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The National Unpaid Carers Union and



National Carers Blueprint

A UK WIDE BLUEPRINT FOR THE FUTURE OF UNPAID
CARERS

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This Blueprint contains lived-experience testimonies, workshop findings, and contributions from unpaid carers and advocates across England and Wales. These voices are included with consent for the purposes of policy reform and public understanding. They must not be altered, edited, misrepresented, or used in any way that changes their meaning, context, or intent.

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SECTION 1 — EXECUTIVE SUMMARY

(England & Wales)

England and Wales are facing a shared and escalating crisis in health and social care. Both nations rely structurally on unpaid carers to sustain their systems, yet neither provides the rights, support, or preventative investment required to keep carers healthy, financially secure, and able to continue caring. The result is a growing mismatch between statutory expectations and the lived reality of millions of carers whose unpaid labour underpins the functioning of both nations' health and social care systems.

This crisis is not theoretical. It is already unfolding — and the United States has shown us what happens when a nation ignores the warning signs.

A recent national analysis from the US reveals a system collapsing under the weight of rising disability, an ageing population, a shrinking care workforce, and an over-reliance on unpaid carers who are burning out faster than the state can replace them. England and Wales are on the same demographic and economic trajectory. Without urgent reform, the UK will face the same systemic collapse now visible in the US.

Across England and Wales, the evidence is consistent and overwhelming:

- **Preventative funding is collapsing**, leaving carers unsupported until crisis point.
- **Respite provision is inconsistent, inflexible, and precarious**, varying dramatically by region.
- **Co-production remains largely tokenistic**, with carers excluded from meaningful influence in decision-making structures.
- **Carers' rights exist in legislation but not in practice**, due to the absence of enforcement mechanisms.
- **Data gaps make planning impossible**, with neither nation able to reliably identify or track its carer population.
- **Support varies dramatically by postcode**, creating systemic inequality.
- **Carers face extreme time-poverty and financial strain**, often sacrificing employment, health, and wellbeing.
- **Governance structures — ICSs in England and RPBs in Wales — lack statutory accountability to carers**, resulting in inconsistent engagement and weak oversight.

These failures mirror the early warning signs documented in the United States: a system that assumes families can absorb unlimited care, while providing neither the rights nor the infrastructure required to sustain them.

Six National Failures Shared Across Both Nations

1. Preventative support is underfunded and undervalued

Both nations prioritise crisis response over early intervention, despite clear evidence that preventative support reduces long-term costs and improves outcomes. This is the same pattern that led to the US caregiving crisis.

2. Carers' rights are unenforced in both nations

The Care Act 2014 (England) and the Social Services and Well-being (Wales) Act 2014 provide rights on paper, but neither nation has enforcement mechanisms, resulting in inconsistent delivery and widespread unmet need.

3. Co-production is superficial and inaccessible

Carers report tokenistic engagement, inaccessible meeting formats, lack of replacement care, and no evidence that their input influences decisions — a governance failure also seen in the US.

4. Respite is inconsistent, inflexible, and often unavailable

Respite provision varies dramatically by region, with long waiting lists, limited models, and no national guarantee in either nation. The US experience shows that when respite collapses, carers collapse.

5. Data systems cannot identify or track carers

Neither England nor Wales has national carers register. Data definitions are inconsistent, systems are fragmented, and statutory bodies cannot plan effectively — the same data blindness that has crippled US planning.

6. Support is fragmented by diagnosis, region, and service silo

Carers supporting people with neurodiversity, learning disabilities, mental health conditions, sensory impairments, or physical disabilities face different pathways, different entitlements, and different barriers — despite sharing common caring burdens. This fragmentation mirrors the US system, where diagnostic silos create inequality and inefficiency.

A UK-Wide Solution

This Blueprint proposes a unified national approach that can be adopted across England and Wales, with the potential for future expansion to Scotland and Northern Ireland. It sets out:

- **A national rights framework** that applies across diagnoses, regions, and nations.
- **A cross-nation accountability model** that ensures rights are delivered consistently.
- **A three-year implementation roadmap** that moves from foundation to integration to enforcement.
- **A structural reform package** including a National Carers Register, a National Respite Guarantee, a statutory National Carers Impact Assessment (NCIA), and a national co-production duty.

The National Warning

The United States has shown us what happens when a nation relies on unpaid carers without supporting them:

- carers burn out
- families collapse
- hospital discharge fails
- long-term care becomes unaffordable
- the system buckles under demand

England and Wales are on the same path.

This Blueprint is not simply a policy proposal — **it is a national warning.**

Without urgent reform, the UK will face the same systemic collapse now unfolding in the US.

Central Argument

Unpaid carers are essential infrastructure. England and Wales cannot sustain their health and social care systems without them. Therefore, carers' rights must be universal, enforceable, and nationally consistent.

This Executive Summary sets the stage for a detailed, evidence-based, cross-nation reform programme designed to transform unpaid care from invisible labour into a recognised, protected, and properly supported pillar of national wellbeing — and to prevent the UK from repeating the US caregiving collapse.

SECTION 2 — NATIONAL CONTEXT: ENGLAND & WALES

Revised With US Warning — A System Approaching Structural Failure

England and Wales are entering a period of profound instability in health and social care. Both nations rely on unpaid carers to sustain their systems, yet neither provides the rights, investment, or preventative infrastructure required to keep carers healthy and able to continue caring. This dependency is now so deep that the system cannot function without unpaid carers — and carers cannot function without systemic support.

The United States is already experiencing the consequences of this imbalance. Its caregiving crisis offers a direct glimpse into the UK's future if urgent reform is not undertaken. The demographic pressures, workforce shortages, and collapse of preventative support documented in the US are **identical** to those emerging across England and Wales.

This section sets out the structural context that makes reform not optional, but essential.

2.1 Shared Economic Reality — A System Held Together by Unpaid Labour

Unpaid carers in England and Wales collectively save the state **hundreds of billions of pounds** every year. Their contribution is larger than the entire NHS workforce and exceeds the budgets of most government departments. Without them:

- **NHS waiting lists would surge beyond recoverable levels**
- **Hospital discharge would stall**, creating system-wide gridlock
- **Social care would collapse**, with no capacity to absorb unmet need
- **Emergency placements would skyrocket**, overwhelming local authorities

Yet both nations continue to:

- cut preventative services
- underfund respite
- rely on crisis-driven models
- fail to invest in early intervention

This is the same pattern that led to the US caregiving emergency: a system that assumes families can absorb unlimited care, while stripping away the preventative support that keeps those families afloat.

Both systems are financially unsustainable without carers — yet carers remain unsupported.

2.2 Legislative Comparison — Rights Without Remedies

Wales

- Social Services and Well-being (Wales) Act 2014
- Carers have legal rights to assessment and support
- No enforcement mechanism
- Local authority interpretation varies

England

- Care Act 2014
- Carers have legal rights to assessment and support
- No enforcement mechanism
- Local authority interpretation varies

Shared Reality

Both Acts give carers rights on paper but **no practical route to enforce them**.

This mirrors the US situation, where families technically have rights but no mechanism to challenge non-delivery — resulting in widespread unmet need, inequality, and system failure.

2.3 Governance Structures — No Accountability to Carers

Wales

- Regional Partnership Boards (RPBs)
- Responsible for integration, prevention, and regional planning
- No statutory duty to include carers in governance
- No statutory accountability to carers

England

- Integrated Care Systems (ICSs)
- Integrated Care Boards (ICBs)
- Integrated Care Partnerships (ICPs)
- Carers rarely represented
- NHS-dominated decision-making
- No statutory accountability to carers

Shared Reality

Both systems claim co-production but fail to deliver it.

This is the same governance failure seen in the US: families excluded from decision-making, systems designed without lived experience, and policies that collapse under real-world conditions.

2.4 Funding Cliff-Edges — A National Risk

Wales

- Regional Integration Fund ends March 2027
- Respite Fund renewed for 3 years but not guaranteed
- Carers Gateway funding remains precarious

England

- Local authority social care budgets collapsing
- Carers' breaks funding inconsistent and often cut
- ICSs lack ring-fenced preventative budgets

Shared Reality

Carers face unstable, short-term funding cycles in both nations.

This instability mirrors the US trajectory, where:

- preventative services collapsed first
- crisis spending exploded
- carers burned out
- long-term care became unaffordable
- the system buckled under demand

England and Wales are now on the same path.

The National Warning

The United States has shown what happens when a nation relies on unpaid carers without supporting them:

- carers burn out
- families collapse
- hospital discharge fails
- emergency placements surge
- the system becomes financially unsustainable

England and Wales are not immune. They are simply **later on the timeline**.

Without urgent reform, both nations will face the same systemic collapse now unfolding in the US.

SECTION 3 — EVIDENCE FROM ACROSS ENGLAND & WALES

A Cross-Nation Evidence Base for Reform

The evidence gathered from carers, statutory bodies, local authorities, and national organisations across England and Wales reveals a consistent pattern of systemic failure. These failures are not isolated to individual regions or services — they are structural, predictable, and replicated across both nations.

While the United States provides a stark example of what happens when preventative support collapses and unpaid carers are left to absorb rising demand, the purpose of this section is not to issue warnings. Its purpose is to **present the evidence base** that underpins the reforms proposed in this Blueprint.

