needs of carers of people with a learning disability

Growing numbers of people (with a learning disability) experience a mid-life transition when their parents or family carer's who they have lived with since childhood become too ill to care for them or they die. It is important that carers of adults with a learning disability are supported both emotionally and practically to plan early for this transition. In addition to this, it is important the person with the learning disability's rights to care for their loved one is recognised. Services for the

older person and the person with the learning disability providing the care need to be joined up to ensure the needs of both are met.

3.5.12. The needs of carers for people at the end of life

It is estimated there are around half a million people in the UK at any one time providing care for someone with a life-limiting illness. While the needs of these carers will in many ways be similar to those of other groups of informal caregivers, there are specific issues that face people caring for someone at the end of their life, such as:

- Possible sudden diagnosis and onset of the caring role
- Uncertainty as to the length of time until death
- Likely rapidly changing care needs
- Information needs on the dying process and associated complex medical and nursing care
- Psychological and emotional strain of knowing that they will face bereavement
- Practical and emotional issues at the time around the death, and in the months and years following bereavement

In common with other groups, people caring for those at the end of life may not identify themselves as 'carers' and so may be unaware of, or reluctant to access, available support. The National Palliative Care Policy is based around a strong preference for death at home. In order to achieve this supporting the needs of family carers is paramount.

The 2015 Marie Curie report^[38] on the impact of caring for someone with a terminal illness concluded that carers of people with a terminal illness face significant challenges to getting the high quality and timely support that should be available to them, both while they are caring and after bereavement. These challenges include:

- not having their needs recognised by support services
- not being supported to look after their own health, wellbeing and finances, and not knowing where to find support when they need it
- a lack of help with preparing for the future, both following their loved one's diagnosis and after bereavement'

The report recommends the following fundamental principles that should underpin the support available to carers of people with a terminal illness:

- People who provide care for someone who is approaching the end of their life have specific needs, which should be assessed as a matter of priority
- Information for carers should be available and accessible in a form that is most useful to them
- Carers are not trained professionals, and they should not be expected to behave as such
- Carers should be treated sensitively by professionals and, where appropriate, provided with training and support to help them look after their loved one and themselves
- No one providing care to a loved one with a terminal illness should suffer financial hardship as a result of their caring role
- Health and social care professionals need to be ready and able to help carers identify themselves in this role and to plan for their future. This must include a sensitive

explanation of what supporting a death at home entails, and a recognition that carers' needs will often continue after bereavement

Carers in the end of life context often describe three priority areas of need:

1. Practical help as a co-worker e.g. with turning bed-bound patients, or with symptom relief
2. Information as to what is likely to happen as the illness progresses and the likely consequences
3. Allocated professional time for attending the patient to allow the carer to have respite from their role

More personal support, such as addressing spiritual, psychological and emotional needs is reported to be less valued. Qualitative data suggest that carers often find it difficult to focus on their personal needs, as they perceive that such focus will take professional time and resources away from the person cared for. The Department of Health End of Life Care Strategy 2008 highlighted the importance of considering carers' opinions and needs, and commissioned the Office for National Statistics to conduct the VOICES (views of informal carers for the evaluation of services) survey since 2011. Analysis of the combined 2012 and 2013 results by NHS Area Team shows that the Merseyside had a higher percentage of respondents stating that they were given enough help and support by the healthcare team at the actual time of death of their loved one; 62.3% compared to 60.1% nationally although the difference was not statistically different. When considering whether the carer felt they were as involved in decisions about their loved ones care as they wanted to be, a slightly lower proportion in Merseyside answered yes compared to England, 76.2% compared to 77.9%. Again the differences were not statistically different. Analysis at a national level also highlighted significant inequalities in the standard of care and support provided, both by geography/socio-economic status and by cause of death of the loved one.

The impact on carers' health and wellbeing

Caring for a loved one, who is dying, carries with it the same risks to the carer's health and wellbeing as in other care situations, but with the additional strain of coping with an impending death. This is likely to have an impact on the physical health and wellbeing of the carer. For example elderly carers for heart failure patients who have pre-existing health problems of their own, are more likely to experience deteriorating health.^[39] In addition, there is a suggestion that the greater the strain and burden reported, the more likely the carer's physical and mental health will have deteriorated. It should not be forgotten that there are positive aspects to a caring role; caring for a loved one when they are most vulnerable can be a valuable experience, potentially boosting self-esteem, confidence and assertiveness and reinforcing relationship bonds. There is little evidence that discrete 'carer support' services within palliative care are necessary; instead, repeated checking of carer needs by those providing 'usual care' in an end of life context is thought to be helpful. The evidence base for specific interventions to improve the health and wellbeing of carers is weak.

Bereavement

Inevitably, carers of people who are dying will have to face bereavement and a change in their role. Bereavement has long been recognised as a risk factor for poor psychological and physical health. Research shows that there is an early increased risk of death from a variety of causes, including

suicide and 'dying from a broken heart' – meaning the psychological distress, loneliness and secondary consequences of loss such as changes in eating habits, economic status and social support. A few authors have found this risk to persist after six months. The recently bereaved are also more likely to have physical health problems; widowed people in general consult with their GP more frequently than the non-widowed, but also may be less likely to consult when they need to. This indicates that there is likely to be significant met and unmet need in terms of the physical and mental health of the recently bereaved, particularly those bereaved of spouses.^[40]

The evidence suggests that it is neither necessary nor desirable for all bereaved people to undergo 'bereavement counselling'. Around 85% of bereaved people will manage their own path through grief using existing social support. 5% will need specialist help to manage their extreme grief reactions, and the remaining 10% need something in between, such as a befriending or counselling service.^[41] However there are no reliable tools for identifying which group an individual falls into and so a network of universally available first-line services is necessary to allow people to access care if they feel they need it.

3.5.13. Other specific groups

This chapter is not exhaustive, only having picked out a few specific groups of carers. Other groups not covered in any detail in this JSNA may have needs which are different from others because of their caring situation, for example so-called 'Sandwich' Carers' who care for people of different generations, for example, caring for a disabled child (of whatever age) and also an elderly parent.

4. Service provision and uptake

4.1. Service Provision

4.1.1. Adult Social Care

The Care Act gives local authorities the responsibility to assess a carer's needs for support. The assessment looks at how caring has an impact on an individual, what support they may need if they want to carry on caring, and what they want to achieve in their day to day life. At the end of the assessment a support plan will be agreed. The support plan will include how a persons needs are going to be met and, if a direct payment is to be made, how much it will be and how often it will be paid. In Halton, these statutory assessments are carried out by the borough council's care management teams

4.1.2. Halton Carers Centre

Halton Carers Centre provides a range of both universal and targeted services for carers. Commissioned jointly by Halton Borough Council and NHS Halton CCG, the centre aims to improve the quality of life for carers and to prevent or delay peoples need for care and support.

As a primary point of contact for carers in the borough, Halton Carers Centre will:

- Increase the number of carers known to them, particularly within underrepresented groups
- Work with a range of local agencies and initiatives to promote and improve carers' health and well-being
- Provide advice and information which supports carers to make informed choices about issues such as; the care and support which is available; their health and well-being; the types of home equipment, telehealth and telecare facilities that are available; and any changes in the welfare benefits system that may have an impact on them as a carer
- Ensure that carers are an integral part of the design, delivery and quality assurance of both the Carers Centre and health and social care services
- Commission community based peer support groups that help carers to cope with their caring responsibilities and alleviate some of the isolation they experience
- Ensure intensive, short term support is provided where there is a high risk of 'carer breakdown'
- Co-ordinate, provide and publish a programme of training for carers and health and social care professionals
- Offer a range of volunteering opportunities for carers, ex-carers and members of the local community
- Provide an advocacy service that ensures that carers' are assisted and enabled to say what they want, to secure their rights, to represent their interests and to obtain the services they require

From 1st April 2015 to 31st March 2016 Halton Carers Centre registered **1,009** new carers (776 adult carers & 233 young carers). **1,630** carers were deregistered (1,452 adult carers, 178 young carers) due to their caring role ending. This means from 1st April 2016 there were **5,263** carers registered with the centre (4,743 adult carers and 520 young carers).

Table 29: Age breakdown of Carers registered with Halton Carers Centre 2015/16

Age group	Number
5-18	520
19 – 25	266
26 – 34	432
35 – 45	621
46 – 54	1096
55 – 70	1448
70 plus	880
Total	5,263

Source: Carers Centre

All carers (5,263) received the newsletter and 5,106 had a service from the centre in the year. Services include review, information and advice, advocacy, referral/signposting to another service, trips, training, forums, therapies and podiatry.

Postcode level data was only available for 1,846 carers, 488 providing 49 hours of care a week or less and 1358 providing 50+ hours. This constitutes significantly different relative proportions than in the Census which showed 69.9% of unpaid carers providing 1-49 hours of care per week and 30.4% providing 50+ hours. This compares to 73.6% of the postcode level data being for carers providing 50 or more hours care per week. Indeed, data for June 2015^[42] shows this is similar to the total Carer's Centre users.