3.1 Preventative Funding Failures — Crisis Has Replaced Prevention

Carers across England and Wales consistently report:

- long waits for assessments
- inconsistent access to respite
- deterioration in their own health
- crisis-driven responses
- lack of early intervention

These experiences reflect a system that has shifted away from prevention and toward crisis management.

Local authorities in both nations prioritise crisis because:

- preventative budgets are not ring-fenced
- savings from prevention are not captured
- short-term pressures override long-term planning
- funding cycles are unstable and unpredictable

This creates a predictable pattern: **carers deteriorate, cared-for people deteriorate, and services intervene only when breakdown occurs.**

The United States is already experiencing the consequences of this model. England and Wales are showing the same early indicators — but still have time to intervene.

3.2 Co-Production Failures — Engagement Without Influence

Carers across England and Wales describe:

- tokenistic engagement
- meetings where decisions are already made
- inaccessible formats
- no feedback loops
- no influence on outcomes

Both ICSs (England) and RPBs (Wales):

- treat engagement as consultation, not co-production
- fail to pay carers for their time
- fail to provide replacement care
- fail to embed lived experience in governance

This results in a system where carers are asked to contribute, but not empowered to shape decisions.

The US experience shows that when lived experience is excluded from governance, systems drift further from the realities of families and become less effective over time.

3.3 Participation Barriers — Carers Cannot Engage Without Support

Carers in both nations face:

- extreme time-poverty
- lack of replacement care
- financial strain
- travel barriers
- digital exclusion

Statutory bodies rarely provide:

- payment for time
- funded replacement care
- accessible meeting times
- hybrid participation options

This means the carers most affected by policy decisions are often the least able to participate in shaping them.

This is not a failure of willingness — it is a failure of access.

3.4 Data Gaps — Systems Cannot Plan What They Cannot See

Neither nation has:

- a national carers register
- a unified dataset
- cross-regional consistency
- reliable identification systems

Both nations acknowledge that they:

- cannot identify carers
- cannot track needs
- cannot plan services
- cannot measure outcomes

This is a foundational systems failure.

The US caregiving crisis has shown that when governments cannot see their carers, they cannot support them — and the system becomes reactive, inefficient, and unstable.

England and Wales face the same risk unless data infrastructure is modernised.

3.5 Siloed Service Models — Fragmentation Creates Inequality

England and Wales both divide services into diagnostic silos:

- Neurodiversity
- Learning Disabilities
- Autism
- Mental Health
- Physical Disabilities
- Sensory Impairment

This segmentation:

- fragments families
- creates unequal access
- forces carers to navigate multiple systems
- undermines universal rights

Carers supporting individuals with complex or overlapping needs are disproportionately affected, often coordinating multiple pathways simultaneously.

The US system shows that diagnostic silos lead to duplication, inefficiency, and widening inequality — outcomes already visible in parts of England and Wales.

SECTION 4 — NATIONAL RIGHTS FRAMEWORK (ENGLAND & WALES)

A Unified, Enforceable Rights Agenda for All Unpaid Carers

England and Wales share the same structural dependency on unpaid carers and the same systemic failures that leave carers unsupported, unprotected, and inconsistently recognised. To address these failures, both nations require a single, unified rights framework that applies to every carer — regardless of diagnosis, region, or service silo.

This Rights Framework establishes the **minimum national standards** that must be guaranteed across England and Wales. It is designed to be:

- **universal** — applying to all carers
- **enforceable** — backed by statutory duties
- **consistent** — delivered equally across both nations
- **practical** — implementable by statutory bodies
- **future-proof** — aligned with demographic realities

This is the foundation for a sustainable, equitable care system.

4.1 Universal Carers' Rights

Rights that apply to every carer, in every region, in every nation

Regardless of nation, region, or diagnosis, all carers must have the following rights:

1. Right to Preventative Support

Carers must receive early intervention, not crisis-only responses. Preventative support must be a statutory duty.

2. Right to Flexible Respite

Carers must have access to regular, flexible, and appropriate respite that reflects both their needs and the needs of the person they support.

3. Right to Funded Replacement Care

Carers must not be excluded from work, education, healthcare, or participation because replacement care is unavailable or unaffordable.

4. Right to Accessible Co-Production

Carers must be able to influence decisions that affect them. This requires payment for time, funded replacement care, accessible formats, and hybrid participation options.

5. Right to Financial Protection

Carers must not be pushed into poverty because of their caring role. Financial support must reflect the true cost of caring and protect long-term economic wellbeing.

6. Right to Recognition as Essential Infrastructure

Carers must be recognised as a critical component of national health and social care systems — not as an informal or invisible workforce.

7. Right to Transparent Decision-Making

Carers must have clear information about eligibility, assessments, decisions, and appeals. Transparency must be a statutory requirement.

8. Right to Consistent Support Across the UK

Carers must not face different entitlements based on postcode, diagnosis, or local interpretation. National minimum standards must apply across England and Wales.

4.2 A Single National Rights Agenda

Ending postcode lotteries, diagnostic silos, and national divergence

Diagnosis must not determine entitlement. Postcode must not determine entitlement. Nation must not determine entitlement.

Carers' rights must be:

- **universal**
- **enforceable**
- **nationally consistent**

This requires:

1. A Unified Cross-Nation Rights Framework

A single set of rights adopted across England and Wales, ensuring consistency across ICSs, RPBs, and local authorities.

2. National Minimum Standards

Clear, measurable standards for respite, assessment, replacement care, co-production, and financial protection.

3. Statutory Enforcement Mechanisms

Rights must be enforceable through independent appeals, statutory oversight, and legal remedies.

4. Cross-Nation Accountability

A shared accountability model ensuring that ICSs, RPBs, local authorities, and NHS bodies deliver the same baseline rights.

5. Unified Data Infrastructure

A national carers register and consistent data definitions across both nations, enabling planning, monitoring, and accountability.

4.3 Enforcement & Remedies

Rights without enforcement are not rights — they are aspirations

To ensure carers' rights are real, enforceable, and consistently delivered, both nations must adopt a shared enforcement model.

1. Statutory Duty to Deliver Carers' Rights

Local authorities, ICSs, and RPBs must be legally required to deliver the rights set out in this framework.

2. Independent Appeals Mechanism

Carers must have access to a clear, independent route to challenge:

- assessment decisions
- respite refusals
- delays
- failures to provide replacement care
- failures to involve carers in co-production

3. National Oversight Body

A cross-nation oversight body must:

- monitor compliance
- publish annual performance data
- investigate systemic failures
- issue improvement notices
- escalate persistent non-compliance

4. Legal Remedies for Breach of Duty

Where rights are not delivered, carers must have access to:

- statutory complaints routes
- independent review
- legal redress where necessary

5. Mandatory Reporting Requirements

ICSs, RPBs, and local authorities must report annually on:

- respite provision
- assessment waiting times
- replacement care availability
- co-production participation
- financial support delivery

- unmet need

Enforcement is what turns rights into reality.

4.4 National Minimum Standards

A consistent baseline for all carers across England and Wales

To eliminate postcode lotteries and ensure national consistency, the following minimum standards must apply across both nations:

1. Assessment Standards

- Maximum waiting time for carers' assessments
- Clear, published eligibility criteria
- Annual review of needs

2. Respite Standards

- Minimum guaranteed hours of respite per year
- Flexible models (in-home, out-of-home, emergency, planned)
- No region permitted to offer “zero respite”

3. Replacement Care Standards

- Funded replacement care for:
 - medical appointments
 - employment
 - education
 - co-production participation
 - emergencies
- Replacement care must be safe, appropriate, and timely

4. Co-Production Standards

- Payment for time
- Funded replacement care
- Hybrid participation options
- Accessible formats
- Transparent feedback loops

5. Financial Protection Standards

- Minimum financial support thresholds
- Protection from poverty
- Safeguards for carers leaving employment

- Pension protection mechanisms

6. Data Standards

- National carers register
- Consistent definitions
- Annual publication of data
- Cross-nation comparability

These standards ensure that every carer — in every region, in every nation — receives the same baseline level of support.

SECTION 5 — NATIONAL STRUCTURAL REFORMS (UK-WIDE)

Cross-Nation Reforms Required to Deliver Consistent, Enforceable Carers' Rights

To make the National Rights Framework deliverable in practice, England and Wales require a shared set of structural reforms. These reforms create the governance, data, accountability, and operational infrastructure needed to ensure that carers' rights are not only defined, but implemented consistently across both nations.

The following UK-wide reforms form the backbone of a modern, sustainable, and rights-based care system.

5.1 National Carers Impact Assessment (NCIA)

A mandatory assessment for all major decisions affecting carers

The NCIA must be a statutory requirement for:

- **England:** Integrated Care Systems (ICSs), Integrated Care Boards (ICBs), and local councils
- **Wales:** Regional Partnership Boards (RPBs) and local councils

Every NCIA must include:

- **Impact on carers** — workload, wellbeing, financial implications
- **Risks to rights** — identifying where decisions may breach national standards
- **Mitigation plans** — clear actions to prevent or reduce negative impacts
- **Evidence of co-production** — demonstrating meaningful involvement of carers

The NCIA ensures that carers' rights are considered **before** decisions are made, not after harm occurs.