Table 30: Breakdown of hours care provided by adult users of the Halton Carers Centre, as at June 2015

Hours per week	Numbers	Percentage
1 to 19	436	9.3%
20 to 49	1,037	22.1%
50+	3,217	68.6%
Total	4,690	100%

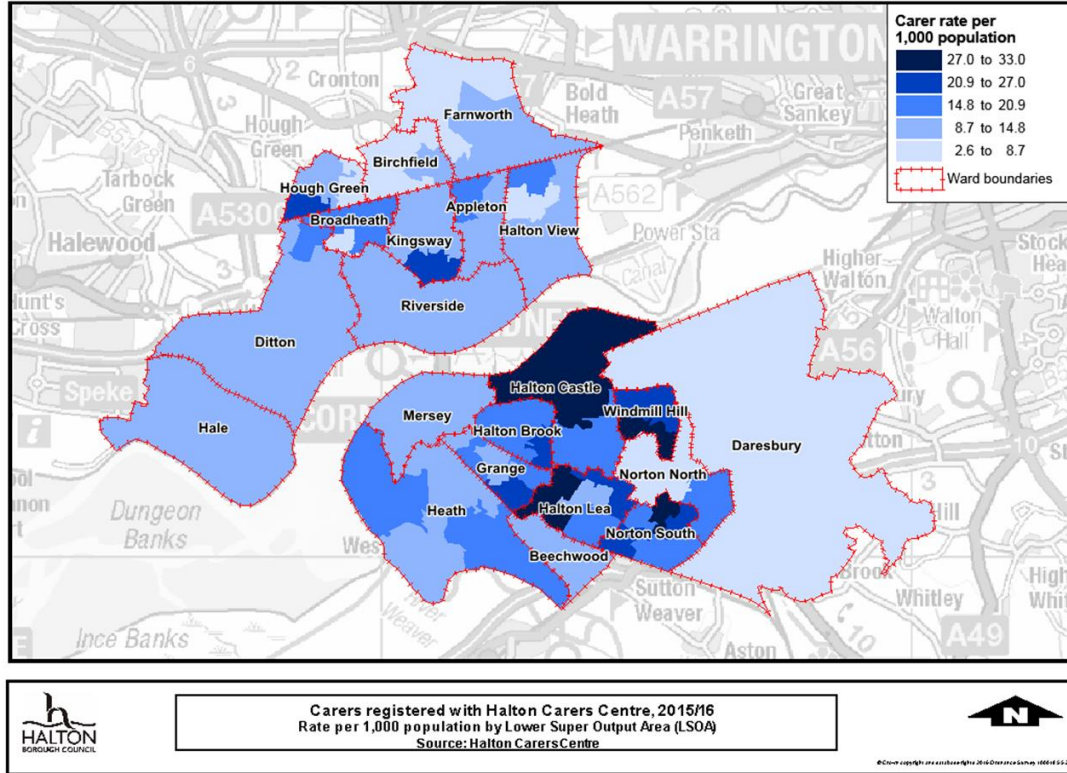
Source: Halton Carers Centre

Of note is that the Census showed 4567 Halton carers stating they provided 50+ hours care per week with the Carers Centre having some level of contact with 3,217 carers providing 50+ hours per week.

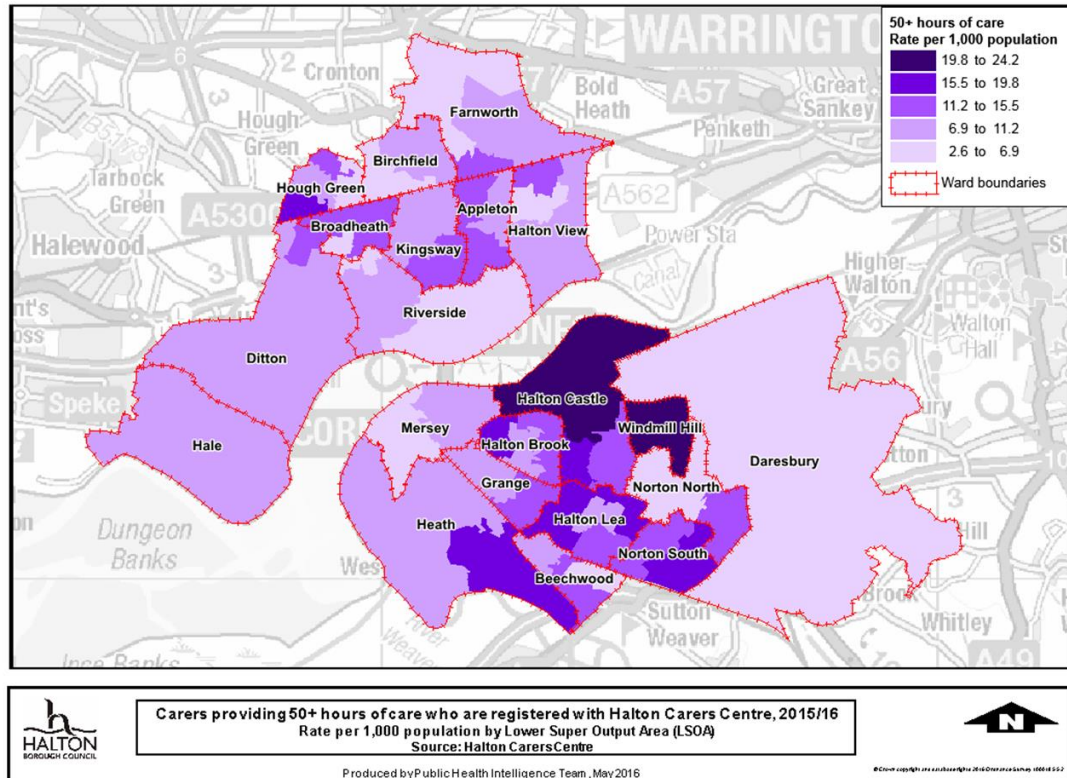
The geographical spread of carers accessing the Carers Centre is fairly similar to that identified earlier from the 2011 Census analysis. There is a slightly higher rate of carers providing any level of care accessing the Carers Centre from Halton Castle, Halton Lea and Windmill Hill than indicated in the Census. However, as particular deprived areas of the borough, this may reflect carers with particular need. When considering only those carers who provide 50+ hours of care a week, the geographical spread is similar to the Census picture.