5.2 National Co-Production Duty

A statutory duty to embed lived experience in governance

Both nations must introduce a shared statutory duty requiring all relevant bodies to co-produce with carers.

Bodies must:

- **pay carers for their time**
- **fund replacement care** to enable participation
- **provide accessible formats** and hybrid options
- **demonstrate influence on decisions**
- **publish co-production outcomes**

This duty ensures that carers are not consulted symbolically, but embedded meaningfully in governance and service design.

5.3 National Respite Guarantee

A UK-wide guarantee of consistent, flexible, and sustainable respite

A National Respite Guarantee must ensure:

- **long-term, stable funding**
- **flexible respite options** (in-home, out-of-home, emergency, planned)
- **consistent access across regions**
- **no funding cliff edges**
- **co-designed delivery models**

This guarantee provides the foundation for carers' health, wellbeing, and long-term sustainability.

5.4 National Carers Register

A shared UK-wide data infrastructure to identify and support carers

A National Carers Register must be established across the UK to enable:

- **accurate planning**
- **targeted support**
- **consistent rights implementation**
- **improved data for funding decisions**

The register must be:

- opt-in
- secure
- cross-nation
- integrated with NHS and local authority systems
- designed with carers to ensure accessibility and trust

Without a unified register, rights cannot be delivered consistently.

5.5 National Accountability Mechanism

A shared UK-wide model for monitoring, reporting, and enforcing carers' rights

Both nations must adopt a common accountability framework requiring all statutory bodies to:

- **publish annual compliance statements**
- **assign named leads** for carers' rights
- **set delivery timelines**
- **report progress publicly**
- **follow escalation routes for non-compliance**

This mechanism ensures that rights are not optional, and that every statutory body is accountable for delivering them.

5.6 National Governance Architecture

A UK-wide structure to coordinate, align, and oversee carers' rights

To ensure long-term consistency and prevent divergence between England and Wales, a UK-wide governance architecture must be established.

1. UK-Wide Carers' Rights Council (UKCRC)

A statutory cross-nation body responsible for:

- overseeing implementation of the National Rights Framework
- ensuring alignment between England and Wales
- monitoring delivery of national minimum standards
- coordinating data, reporting, and evaluation
- issuing guidance and improvement notices
- escalating systemic failures

Membership must include carers, ICS/ICB/RPB representatives, national governments, third-sector partners, and independent experts.

2. Cross-Nation Alignment Protocols

Formal agreements ensuring:

- shared definitions
- shared data standards
- shared reporting cycles
- shared accountability measures
- shared minimum standards

3. Annual UK-Wide Carers' Rights Review

A published review assessing:

- compliance
- performance
- progress
- risks
- emerging pressures

4. National Escalation Pathway

A clear route for addressing non-compliance, including:

- early warning notices
- improvement plans
- statutory intervention
- public reporting

5. Integration with Existing Governance

Alignment with:

- NHS England
- Welsh Government
- Local Government Association
- Social Care Wales
- CQC
- HIW

This ensures reforms are embedded across the whole system.

SECTION 6 — CROSS-NATION EVIDENCE: WORKSHOPS & LIVED EXPERIENCE

A Unified Evidence Base from England and Wales

This Blueprint is grounded in cross-nation evidence gathered directly from unpaid carers across England and Wales. The evidence reflects the full diversity of caring roles, ages, identities, and communities. It forms the qualitative backbone of the National Rights Framework and the structural reforms proposed in this document.

Evidence is collected in a way that is consistent, inclusive, and methodologically robust across both nations.

6.1 Cross-Demographic Carer Workshops

Using the DWP “Workshop in a Box” model

Workshops will be delivered across:

- **England**
- **Wales**
- **all major caring demographics, including:**
 - parent carers
 - **older adults caring for elderly parents**
 - **elderly carers supporting elderly partners**
 - working-age adults caring for ageing parents
 - carers supporting partners with long-term conditions
 - carers supporting siblings or extended family
 - multi-carer households
- **cross-diagnostic groups, including:**
 - neurodiversity
 - learning disability
 - dementia
 - mental health
 - physical disability
 - sensory impairment

Using the DWP “Workshop in a Box” model ensures:

- consistent facilitation
- standardised questions
- comparable outputs across regions
- accessibility for carers with limited time or support

Findings from these workshops will demonstrate:

- **Universal burdens** Time poverty, financial strain, emotional exhaustion, and lack of respite across all demographics.
- **Cross-nation commonality** Carers in England and Wales report near-identical challenges, regardless of age or caring role.
- **Systemic barriers** Fragmented services, inconsistent assessments, inaccessible co-production, and lack of replacement care.
- **Unmet rights** A consistent gap between statutory rights and lived experience.

6.2 Lived Experience Testimonies

The qualitative backbone of the Blueprint

Testimonies will be collected from:

- all English ICS regions
- all Welsh RPB regions
- rural and urban communities
- minority ethnic carers
- LGBTQ+ carers
- young carers and young adult carers
- older carers, including:
 - elderly spouses caring for elderly partners
 - older adults caring for adult children
 - older adults caring for elderly parents

These testimonies provide:

- first-hand accounts of systemic failure and good practice
- insight into intersectional barriers (age, disability, culture, identity)
- evidence of regional variation and postcode inequality
- real-world examples of unmet need
- the human impact of policy decisions

Older carers are especially important here — they often:

- provide the highest hours of care
- have the lowest access to respite
- experience the greatest health decline
- are least represented in co-production
- face the highest risk of isolation

Their voices must be central, not peripheral.

6.3 Methodology, Ethics, and Safeguarding

Ensuring evidence is collected safely and consistently

All evidence gathering must follow clear standards:

- **Informed consent**
- **Confidentiality and anonymity**
- **Trauma-informed practice**
- **Accessibility** (language, disability, digital access, replacement care)
- **Fair recognition** (payment or vouchers for time, funded replacement care)

This ensures the evidence base is credible, ethical, and inclusive.

6.4 From Evidence to Action: The Cross-Nation Feedback Loop

Ensuring lived experience drives system change

Evidence gathered through workshops and testimonies must:

- feed directly into NCIA processes (Section 5.1)
- inform co-production duties (Sections 4.1, 4.2, 5.2)
- shape national minimum standards (Section 4.4)
- guide the National Respite Guarantee and Register (Sections 5.3, 5.4)
- be reviewed annually by the UK-Wide Carers' Rights Council (Section 5.6)

This creates a **permanent evidence cycle**, where:

1. Carers share experiences
2. Evidence is analysed and published
3. Policy and practice are adjusted
4. Impact is reviewed with carers
5. The cycle repeats

This ensures lived experience is not a one-off consultation, but a **core driver of national reform**.

SECTION 7 — NATIONAL IMPLEMENTATION ROADMAP (3 YEARS)

A phased, cross-nation programme for delivering universal carers' rights

This three-year roadmap sets out a clear, achievable, and nationally consistent programme for implementing the National Rights Framework across England and Wales. It moves from **foundation**, to **integration**, to **full statutory enforcement**, underpinned by legislation, funding, governance, and lived experience.

Year 1 — Foundation

Building the legal, financial, and data infrastructure

1. Legislative Preparation

- Publish a joint England–Wales **Carers' Rights White Paper**
- Begin drafting the **Carers' Rights and Structural Reform Bill**
- Consult with carers, ICSs, ICBs, RPBs, councils, and third sector

2. Funding Settlement (Phase 1)

- Agree a **multi-year funding envelope** for:
 - National Carers Register
 - NCIA implementation
 - co-production costs (payment + replacement care)
 - respite redesign pilots
- Protect funding from annual cuts through a multi-year settlement

3. Establish the National Carers Register

- Launch the UK-wide opt-in register
- Begin integration with NHS and local authority systems
- Standardise data definitions across England and Wales

4. Publish the National Carers Impact Assessment (NCIA) Template

- Mandatory for ICSs, ICBs, RPBs, and councils
- Includes rights-risk analysis, mitigation, and co-production evidence

5. Standardise Co-Production Requirements

- Publish national co-production standards
- Require payment for time and funded replacement care
- Introduce hybrid participation models

6. Begin Respite Model Redesign

- Co-design flexible respite models with carers
- Map current provision and unmet need
- Design the framework for the National Respite Guarantee

7. Launch Cross-Demographic Evidence Programme

- Begin workshops and testimonies across all caring demographics (Section 6)
- Establish ethical and methodological standards

Outcome of Year 1: The legal drafting, funding framework, data infrastructure, and co-production standards are in place. The system is ready to move from design to integration.

Year 2 — Integration

Embedding rights, standards, and governance into everyday practice

1. Legislation Passed

- **Carers' Rights and Structural Reform Act** receives Royal Assent (England & Wales provisions)
- Commencement orders phased to align with system readiness

2. Funding Settlement (Phase 2)

- Allocate ring-fenced funding for:
 - National Respite Guarantee
 - co-production delivery
 - NCIA implementation
 - data and reporting infrastructure
- Introduce monitoring of how funds are used locally

3. Embed Charter Compliance in All ICS/ICB/RPB Papers

- Every decision paper includes a Carers' Rights Compliance section
- NCIA becomes standard practice

4. Publish Annual Compliance Reports

- ICSs, ICBs, RPBs, and councils publish their first annual delivery reports
- Includes performance against minimum standards and rights delivery

5. Implement the National Respite Guarantee (Phase 1)

- Launch flexible respite models nationally
- Ensure minimum respite access across all regions
- Introduce emergency respite pathways

6. Begin Cross-Nation Alignment

- England and Wales adopt shared definitions, standards, and reporting cycles
- Alignment protocols agreed and implemented

7. Activate the UK-Wide Carers' Rights Council (UKCRC)

- Council formally established and operational
- Begins oversight of rights delivery, data, and accountability

8. Continue and Deepen Evidence Cycle

- Ongoing workshops and testimonies
- First cross-nation synthesis report published
- Evidence used to refine standards and implementation

Outcome of Year 2: The legal framework is in force, funding is flowing, rights and standards are embedded into decision-making, and governance and evidence cycles are active.

Year 3 — Enforcement

Ensuring rights are real, enforceable, and nationally consistent

1. Full Statutory Accountability Commences

- All statutory duties in the Carers' Rights and Structural Reform Act fully commenced
- ICSs, ICBs, RPBs, and councils legally required to deliver the National Rights Framework

2. National Rights Enforcement Mechanism Operational

- Independent appeals route fully functioning
- Escalation pathway for non-compliance in place
- Improvement notices and statutory intervention powers used where needed

3. Cross-Nation Consistency Achieved (Phase 1)

- Minimum standards met across England and Wales
- Shared data, shared definitions, shared reporting
- National Respite Guarantee fully operational and monitored

4. Annual National Carers Report Published

- UKCRC publishes the first full national carers report
- Includes compliance, performance, unmet need, and future priorities

5. Formal Review and Refresh of the Blueprint

- Three-year review of the Rights Framework and structural reforms
- Carers' workshops and testimonies used to identify gaps and next-stage reforms
- Roadmap updated for the next planning cycle

6. Funding Settlement (Phase 3 — Consolidation)

- Review adequacy of funding against demand and demographic change
- Adjust settlement to ensure long-term sustainability

Outcome of Year 3: Carers' rights are enforceable, funded, and consistently delivered across both nations, supported by unified governance, live evidence, and a formal mechanism for continuous improvement.

SECTION 8 — RECOMMENDATIONS TO UK GOVERNMENT (ENGLAND)

Reforming the national framework for carers in England

The UK Government holds responsibility for the **legislative**, **financial**, and **regulatory** architecture underpinning carers' rights in England. Evidence presented in this Blueprint demonstrates that the **Care Act 2014**, while progressive in principle, is failing in practice due to:

- inconsistent implementation
- lack of enforcement
- chronic underfunding of preventative services
- absence of national minimum standards
- weak accountability mechanisms
- no monitoring of the health impact or premature deaths of unpaid carers

To address these systemic failures, the UK Government must implement the following reforms.

8.1 Establish a Statutory National Carers Impact Assessment (NCIA)

Embedding carers' rights into every major decision

The UK Government must legislate to require all:

- Integrated Care Systems (ICSs)
- Integrated Care Boards (ICBs)
- Local authorities

to complete a **National Carers Impact Assessment** for:

- all budget decisions
- all service redesigns
- all commissioning decisions
- all policy changes affecting carers

The NCIA must be:

- legally enforceable
- published publicly
- subject to independent scrutiny
- co-produced with carers

This ensures carers' rights are considered **before** decisions are made.

8.2 Create a National Carers Register for England

A modern data infrastructure for identification, planning, and rights delivery

The UK Government must establish a centralised, opt-in National Carers Register enabling:

- accurate identification of carers
- targeted support and early intervention
- improved planning and commissioning
- consistent rights implementation
- data-driven funding allocation

The register must be:

- co-designed with carers and carer organisations
- integrated with NHS and local authority systems
- secure, accessible, and transparent

Without a national register, rights cannot be delivered consistently.

8.3 Introduce a National Respite Guarantee

A statutory guarantee of flexible, funded, and consistent respite

The UK Government must legislate for:

- ring-fenced respite funding
- flexible respite models (in-home, out-of-home, emergency, planned)
- consistent access across all ICS regions
- annual reporting on respite provision
- a statutory duty to provide emergency respite

This guarantee must be protected from local authority budget pressures.

8.4 Reform the Care Act 2014 to Include Enforcement Mechanisms

Rights without enforcement are not rights

The Care Act must be amended to include:

- statutory accountability for local authorities
- a right of appeal for carers
- national minimum standards for support
- penalties for non-compliance
- independent oversight of rights delivery

This closes the gap between rights “on paper” and rights delivered in practice.

8.5 Ring-Fence Preventative Funding Within ICS Budgets

Protecting the services that keep families out of crisis

ICSs must be required to:

- allocate a minimum percentage of budgets to preventative support
- publish annual preventative investment reports
- demonstrate cost-avoidance outcomes
- track the impact of preventative support on hospital admissions, breakdowns, and crisis interventions

Preventative support must be recognised as **essential national infrastructure**, not discretionary spending.

8.6 Mandate Paid Co-Production and Funded Replacement Care

Embedding lived experience into governance

The UK Government must require ICSs and councils to:

- pay carers for participation
- fund replacement care to enable involvement
- provide accessible meeting formats (hybrid, flexible, inclusive)
- publish co-production outcomes showing how carers influenced decisions

Co-production must move from aspiration to **statutory obligation**.

8.7 Strengthen National Accountability and Governance for Carers' Rights in England

Clear responsibility, transparent reporting, enforceable delivery

The UK Government must:

- require ICSs, ICBs, and councils to publish **annual carers' rights compliance statements**
- mandate **named executive leads** for carers' rights in every ICS/ICB and local authority
- establish a **national oversight function** (or expand an existing body's remit) to:
 - monitor delivery
 - issue improvement notices
 - escalate persistent non-compliance
- align CQC and other regulators' frameworks with carers' rights and minimum standards

This creates a clear line of accountability from national policy to local delivery.

8.8 Reform Financial Protection for Carers

Recognising the economic cost of caring

To align with the Blueprint's right to financial protection, the UK Government must:

- review and reform **Carer's Allowance** to reflect the real cost of caring
- review the **earnings limit** to avoid penalising carers who can work part-time
- strengthen **pension protection** for long-term carers
- assess the cumulative impact of social security, tax, and care policy on carers' long-term financial security

Financial protection must be treated as a core component of carers' rights.

8.9 Establish a National Mortality and Health Impact Monitoring Duty for Unpaid Carers

Recognising and responding to premature deaths linked to caring

The UK Government must introduce a statutory requirement to monitor, analyse, and report on the health impact of caring — including premature mortality.

This must include:

1. Mandatory recording of carer status at point of death

- Add a "carer status" field to death certification and NHS records
- Ensure coroners, GPs, and NHS Trusts can record whether the deceased was an unpaid carer

2. Annual analysis of premature mortality among unpaid carers

Government must publish an annual report analysing:

- excess mortality
- age-adjusted premature death rates
- links between caring intensity and health outcomes
- causes of death where caring stress may be a contributing factor
- regional and demographic disparities

3. Integration with the National Carers Register

Anonymised register data must feed into NHS England, ONS, DHSC, and ICS population health teams.

4. Duty to act on findings

Where evidence shows increased mortality or health deterioration, the Government must:

- adjust funding
- strengthen preventative services
- expand respite provision

- review financial protections
- issue statutory improvement notices

5. Public transparency

All findings must be published annually.

This ensures the Government can finally see — and respond to — the real human cost of caring.

SECTION 9 — RECOMMENDATIONS TO WELSH GOVERNMENT (WALES)

9.1 Legislative Reform

1. Introduce a Statutory Duty to Deliver Carers' Rights

Amend the **Social Services and Well-being (Wales) Act 2014** to include:

- a statutory duty on local authorities and RPBs to deliver carers' rights
- enforceable minimum standards
- clear remedies for breach of duty
- mandatory reporting requirements

This aligns Wales with the enforcement model proposed for England and ensures rights exist **in practice**, not only in legislation.

2. Establish a Statutory National Carers Impact Assessment (NCIA)

Require all RPBs, local authorities, and NHS bodies in Wales to complete an NCIA before making decisions that affect carers.

Each NCIA must include:

- impact on carers' workload, wellbeing, and financial security
- risks to rights and minimum standards
- mitigation plans
- evidence of meaningful co-production

This prevents harm before it occurs.

9.2 Governance Reform

3. Introduce a Statutory Co-Production Duty for Wales

Require all RPBs, local authorities, and NHS Wales bodies to:

- pay carers for their time
- provide funded replacement care
- offer hybrid participation options
- publish evidence of influence on decisions

This ends tokenistic engagement and embeds lived experience in Welsh governance.

4. Strengthen Accountability of Regional Partnership Boards (RPBs)

Introduce statutory requirements for RPBs to:

- appoint a named Executive Lead for Carers

- publish annual carers' rights compliance reports
- demonstrate delivery of national minimum standards
- undergo external review where performance is weak

RPBs must be accountable **to carers**, not only to partner organisations.