Figure 16: Location of carers accessing Halton Carers Centre: all carers and those providing 50 or more hours of care per week

All Carers



Carers providing 50+ hours/week



4.1.3. Community Based Support

Each year, small community groups and local organisations apply to the directorate for a small amount of funding to support carers. In their application, groups should be able to demonstrate how they will increase the number of Carers known to them; support individuals to have a life outside of caring and have a positive impact on carers well being.

At present 17 groups and organisations receive funding supporting people caring for individuals with dementia, learning disability, autism, substance misuse, stroke, mental health and physical disability.

4.1.4. Support from GPs

As at December 2015 there were 1,590 people registered with Halton GPs who were known to be carers. This represents just 10.6% of the total number of carers identified in the 2011 Census. This is based on the influenza vaccination return and so will not include those aged 65 and over. Thus it under-represents the true picture, despite this, does show a considerable variation from the census figures.

Table 31: Number of patients registered as carers, 2014/15, per GP practice

Practice code	Practice	No. of patients registered as a carer
N81035	Appleton	76
N81011	Beaconsfield	177
N81096	Brookvale	77
N81019	Castlefields	127
N81066	Grove House	145
N81618	Heath Road	15
N81119	Hough Green	49
N81072	Murdishaw	95
N81064	Newtown	82
N81619	Oaks Place	55
N81045	Peelhouse	272
N81037	The Beeches	51
N81057	Tower House	118
N81651	Upton Rocks	35
N81054	Weaver Vale	119
N81625	West Back	25
Y02512	Windmill Hill	72
01F	Halton CCG	1590

Source: NHS England and HSCIC

Despite this low figure a considerable proportion of respondents to the annual GP survey stated they had caring responsibilities

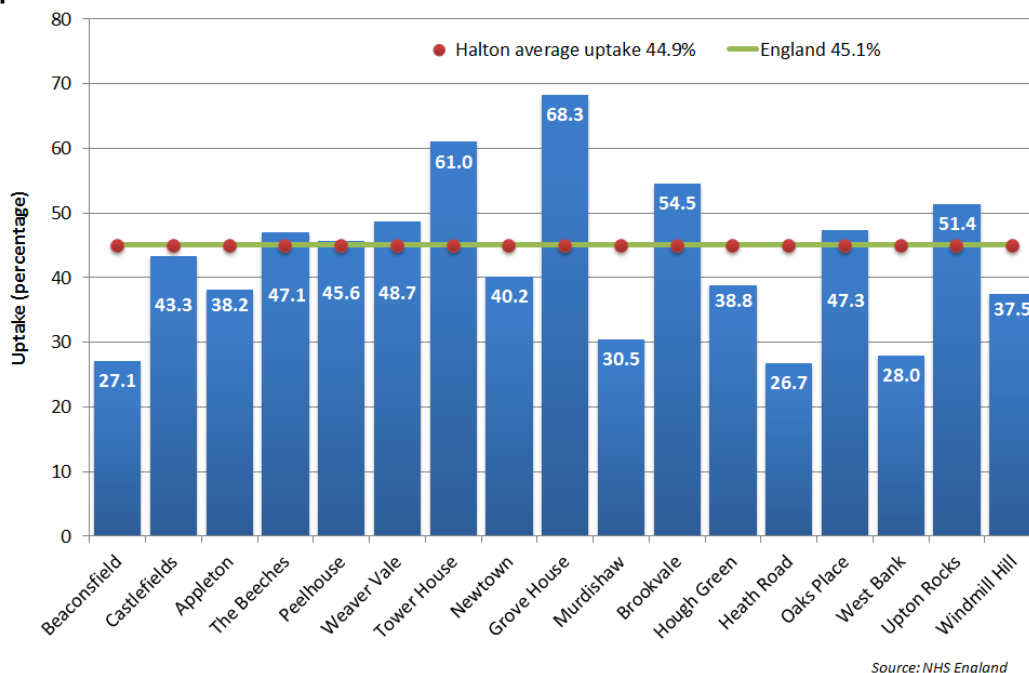
Table 32: Percentage of respondents to the GP survey stating they have caring responsibilities, GP practice, Halton CCG and England, 2011/12 to 2014/15