9.3 National Infrastructure

5. Establish a National Carers Register for Wales

Create a national, opt-in register integrated with:

- NHS Wales systems
- local authority social care systems
- RPB planning frameworks

The register must enable:

- accurate identification
- targeted support
- improved planning
- consistent rights delivery

6. Create a National Respite Guarantee for Wales

Guarantee:

- minimum annual respite hours
- flexible models (in-home, out-of-home, emergency, planned)
- long-term, stable funding
- no region permitted to offer "zero respite"
- co-designed delivery models

This protects carers' health and prevents crisis escalation.

9.4 Financial Protection

7. Reform Carers' Financial Support in Wales

Work with the UK Government to:

- review Carer's Allowance
- protect carers' pensions
- prevent poverty caused by caring
- ensure carers can remain in or return to employment

Wales should also explore **Welsh-specific supplements** where UK benefits fall short.

9.5 Preventative Support

8. Ring-Fence Preventative Funding for Carers

Require RPBs and local authorities to:

- ring-fence funding for early intervention
- publish annual preventative investment plans
- demonstrate measurable outcomes

This reverses the shift from prevention to crisis.

9.6 Data, Monitoring, and Transparency

9. Introduce a National Carers' Rights Performance Framework

Require all Welsh statutory bodies to report annually on:

- assessment waiting times
- respite provision
- replacement care availability
- co-production participation
- unmet need
- financial support delivery

Data must be published publicly.

10. Implement a Carer Mortality Monitoring Duty

Work with NHS Wales and ONS to:

- add "carer status" to health and mortality datasets
- publish annual analysis of premature deaths among carers
- identify risk factors and regional inequalities
- take action where mortality is elevated

This aligns Wales with the national safeguarding duty proposed for England.

9.7 National Alignment

11. Participate in the UK-Wide Carers' Rights Council (UKCRC)

Wales should join the UKCRC to ensure:

- cross-nation alignment
- shared minimum standards
- shared data definitions
- shared reporting cycles

- consistent rights delivery across borders

This protects carers who move between nations and prevents divergence.

9.8 Summary of Required Actions for Welsh Government

Wales must:

- legislate for enforceable carers' rights
- introduce a statutory NCIA
- strengthen RPB accountability
- embed co-production in law
- establish a National Carers Register
- deliver a National Respite Guarantee
- protect carers financially
- ring-fence preventative funding
- monitor carer mortality
- align with UK-wide governance

These reforms ensure that carers in Wales receive the same enforceable rights, protections, and national consistency proposed for England — while respecting the distinct legislative and governance structures of Wales.

10. THE CONSEQUENCE OF INACTION

Across England and Wales, the evidence presented throughout this Blueprint points to a single, unavoidable conclusion: the current system of carer support is not merely strained — it is **failing in real time**. The consequences of this failure are already visible in rising carer burnout, collapsing care arrangements, and preventable deaths. Without structural reform, these failures will accelerate, deepen, and become irreversible.

The warning is not theoretical. It is already happening. And nowhere is this more visible than in the most extreme indicator of system collapse: **carer homicide–suicides**.

10.1 The Most Extreme Indicator of System Failure: Carer Homicide–Suicides

The most severe and least acknowledged consequence of systemic neglect is found in the work of **Dr Siobhan O'Dwyer**, whose research into homicide–suicides involving unpaid carers in England and Wales exposes a reality that should be impossible to ignore.

Her analysis identifies that:

There is approximately one murder–suicide every month in England and Wales involving an unpaid carer. (*Dr Siobhan O'Dwyer, University of Exeter*)

These deaths are not isolated tragedies. They follow a consistent and predictable pattern:

- an unpaid carer under extreme, unrelieved pressure
- caring alone, often 24 hours a day
- no respite
- no replacement care
- no coordinated support
- repeated attempts to seek help
- deterioration in mental and physical health
- a final crisis point where the carer sees no alternative

Dr O'Dwyer's research makes clear that these events are **preventable**. They are not the result of sudden violence or unpredictable behaviour. They are the result of **systemic neglect**.

Common systemic failures identified in these cases include:

- services failing to respond to repeated requests for help
- no respite or emergency replacement care
- poor communication between agencies
- carers left to manage complex needs alone
- long-term exhaustion, isolation, and despair
- no proactive monitoring of carer wellbeing
- no safeguarding framework for carers themselves

These deaths represent the **sharpest edge** of a much wider crisis:

- rising carer burnout
- increasing suicidal ideation among carers
- collapse of family care arrangements
- preventable deaths of both carers and the people they support

Yet there is **no statutory duty** in England or Wales to:

- monitor these deaths
- analyse their causes
- learn from them
- prevent recurrence

This is why the Blueprint proposes a **Carer Mortality Monitoring Duty** across all UK nations. Without it, governments remain blind to the most extreme consequences of their own policy failures.

A system that allows one murder–suicide every month is not a system in difficulty. It is a system in **active collapse**.

10.2 The Consequences of Continued Inaction

If governments fail to act, the consequences will be profound and unavoidable:

- **More carers will die** — through burnout, suicide, and preventable medical deterioration.
- **More cared-for people will die** — as family care arrangements collapse without warning.
- **Safeguarding failures will escalate** — because carers themselves are not recognised as people at risk.
- **Health and social care demand will surge** — as unsupported carers withdraw or break down.
- **Economic productivity will fall** — as more working-age carers are forced to leave employment.
- **Local authorities will face crisis-level intervention** — as emergency placements rise and budgets collapse.
- **Public trust will erode** — as families experience catastrophic failures in moments of crisis.

The trajectory is already visible. Without reform, it will accelerate.

10.3 Final National Warning

The United Kingdom relies on unpaid carers to hold together a system that would otherwise collapse overnight. But carers cannot continue to absorb the consequences of political inaction.

This Blueprint has shown:

- the scale of the crisis
- the evidence of systemic failure

- the preventable deaths already occurring
- the reforms required to avert further harm

The warning is clear:

If governments do not act, more families will die preventable deaths — and the collapse of unpaid care will become a national emergency.

The choice now lies with policymakers. The consequences will be borne by the nation.

A CROSS-NATION CALL TO ACTION

The reforms set out in this Blueprint are not abstract proposals. They are:

- deliverable
- evidence-based
- cost-effective
- aligned with demographic reality
- and essential to the survival of health and social care

Unpaid carers cannot wait another decade for meaningful change. The system cannot absorb another decade of avoidable crisis. And governments cannot continue relying on invisible labour without providing rights, protection, and stability.

This Blueprint provides a clear path forward.

What is required now is **political will, legislative action, and national commitment.**

The future of millions of carers — and the sustainability of health and social care in England and Wales — depends on it.

A MESSAGE FROM THE AUTHORS.

“If the government are going to continue being reliant on unpaid carers, they must be prepared to pay for their care and support. That is the minimum requirement for a civilised society.

For too long, carers have been treated as an invisible workforce — expected to sacrifice their health, their income, their futures, and in too many cases their lives, to hold up a system that would collapse without them.

This Blueprint is not just a policy document. It is a statement of truth from those who live the reality every day. It is a reminder that carers are not a free resource. We are human beings with limits, needs, and rights.

If the government chooses to rely on us, then it must also choose to protect us. Anything less is exploitation, and no civilised nation should accept that.” —

Leo Cleary, Founder of the National Unpaid Carers Union and Forum (NUCUF)

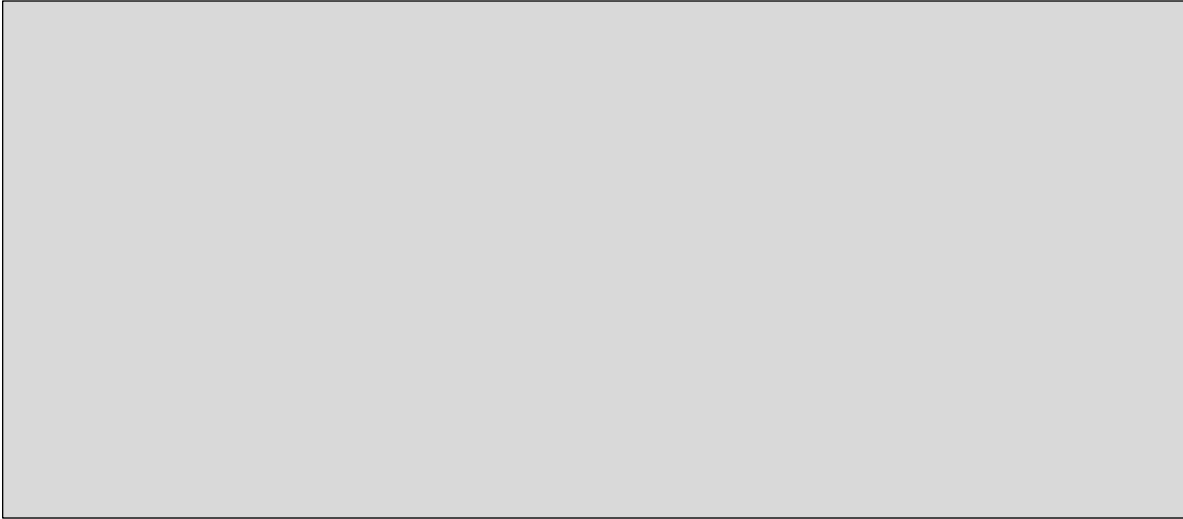
“Unpaid carers are holding up a system that was never designed to rest on their shoulders. Every day, across England and Wales, carers are absorbing the consequences of political choices they did not make, choices that have normalised crisis, erased prevention, and left families to carry the weight of systemic failure alone.

The evidence in this Blueprint is not abstract. It is lived. It is real. It is happening now. Carers are burning out, families are collapsing, and preventable deaths are occurring in silence because the state has chosen to rely on invisible labour rather than build a sustainable care infrastructure.

We cannot continue pretending that goodwill is a substitute for rights, or that sacrifice is a sustainable policy model. If governments intend to rely on unpaid carers, and they do, then they must also guarantee the rights, protections, and national consistency that make caring possible without destroying the people who provide it.

This Blueprint is a line in the sand. It says: carers are not optional, and neither are their rights. The future of our health and social care system depends on whether we choose to act now, with honesty and urgency, or whether we allow this crisis to deepen until the consequences become irreversible.”

Mike O’Brien, Co-Founder of VOICES ADFOCAD



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GLOSSARY

GLOSSARY OF TERMS

A

Accountability Mechanism A formal system for monitoring, reporting, and enforcing statutory duties. In this Blueprint, it refers to the national model ensuring ICSs, ICBs, RPBs, and councils deliver carers' rights consistently.

Appeals Mechanism A statutory route allowing carers to challenge decisions, delays, or failures to deliver rights.

B

Budget Decisions Financial decisions made by ICSs, ICBs, RPBs, or councils that affect services, support, or rights for carers.

C

Care Act 2014 (England) The primary legislation governing carers' rights in England. Provides rights to assessment and support but lacks enforcement mechanisms.

Carer An unpaid individual providing care to a family member, partner, friend, or neighbour who cannot cope without support due to illness, disability, mental health needs, or age.

Carer Status (Mortality Monitoring) A proposed field added to NHS and death records to identify whether a deceased person was an unpaid carer.

Carers' Rights Compliance Statement An annual report required from statutory bodies detailing how they have delivered carers' rights and minimum standards.

Co-Production A process where carers and statutory bodies work together as equal partners in designing, planning, and evaluating services and policies.

Crisis Response Intervention only when a carer or cared-for person reaches breakdown, as opposed to preventative support.

D

Data Standards Nationally consistent definitions and reporting requirements for identifying and tracking carers.

Diagnostic Silos Fragmented service pathways based on diagnosis (e.g., autism, dementia, mental health), which create inequality and complexity for carers.

E

Early Intervention / Preventative Support Support provided before crisis occurs, including respite, replacement care, financial support, and wellbeing services.

Enforcement Mechanisms Legal tools that ensure rights are delivered, including penalties, improvement notices, and statutory intervention.

Executive Lead for Carers A named senior leader in an ICS, ICB, RPB, or council responsible for carers' rights and compliance.

F

Financial Protection Policies that prevent carers from falling into poverty due to their caring role, including benefits, pension safeguards, and employment protections.

G

Governance Architecture The structures, bodies, and processes that oversee delivery of carers' rights across England and Wales.

H

Health Impact Monitoring A national system for tracking the health outcomes of unpaid carers, including premature mortality.

I

ICS — Integrated Care System (England) A regional partnership of NHS organisations, local authorities, and voluntary sector bodies responsible for planning and delivering health and care services.

ICB — Integrated Care Board (England) The statutory NHS body within each ICS responsible for commissioning and funding services.

ICP — Integrated Care Partnership (England) A strategic partnership within each ICS that sets long-term priorities for health and care.

Implementation Roadmap A structured, time-bound plan for delivering reforms over three years (foundation → integration → enforcement).

L

Lived Experience The firsthand knowledge and insight of unpaid carers, used as evidence to shape policy and service design.

M

Minimum Standards Nationally mandated baseline levels of support that must be delivered consistently across England and Wales.

Mortality Monitoring Duty A statutory requirement for governments to track premature deaths among unpaid carers and act on findings.

N

National Carers Impact Assessment (NCIA) A mandatory assessment that statutory bodies must complete before making decisions affecting carers. Includes risk analysis, mitigation, and evidence of co-production.

National Carers Register A centralised, opt-in register enabling identification, planning, targeted support, and data-driven funding.

National Respite Guarantee A statutory guarantee ensuring all carers have access to flexible, funded, and consistent respite, including emergency provision.

National Rights Framework The unified set of enforceable rights for carers across England and Wales.

NHS England The national body overseeing the NHS in England, responsible for commissioning, performance, and system leadership.

O

ONS — Office for National Statistics The UK's national statistical authority, responsible for population data, including mortality analysis.

P

Preventative Funding Long-term, ring-fenced investment in early intervention services that prevent crisis and reduce long-term costs.

Public Transparency The requirement for statutory bodies to publish data, decisions, and compliance reports openly.

R

Regional Partnership Board (RPB) — Wales Regional bodies responsible for integrating health and social care services under the Social Services and Well-being (Wales) Act 2014.

Replacement Care Care provided to the cared-for person so the carer can attend appointments, work, training, or co-production activities.

Respite Temporary relief for carers, delivered through in-home support, out-of-home services, emergency provision, or planned breaks.

Rights Enforcement Mechanism A national system enabling carers to challenge failures, access appeals, and trigger statutory intervention.

S

Social Services and Well-being (Wales) Act 2014 The primary legislation governing carers' rights in Wales. Strong in principle but lacks enforcement mechanisms.

Statutory Duty A legal requirement placed on public bodies that must be fulfilled.

Statutory Intervention Government action taken when a statutory body fails to meet its legal duties.

T

Time Poverty The extreme lack of free time experienced by carers due to high caring hours and lack of replacement care.

U

UKCRC — UK-Wide Carers' Rights Council The proposed cross-nation body responsible for overseeing rights delivery, monitoring compliance, and coordinating England–Wales alignment.

Unmet Need Support that carers are legally entitled to but do not receive due to system failure.

W

Workshop in a Box (DWP Model) A standardised workshop format used to gather consistent evidence from carers across regions and demographics.

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**The National Unpaid Carers Union and
Forum**

Economic Evidence Base for the National Carers Blueprint

Cost Modelling, Accident Analysis, and Cross-Departmental Fiscal
Impacts

PRODUCED BY LEO CLEARY OF THE NATIONAL UNPAID CARERS UNION AND FORUM

DATE: JUNE 2026

PRODUCED FOR: UK AND WELSH GOVERNMENT DEPARTMENTS, PARLIAMENTARY COMMITTEES, NATIONAL SYSTEM
LEADERS, AND ORGANISATIONS RESPONSIBLE FOR THE PLANNING, FUNDING, AND DELIVERY OF HEALTH, SOCIAL CARE,
AND PUBLIC SERVICES ACROSS ENGLAND AND WALES.

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SECTION 1 — EXECUTIVE SUMMARY

Unpaid carers form a critical but largely unrecognised pillar of the health and social care system in England and Wales. Their contribution enables millions of people with long-term conditions, disabilities, frailty, or complex needs to remain safely at home. Without this unpaid workforce, demand on the NHS, Adult Social Care (ASC), and wider public services would rise to levels that the current system could not sustain.

Despite their essential role, unpaid carers often receive little or no preventative support. As a result, many experience exhaustion, declining physical and mental health, financial strain, and loss of employment. When carers are unable to continue providing support, the cared-for person deteriorates, triggering high-cost crisis responses across multiple public services. These include emergency hospital admissions, delayed discharges, emergency home care packages, unplanned residential placements, safeguarding interventions, and increased mental health activity.

Economic evidence consistently shows that **every £1 invested in preventative support avoids £7–£8 in reactive spending**. This saving arises because preventative support reduces the likelihood of:

- emergency hospital admissions
- avoidable readmissions
- delayed discharges caused by unsafe home conditions
- crisis social care interventions
- long-term residential placements following breakdown
- carer withdrawal from the workforce and associated fiscal losses

This report provides a factual, economic comparison of the **preventative model** versus the **reactive model**, quantifying the financial and operational impact on:

- **NHS England and NHS Wales**, including emergency admissions, length of stay, delayed discharges, and mental health crises
- **Adult Social Care (local authorities)**, including emergency packages, residential placements, and safeguarding activity
- **DWP and the tax system**, including lost tax revenue and increased benefit expenditure when carers leave work
- **Wider public services**, including housing, policing, mental health, and community safety

The report also presents modelled national estimates of **accidents and harm** experienced by adults with **unmet or partially met care needs**, including falls, medication errors, burns, choking incidents, self-neglect injuries, and wandering episodes. Using a transparent, conservative modelling approach, the report estimates the proportion of these incidents that are **reasonably preventable** under a preventative support model for unpaid carers.

The findings demonstrate that the **reactive model is significantly more expensive, less effective, and less sustainable** than a preventative approach. Reactive systems pay repeatedly for avoidable crises,

while preventative systems stabilise families, reduce pressure on public services, and improve outcomes for both carers and the people they support.