Practice Code	Practice Name	2012/13	2013/14	2014/15
N81035	Appleton	28.9	22.0	22.1
N81011	Beaconsfield	22.8	13.7	31.4
N81096	Brookvale	21.2	23.8	22.4
N81019	Castlefields	24.1	20.1	25.7
N81066	Grove House	21.9	29.2	25.8
N81618	Heath Road	15.0	17.8	22.0
N81119	Hough Green	28.1	18.6	14.1
N81072	Murdishaw	19.9	23.2	27.3
N81064	Newtown	17.7	28.5	20.4
N81619	Oaks Place	19.6	12.1	22.4
N81045	Peelhouse	20.7	16.9	18.8
N81037	The Beeches	24.2	23.5	14.1
N81057	Tower House	22.8	19.5	25.7
N81651	Upton Rocks	29.2	25.7	25.1
N81054	Weaver Vale	18.5	21.3	21.2
N81625	West Bank	22.5	20.8	19.5
01F	Halton CCG	22.3	21.0	22.8
England		18.6	18.4	18.2

NB: no data for Windmill Hill Source: GP survey via PHE

Despite both the Royal College of General Practitioners^[43] and NHS England^[44] recognising the vital role that carers play and the impact this role can have on their health, there is virtually no routinely collated data on the health status of carers from either GP records or that can be gleaned from hospital admissions. The only data available is that relating to annual influenza vaccinations. In recognition of the need to support carers to remain healthy, all registered carers, irrespective of their age, are eligible for a free influenza (flu) vaccination. Data for 2014/15 shows only 44.9% of Halton eligible carers (aged under 65 years, not at-risk, not pregnant and fulfils the ‘carer’ definition) received their vaccination, slightly lower than the England figure.

Figure 17: uptake of influenza vaccination amongst Halton eligible carers, 2014/15, per GP practice



4.2. Carers assessments

There has been an increase in the number of carers receiving an assessment over the last three years.

Table 33: Number of carers assessments

2012/13	Number
Carers Assessed	1044
Number Assessed who were assessed in 2013/14	512
Total number Assessed who were assessed in 2014/15	380
2013/14	
Carers Assessed	1128
Total number Assessed who were assessed in 2012/13	516
Total number Assessed who were assessed in 2014/15	529
2014/15	
Carers Assessed	1166
Total number Assessed who were assessed in 2012/13	380
Total number Assessed who were assessed in 2013/14	527

Source: Care First 6, Halton Borough Council

There have been substantially more women receiving a carers assessment than men for the last three full reporting periods, with the difference being more marked amongst carers aged 18-64. For both male and females carers aged 18-64, mental health is the primary support reason of the person cared for, followed by physical support. Whilst the numbers vary year on year, this pattern is consistent. However, for carers aged 65+, physical support is the primary need, reflecting the development of multiple long term conditions and the effects of ageing.

Table 34: Carer assessments, gender, age group and primary support reason^[iii]

Carer Age Group - 18-64	2012/13		2013/14		2014/15	
	Male	Female	Male	Female	Male	Female
Total Number of Carers Assessed	193	452	191	368	239	542
Of Which Total Number of Carers Assessed and with Services	166	376	178	342	206	463
Prime/Primary Support Reason of Person Cared For:-						
Learning Disability	<10	44	10	72	<10	<10
Physical Support	79	170	72	125	<10	16
Mental Health	80	163	102	161	<10	<10
Social Isolation	<10	<10	<10	<10	<10	<10
Unknown	27	73	<10	<10	213	509
Carer Age Group - 65+	2012/13		2013/14		2014/15	
	Male	Female	Male	Female	Male	Female
Total Number of Carers Assessed	151	234	174	380	151	232
Of Which Total Number of Carers Assessed and with Services	112	185	135	304	131	183
Prime/Primary Support Reason of Person Cared For:-						
Learning Disability	<10	11	<10	<10	0	0
Physical Support	84	141	122	291	19	42
Mental Health	29	46	40	65	<10	<10
Social Isolation	<10	<10	<10	<10	<10	<10
Unknown	30	34	<10	11	129	183

NB: figures under 10 (<10) suppressed for confidentiality

Source: Care First 6, Halton Borough Council

ⁱⁱⁱ There were a small number of records each year for which the age of the carer was not recorded. When broken down by gender all figures are under 10 and so are not reported in Table 29

4.3. Service Uptake and Outcomes

Data for 2014/15 shows that those receiving carer-specific services in Halton are more likely to receive self-directed support and direct payments than those across the North West and England as a whole. The differences are substantial and apply to carers at all ages.