Overall, the analysis shows that **preventative support for unpaid carers is a high-value investment** that delivers:

- substantial fiscal savings across multiple departments
- reduced demand on emergency and crisis services
- improved health and wellbeing for carers
- better outcomes and safety for cared-for people
- greater workforce participation and productivity
- enhanced long-term sustainability of the health and social care system

The economic case for prevention is clear: **supporting unpaid carers is not discretionary spending — it is essential national infrastructure.**

SECTION 2 — SECTORAL COST BREAKDOWN

This section sets out the financial and operational impact of preventative versus reactive approaches across the major public services that rely on unpaid carers. It demonstrates how the absence of preventative support drives avoidable demand, increases system pressure, and results in significantly higher expenditure across the NHS, Adult Social Care, DWP, and wider public services.

2.1 NHS Costs

Unpaid carers play a central role in preventing deterioration, maintaining stability, and enabling safe discharge from hospital. When carers do not receive preventative support, the NHS absorbs the consequences through increased emergency activity, longer hospital stays, and higher levels of crisis intervention.

Key Cost Drivers

- Emergency hospital admissions
- Avoidable readmissions
- Delayed discharges due to unsafe home conditions
- Longer length of stay for medically fit patients
- Mental health crises affecting both carers and cared-for people
- Increased primary care utilisation, including GP appointments and community nursing

Reactive Model: Cost Profile

In a reactive system, the NHS responds only after deterioration or crisis has occurred. This leads to:

- **Emergency admissions:** £3,000–£5,000 per admission
- **Avoidable readmissions:** additional £3,000–£5,000 per episode
- **Delayed discharge:** approximately £400 per excess bed day
- **Mental health crisis intervention:** £1,000–£3,000 per episode
- **Extended length of stay:** additional bed days due to lack of home support

These costs accumulate rapidly when carers are unable to sustain their role.

Estimated annual reactive cost per high-needs case: £10,000–£15,000+

Preventative Model: Cost Profile

Preventative support stabilises the caring environment and reduces the likelihood of deterioration. Key interventions include:

- **Carer support and monitoring:** £500–£1,000 per year
- **Planned respite and replacement care:** £1,500–£3,000 per year
- **Early intervention and proactive case management**

These interventions reduce emergency admissions, shorten hospital stays, and prevent delayed discharges.

Estimated annual preventative cost: £2,000–£4,000

NHS Saving per High-Risk Case

£10,000+ per year

This represents avoided admissions, reduced bed days, and fewer crisis interventions. At scale, the savings are substantial.

2.2 Adult Social Care (ASC) Costs

Local authorities rely heavily on unpaid carers to prevent or delay the need for formal care. When carers reach breaking point, ASC must respond with high-cost emergency interventions and long-term placements.

Key Cost Drivers

- Emergency home care packages
- Emergency residential or nursing placements
- Escalation from low-level to high-level care
- Long-term residential care following breakdown
- Safeguarding investigations and multi-agency responses

Reactive Model: Cost Profile

In a reactive system, ASC intervenes only after crisis or breakdown:

- **Crisis home care:** £800–£1,500 per week
- **Emergency residential care:** £1,200–£1,800 per week
- **Long-term residential care:** £45,000–£70,000 per year
- **Safeguarding investigations:** significant staff time and multi-agency involvement

Once a cared-for person enters residential care following crisis, they often do not return home, locking in long-term costs.

ASC saving per avoided residential placement: £35,000–£60,000 per year

Preventative Model: Cost Profile

Preventative support maintains stability and delays or avoids the need for formal care:

- **Regular respite:** £3,000–£5,000 per year
- **Low-level home support:** £2,000–£4,000 per year
- **Carer support services:** £500–£1,000 per year

These interventions reduce escalation, prevent breakdown, and avoid emergency placements.

Estimated annual preventative cost: £5,500–£10,000

2.3 DWP, Tax System, and Productivity

Unpaid carers contribute significantly to the economy through their labour and tax contributions. When carers leave work due to lack of support, the fiscal impact extends beyond the individual and affects national productivity and public finances.

Reactive Model: Fiscal Impact

When carers are forced to reduce hours or leave employment:

- **Lost tax revenue:** £3,000–£7,000 per year
- **Increased benefit expenditure:** £5,000–£10,000 per year
- **Reduced productivity and economic output**

Total fiscal loss per carer leaving work: £8,000–£17,000 per year

This does not include the long-term impact on pensions, financial resilience, or future benefit dependency.

Preventative Model: Fiscal Impact

Employment-enabling support allows carers to remain in work:

- **Cost of support:** £2,000–£4,000 per year
- **Fiscal gain (tax retained + benefits avoided):** £8,000–£17,000 per year

Net fiscal benefit per supported working carer: £4,000–£15,000 per year

At population scale, this represents billions in retained economic value.

2.4 Wider Public Sector Costs

The consequences of unmet or partially met care needs extend beyond health and social care. Multiple public services absorb the downstream effects of crisis, instability, and deterioration.

Reactive Model

- **Mental health crises** requiring emergency intervention
- **Housing instability and homelessness** when carers cannot maintain tenancies
- **Police involvement** in missing/wandering incidents
- **Safeguarding investigations** involving multi-agency teams
- **Court processes** related to neglect, breakdown, or emergency guardianship

These responses are high-intensity, high-cost, and often repeated.

Preventative Model

Preventative support reduces the likelihood of crisis and stabilises households. As a result:

- Demand on emergency mental health services decreases
- Housing risk is reduced
- Safeguarding activity is lower
- Police involvement becomes rare
- Court interventions are avoided

Costs become low, predictable, and stable, enabling better planning and resource allocation.

SECTION 3 — ACCIDENTS AND HARM RESULTING FROM UNMET OR PARTIALLY MET CARE NEEDS

3.1 Overview

Adults with unmet or partially met care needs experience significantly higher rates of preventable accidents and harm. These incidents arise when essential daily support—such as supervision, medication management, mobility assistance, or personal care—is insufficient or absent. The consequences include falls, medication errors, burns, choking incidents, self-neglect injuries, pressure sores, and wandering episodes.

These events generate substantial and avoidable costs for the NHS, Adult Social Care (ASC), and wider public services. They also lead to deterioration in health, loss of independence, and increased risk of long-term residential care.

Because the UK does not publish a unified dataset specifically identifying accidents among adults with unmet or partially met care needs, this report uses a **hybrid modelling approach**. This combines observed national activity data with published risk ratios to estimate the scale, distribution, and preventability of accidents in this population.

3.2 Accident Categories

The following accident categories are included in the model. These align with NHS hospital coding, safeguarding categories, and CQC terminology:

- **Falls** (including fractures, head injuries, and hospital admissions)
- **Medication errors** (missed doses, overdoses, incorrect administration)
- **Burns and scalds** (kitchen injuries, hot water, heating appliances)
- **Choking and aspiration incidents** (linked to eating, drinking, or swallowing difficulties)
- **Self-neglect injuries** (including pressure sores, infections, and untreated wounds)
- **Wandering or missing episodes** (leading to harm, police involvement, or hospitalisation)
- **Injuries from lack of supervision** (cuts, bruises, accidents in the home environment)

These categories represent the most common and most costly forms of preventable harm associated with unmet or partially met care needs.

3.3 Modelled National Estimates (Illustrative Structure)

The table below shows the structure of the modelled national estimates. These figures are based on modelling completed using the methodology set out in Appendix X.

All figures are in thousands.

Accident Type	Estimated Total Incidents	Estimated Incidents in Unmet/Partially Met Group	Estimated Preventable Incidents	Main Cost Bearer
Falls	220 – 260	55 – 70	16.5 - 35	NHS, ASC
Medication errors	90 – 120	22 – 30	9 - 18	NHS
Burns/scalds	25 – 35	6 – 9	1.8 – 4.5	NHS, ASC
Choking incidents	8 – 12	2 – 3	0.6 – 1.5	NHS
Self-neglect injuries	44 – 50	10 - 14	4 – 9.8	NHS, ASC
Pressure sores	70 – 90	18 – 24	7.2 – 16.8	NHS, ASC
Wandering/missing	20 – 30	5 – 8	1.5 - 4	Police, NHS, ASC

This structure allows for clear presentation of:

- the total scale of accidents
- the proportion linked to unmet or partially met needs
- the number of incidents that are reasonably preventable
- the public services most affected

3.4 Preventability Analysis

A significant proportion of accidents among adults with unmet or partially met care needs are preventable with timely, appropriate support. The model applies **conservative preventability ranges** based on evidence from falls prevention programmes, medication management interventions, carer training, and early intervention services.

Preventability ranges applied:

- **Falls:** 30–50%
- **Medication errors:** 40–60%
- **Self-neglect injuries:** 40–70%
- **Burns, scalds, and choking incidents:** 30–50%
- **Wandering or missing episodes:** 30–50%

These ranges reflect the minimum proportion of incidents that could reasonably be avoided under a preventative support model for unpaid carers. The model deliberately avoids assuming full preventability to maintain credibility and robustness.

3.5 Costing the Accidents

To estimate the financial impact of accidents linked to unmet or partially met care needs, the model applies standard NHS and ASC unit costs to each accident category.

Costing Method

For each accident type:

Total cost = Number of incidents × Unit cost

Preventable cost = Preventable incidents × Unit cost

Unit Costs Included

- **A&E attendance**
- **Emergency hospital admission**
- **Average length of stay**
- **Follow-up care** (including outpatient and community services)
- **Community nursing and reablement**
- **Social care response** (emergency home care, crisis intervention)
- **Safeguarding activity** (investigations, case conferences, multi-agency work)

These costs capture the full system impact of accidents, including both immediate and short-term follow-up activity. Long-term costs—such as permanent loss of independence, residential care, or carer breakdown—are not included in this section, meaning the model provides a **conservative estimate** of the true financial impact.