Table 35: Proportion of carers receiving carer-specific services in the year to 31 March who received self-directed support and direct payments

		Halton	North West	England
Proportion of carers who received self-directed support	Total	98.5	75.6	77.4
	Carers under age 65	99.5	77.1	81.1
	Carers aged 65-84	95.9	72.7	73.1
	Carers aged 85+	100.0	76.6	68.0
Proportion of carers who received direct payments	Total	98.5	67.3	66.9
	Carers aged 64 and under	99.5	71.8	72.5
	Carers aged 65 to 84	95.9	61.5	60.5
	Carers aged 85 and over	100.0	54.5	51.6

Source: ASCOF 2014/15: 1C(1B) & 1C(2B), HSCIC

Less than half of all carers known to adult social care were satisfied with their experience of care and support. Men were slightly more satisfied than women with no differences by age. Whilst these figures may appear low they are higher than the North West and England. It would be helpful to understand why levels of satisfaction are so low.

Table 36: Proportion of respondents who were satisfied with their experience of care and support

	Total	Males	Females	18-64	65+
Halton	48.9	51.6	47.5	49.4	50.0
North West	42.9	45.5	41.5	41.6	44.9
England	41.2	43.3	40.2	38.8	43.6

Source: ASCOF 2014/14: 3B, HSCIC

A greater percentage of Halton carers known to adult social care received emergency breaks or breaks for more than 24 hours. In terms of the person they care for, there was less use of personal assistants, home care/home help, day centres, use of equipment or adaptations and permanent residence in a care home. Conversely, there was a greater percentage using meals services, lunch clubs and Lifeline Alarm.

Table 37: Services Halton carers received from Halton Borough Council, 2014/15

		Halton	North West	England
Carer received services to provide a break from caring at short notice or in an emergency	Yes	20.4	14.9	16.1
	No	76.3	82.0	81.1
Carer received services to provide a break from caring for more than 24 hours	Yes	27.8	21.5	22.3
	No	70.5	76.3	75.8
	Don't know	1.8	2.1	1.8
Carer received services to provide rest from caring for between 1 and 24 hours (e.g. sitting service)	Yes	22.3	19.4	24.6
	No	76.6	78.4	73.3
	Don't know	1.1	2.1	2.1
Person cared for has used a personal assistant	Yes	12.5	13.7	14.8
	No	86.7	84.5	83.5
	Don't know	0.8	1.8	1.8
Person cared for used home care/home help	Yes	25.4	35.3	40.6
	No	73.9	63.7	58.4
	Don't know	0.7	0.9	1.0
Person cared for used a day centre or day activities	Yes	21.2	26.6	29.8
	No	78.4	72.6	69.3
	Don't know	0.4	0.8	0.9
Person cared for used a lunch club	Yes	6.6	3.1	3.8
	No	92.7	96.0	95.1
	Don't know	0.8	0.9	1.1
Person cared for used Meals Services	Yes	7.3	3.9	5.5
	No	92.0	95.0	93.5
	Don't know	0.8	1.1	0.9
Person cared for used equipment or adaptation to their home (such as a wheelchair or handrails)	Yes	56.8	57.5	59.8
	No	42.5	41.9	39.5
	Don't know	0.7	0.6	0.7
Person cared for used Lifeline Alarm	Yes	37.0	33.8	36.6
	No	62.0	65.2	62.3
	Don't know	1.1	1.0	1.0
Person cared for permanently resident in a care home	Yes	8.1	8.4	10.0
	No	91.5	91.0	89.3
	Don't know	0.4	0.6	0.7

Source: HSCIC

The majority of Halton carers reported that they had been included in discussions about the person they care for, slightly more women than men and higher percentages than the North West and England averages.

Table 38: The proportion of carers who report that they have been included or consulted in discussion about the person they care for CSQ15

	Total	Males	Females	18-64	65+
Halton	78.8	77.9	79.2	78.6	78.3
North West	71.6	71.7	71.5	72.4	71.6
England	72.3	71.7	72.7	71.6	72.9

Source: ASCOF 2014/15: 3C (Carers Survey Q15), HSCIC

A substantially higher proportion of Halton carers reported findings information about support available to them was fairly or very easy.

Table 39: The proportion of carers who find it easy ('very easy' or 'fairly easy') to find information about support (CS Q13)

	Total	Males	Females	18-64	65+
Halton	81.5	88.5	78.2	78.1	85.9
North West	68.2	69.6	67.5	65.8	72.2
England	65.5	67.2	64.8	61.2	69.8

Source: ASCOF 2014/15: 3D(2) (Carers Survey Q13), HSCIC

5. User views

National Views of Carers

A national survey of 4,500 carers showed that more than 82% of carers feel that caring has a negative effect on their health, 2% more than in 2014^[45]

- 74% of carers find it difficult to get a good night's sleep as a result of caring, 5% more than 2014
- Nearly half (47%) struggle to maintain a balanced diet
- Four in ten (41%) have experienced an injury or their physical health has suffered as a result of caring
- 84% said that they feel more stressed, 78% said they feel more anxious, and 55% reporting that they have suffered from depression as a result of their caring role – significantly more than in 2014
- Over three quarters (76%) of carers responding to our survey are concerned about the impact of caring on their health over the next year
- Well over half (62%) of those carers who are struggling to make ends meet said they were cutting back on seeing friends or family to save money.
- Over half (53%) of respondents said that they are concerned about the impact of caring on their relationship with the person they care for over the next year and 3 in 5 (61%) are worried about the impact their caring role will have on relationships with their friends and family over the next year
- 45% said that financial worries were affecting their health. Over half (52%) were worried about the impact of cuts to social security over the next year and a similar number (54%) were worried about their finances
- 60% of working carers were worried about their ability to remain in work
- Over half (53%) of carers responding to our survey have experience of social care services such as home care or respite care. Of these, over a quarter (27%) of carers with experience of social care services such as home care or respite report positive experiences. However, worryingly, a third (33%) said that they had refused or stopped using a service altogether because of concerns over quality

The Carers Manifesto 2014^[46] set out what good support would mean for carers and what they want. It identified the following;

In terms of income and finances, carers want:

- To be able to maintain financial resilience which enables them to have a life alongside caring and which means they aren't left in debt, with little or no savings and facing financial hardship into retirement
- For carers' benefits to recognise their huge contribution to society rather than highlight how poorly valued they are
- A social security system which supports rather than prevents carers working or studying alongside caring
- For all financial support to rise with the cost of living and for the additional costs of caring in household bills and transport costs to be recognised through additional support

In terms of health and care, carers want:

- Good quality, reliable and affordable care services which enable them to have a life alongside caring
- Health and care services which recognise carers as expert partners in care
- Health services which recognise that carers' have their own health needs and provide flexible support which proactively seeks to reduce carer ill-health
- Reform of funding for social care

In terms of employment and training, carers want:

- To have access to good quality, reliable and affordable replacement care services so they can have confidence in the care being provided whilst they are at work
- Flexible, understanding employers who recognise the value of supporting carers to combine work and caring
- Rights at work which recognise and value caring as much as other family responsibilities and allow carers time off to care
- Support to return to work when caring comes to an end
- A benefits system which supports carers to work or study alongside caring, rather than makes it harder

In terms of recognition, information and advice, carers want:

- Their role to be recognised and respected as a crucial part of society
- Government and the media to proactively combat myths about families receiving disability and carers benefits
- Advice, information and support to be easily accessible wherever carers are, rather than them having to seek it out. Health and social care professionals, workplaces and community settings should work to identify carers and guide them to support
- Caring to be given the same political and economic prominence as becoming a parent – so that 'supporting families' financially, through services and in workplaces is not just about childcare but about caring across the life course

6. Future Demand – Projecting Number of Carers and Support Needed

In England and Wales, the number of people reporting that they were an unpaid carer as part of the census increased from 5.2 million to 5.8 million between 2001 and 2011. The greatest rise has been amongst those providing over 20 hours care, which can have a significant impact on the health and wellbeing of the carer, including their ability to retain paid employment alongside their caring responsibilities. It is predicted that the number of carers will increase significantly to 9 million by 2037.

The number of carers in the borough and their needs are likely to change dramatically over the next ten years and beyond. Population changes will mean that there will be an increasing number of people that will require support from a carer. Below highlights the changing population demographics and how this will have an impact.

6.1. Increase in Ageing Population

The number of people aged over 65 in the borough is expected to increase by 42% between 2012 and 2037. This means:

- There will be an additional 14,123 people aged over 65 by 2037
- The greatest proportion increase is anticipated to occur in the 85 and over, age group where an additional 4,305 people are expected to be residing in the Borough by 2019 (a 67% increase)
- By 2037 the overall older people's dependency ratio on those of working age in Halton will be larger than the child dependency ratio

The implications of an ageing population are three fold in relation to carers:

- There will be more people requiring caring support because of age-related conditions
- There will also be potentially more old carers, who will have their own needs to meet also and thus may find it more difficult to care for others
- The older people's dependency ratio will potentially mean that there are less working age people available to provide the carer support

6.2. Increase in dementia prevalence

A particular issue for Halton will be dealing with the rising rates of dementia. In 2015 the number of people suffering from dementia in Halton is estimated to be 1,343 of which 893 are known to services (based on GP registers 2014/15). This is expected to rise to 2,262 by 2030. Of this figure around 11% of cases are expected to be severe. During the later stages of ageing the problems of dementia increase rapidly. The future expansion of services for dementia sufferers and their carers will present special challenges to the health and social care system, particularly where a greater proportion of the population are able to remain living in their own homes for longer.

6.3. Increase in survival rates

More people are living longer and surviving with chronic diseases and complex care needs. This requires a different approach to longer term care and a new way of supporting people to manage illness. The impact in Halton is likely to be greater than national as the borough currently experiences high levels of poor health. Areas with previously poor health are characterised by an effect described as “adding years to life but not life to years”, which points out the impact of people growing old with long-term limiting conditions. Life is prolonged but without health improvement, resulting in an associated demand for all health and social care services. The level of disability free life expectancy at age 15, 50 and 65 is lower in Halton than the North West and England.

6.4. Increase in numbers with long term conditions, including multiple conditions

In England, more than 15 million people have a long term condition (LTC) - a health problem that can't be cured but can be controlled by medication or other therapies. This figure is set to increase over the next 10 years, particularly those people with 3 or more conditions at once. One in three people are living with at least one chronic condition, such as hypertension, diabetes or depression. By 2018 nearly three million people, mainly older people, will have three or more conditions all at once. Data for Halton^{iv} shows that not only does the borough have higher prevalence of each of the main long term conditions but, based on current prevalence rates, the numbers are predicted to rise as the population ages. The borough also has a higher proportion of its population with multiple long-term conditions than the national average. All of these factors will have an influence on the need for more people to take on unpaid carer roles. Data earlier in this report also shows that unpaid carers in Halton themselves are more likely to have limiting life-long conditions. This makes it especially important to ensure the health and support needs of unpaid carers adequately addressed.

6.5. Patterns of care home admissions

In line with national policy there has been substantial efforts made to support people to be able to remain independent, living in their own homes. The Halton Care Homes JSNA shows that despite an increase in the older population, i.e. those aged 65 and over, the rate of admissions to care homes has remained steady. However, even with a constant prevalence rate the numbers entering care homes will increase as the number of older people in our population increases.

6.6. Potential decrease in people undertaking caring roles

While the number of people needing care is set to rise, social trends could, in the future, have an effect on the number of available carers. The growth in the number of lone parents, falls in birth rates, higher divorce rates, the increase in the numbers of people living alone and greater family mobility may all have an impact on the numbers of people available to assume a caring role. In addition, the growing number of women who are employed outside the home will have implications for the number of carers, since women have traditionally fulfilled the caring role.

iv. See Long Term Conditions JSNA chapters: Long term conditions, cardiovascular disease, diabetes, respiratory health and others at <http://www4.halton.gov.uk/Pages/health/JSNA.aspx>

6.7. Welfare reforms and public sector funding reductions

Welfare reforms and a significant reduction in public sector funding are increasingly creating significant challenges. Welfare reforms are having a direct impact on carers through reductions in housing, welfare and benefits support to themselves and individuals with disabilities / caring needs exacerbating existing financial pressures. In addition, an increasing demand for support services alongside a significant reduction in public sector funding means that services to support carers and those that they care for are likely to be reduced. This is likely to mean increased reliance on unpaid carers to provide services that would previously have been provided by the formal care system, putting extra strain on carers.

7. Best practice interventions

There are a number of national sources of evidence and guidance on the types of services, support and interventions that have a positive impact on carers. Below is a brief summary of the evidence.

The Carers Trust

The Carers Trust provides extensive resources for the effective commissioning of services to support carers. The Carers Hub (below) is an interactive model based on the outcomes of the National Carers Strategy for England and contains practical guidance and innovative examples of service design and delivery.

The Royal College of General Practitioners (RCGP) Guidance

The RCGP recommends that all carers routinely receive an assessment from their GP in relation to their health and wellbeing. They provide a range of evidence based resources to help GPs and primary healthcare staff in their support of people with caring responsibilities.

The RCGP, in collaboration with NHS England and NHS Improving Quality, also regularly facilitates Carers Evidence Summits, which identify best practice examples of what is working well for carers across the UK, with topics including:

- Carers' break - health and wellbeing
- Carer support
- Dementia
- Eating disorders and substance abuse
- Education, information and signposting
- End of Life Care
- Identification and recognition
- Mental health
- Young carers

Carers UK

A systematic review of interventions directly targeted at carers was undertaken to support local commissioning of services.^[47] The review included those concerned with supporting carers to access services; those targeted at carers' physical health; interventions focused upon emotional and social support; education and training for carers; employment-related interventions; and carer breaks.

The Royal College of Nursing (RCN)

The RCN provides a wealth of guidance, information and support for carers, those working with carers and those commissioning services to support carers. Assessment tools, strategies and information documents are available.

National Institute for Health and Social Care Excellence (NICE) Guidance

NICE provides specific guidance identifying recommendations for carers including:

- ([CG185, 2014](#)) NICE recommends that carers of people with bipolar disorder are offered an assessment, provided by mental health services, of their own needs and discuss with them their strengths and views.
- ([CG178, 2014](#)) In their updated guidance on treating and managing psychosis and schizophrenia in adults, NICE recommends that carers' needs should be assessed to ensure they get the right level of support.
- ([CG42, 2012](#)) In their guidance for supporting people with dementia and their carers, NICE recommends that wherever possible and appropriate, agencies should work in an integrated way to maximise the benefit for people with dementia as well as their carers.

Department of Health Guidance: School Nurse Programme

The Government provides evidence around what works locally in providing seamless support and local solutions to support the health and wellbeing of young carers.

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