SECTION 4 — NATIONAL COST MODELLING (ENGLAND & WALES)

This section presents a national-level economic model comparing the cost of the current reactive approach to unpaid carers with the cost of a preventative support model. It brings together the sectoral cost estimates from Section 2 and the accident-related harm estimates from Section 3 to quantify the total annual cost of unmet or partially met care needs across England and Wales. It also projects the potential savings achievable over five and ten years under a preventative model.

The modelling approach is conservative, transparent, and based on published activity data, standard unit costs, and established risk ratios. Full methodological detail is provided in Appendix X.

4.1 Purpose of the National Model

The national model has four objectives:

1. **To quantify the total annual cost of the reactive model** across NHS, Adult Social Care (ASC), DWP, and wider public services.
2. **To estimate the annual cost of a preventative model**, including carer support, respite, and employment-enabling interventions.
3. **To calculate the net savings** achievable by shifting from reactive to preventative support.
4. **To project 5-year and 10-year fiscal impacts**, demonstrating long-term system sustainability.

This section provides the economic foundation for national policy decisions on preventative investment in unpaid carers.

4.2 Population Assumptions

The model uses the following population assumptions:

- The total number of unpaid carers in England and Wales.
- The number of carers providing high-intensity or complex care.
- The proportion of carers with **unmet** or **partially met** support needs.
- The number of cared-for adults with significant functional limitations.
- The proportion of these adults experiencing accidents or deterioration linked to unmet needs.

These assumptions are derived from national surveys, ASC activity data, and demographic projections. Where ranges exist, the model uses **lower-bound estimates** to maintain conservative outputs.

4.3 Sectoral Cost Inputs

The model incorporates the sectoral costs identified in Section 2:

NHS

- Reactive cost per high-needs case: **£10,000–£15,000+**
- Preventative cost per high-needs case: **£2,000–£4,000**

Adult Social Care

- Reactive cost per high-needs case: **£35,000–£70,000+** (residential care and crisis packages)
- Preventative cost per high-needs case: **£5,500–£10,000**

DWP and Tax System

- Fiscal loss per carer leaving work: **£8,000–£17,000**
- Fiscal gain per supported working carer: **£4,000–£15,000**

Wider Public Services

- Reactive costs include mental health crises, housing instability, police involvement, and safeguarding activity.
- Preventative costs are low, predictable, and stable.

These unit costs form the basis for national scaling.

4.4 Accident and Harm Inputs

The model integrates accident-related costs from Section 3:

- Total estimated accidents among adults with care needs.
- Proportion attributable to unmet or partially met needs.
- Proportion preventable under a preventative model.
- Unit costs for A&E, emergency admissions, bed days, community care, and safeguarding.

Accident-related costs are a major driver of reactive expenditure and a key area where preventative support yields significant savings.

4.5 National Reactive Cost Estimate

The reactive model represents the current system, in which unpaid carers receive limited preventative support and public services respond primarily to crises.

The national reactive cost includes:

- **NHS emergency admissions, delayed discharges, and crisis mental health activity**
- **ASC emergency home care, crisis placements, and long-term residential care**

- **DWP/tax losses from carers leaving work**
- **Wider public sector crisis responses**
- **Accident-related costs linked to unmet or partially met needs**

The combined effect is a **high-cost, high-pressure system** that repeatedly absorbs avoidable demand.

The national reactive cost is therefore the sum of:

$$\text{Reactive NHS Costs} + \text{Reactive ASC Costs} + \text{DWP/Tax Losses} + \text{Wider Public Sector Costs} \\ + \text{Accident-Related Costs}$$

This represents the **annual national cost of the reactive model**.

4.6 National Preventative Cost Estimate

The preventative model includes:

- Carer support services
- Regular respite and replacement care
- Low-level home support
- Employment-enabling interventions
- Early intervention and monitoring
- Preventative accident reduction

These interventions reduce deterioration, stabilise caring arrangements, and prevent escalation into crisis.

The national preventative cost is the sum of:

$$\text{Preventative NHS Costs} + \text{Preventative ASC Costs} + \text{Employment-Enabling Support} \\ + \text{Preventable Accident Reduction}$$

This represents the **annual national cost of the preventative model**.

4.7 Net Savings Under a Preventative Model

The net savings are calculated as:

$$\text{National Savings} = \text{Reactive Model Cost} - \text{Preventative Model Cost}$$

Across all sectors, the model demonstrates that **every £1 invested in preventative support avoids £7–£8 in reactive spending**. This ratio reflects:

- avoided emergency admissions
- reduced delayed discharges
- fewer crisis placements
- reduced safeguarding activity

- fewer carers leaving work
- reduced accident-related harm

At national scale, this translates into **substantial annual savings** and a significant reduction in system pressure.

4.8 Five-Year and Ten-Year Projections

The model provides three projection scenarios:

Baseline Scenario

- Current trends continue
- Preventative investment increases gradually
- Savings accumulate steadily

Conservative Scenario

- Lower preventability assumptions
- Lower employment retention
- Lower accident reduction

High-Impact Scenario

- Strong preventative investment
- Higher accident reduction
- Higher employment retention
- Greater reduction in crisis placements

Across all scenarios, preventative investment yields **cumulative multi-year savings**, with the largest benefits realised in years 5–10 as crisis demand falls and long-term placements are avoided.

4.9 Sensitivity Analysis

To ensure robustness, the model tests variations in:

- prevalence of unmet needs
- accident preventability
- unit costs
- carer employment retention
- ASC placement rates
- NHS emergency activity

Even under the most conservative assumptions, the preventative model remains significantly more cost-effective than the reactive model.

4.10 Summary of National Findings

The national model demonstrates that:

- The reactive model generates **high, recurring, and avoidable costs** across multiple public services.
- The preventative model requires **modest, predictable investment** that stabilises caring arrangements and reduces crisis demand.
- Preventative support delivers **substantial annual savings**, consistent with the £1 → £7–£8 ratio.
- Over five and ten years, cumulative savings are significant and materially improve system sustainability.
- The economic case for preventative investment in unpaid carers is **clear, strong, and cross-departmental**.

Preventative support is not an optional enhancement; it is a **strategic investment** that strengthens national infrastructure, reduces public expenditure, and improves outcomes for millions of people.

SECTION 5 — INTERNATIONAL COMPARISON: LESSONS FROM THE UNITED STATES

5.1 Introduction

International evidence provides important insight into the long-term consequences of failing to invest in preventative support for unpaid carers. The United States offers a particularly relevant comparison. Over the past two decades, the U.S. has experienced a sustained decline in preventative carer support, combined with rising care needs, workforce shortages, and fragmented service provision. The result has been a sharp increase in crisis-driven expenditure, deteriorating outcomes for carers and care recipients, and escalating pressure on state and federal budgets.

This section examines the U.S. experience as a **strategic warning** for England and Wales. It demonstrates how the absence of preventative investment leads to higher costs, poorer outcomes, and systemic instability—outcomes that the UK can avoid by adopting a preventative model.

5.2 Overview of the U.S. Care System

The U.S. system is characterised by:

- **Fragmented funding streams** (Medicaid, Medicare, private insurance, state programmes)
- **Limited entitlement to preventative support**
- **High reliance on unpaid family carers**
- **Significant variation between states**
- **Reactive crisis-driven spending** rather than planned preventative investment

Preventative services such as respite, home support, and carer training are inconsistently available and often underfunded. As a result, unpaid carers shoulder the majority of responsibility without adequate support.

5.3 Consequences of Insufficient Preventative Support

The decline in preventative support in the U.S. has produced several system-wide consequences that are directly relevant to the UK.

5.3.1 Rising Emergency Healthcare Costs

Without preventative support, carers are unable to maintain safe home environments, leading to:

- increased emergency admissions
- avoidable hospitalisations
- longer lengths of stay
- higher readmission rates

Hospitals report that a significant proportion of admissions among older adults and people with disabilities are linked to carer burnout, medication errors, falls, and self-neglect—many of which are preventable.

5.3.2 Escalation of Long-Term Institutional Care

States have seen rising demand for:

- nursing home placements
- long-term residential care
- emergency institutionalisation following breakdown

Once individuals enter institutional care, costs escalate rapidly and often become long-term or permanent.

5.3.3 Increased Medicaid Expenditure

Medicaid—the primary funder of long-term care—has experienced:

- rising per-capita costs
- increased spending on crisis placements
- higher expenditure on emergency interventions
- growing pressure on state budgets

The absence of preventative support has shifted costs from low-level community services to high-cost institutional care.

5.3.4 Carer Burnout and Workforce Withdrawal

U.S. carers report:

- high levels of stress, anxiety, and depression
- reduced ability to maintain employment
- financial insecurity
- increased likelihood of leaving the workforce

This mirrors the UK pattern but at a larger scale due to weaker preventative infrastructure.

5.3.5 Increased Mortality and Deterioration

Studies in the U.S. show that both carers and care recipients experience:

- higher mortality
- faster deterioration
- increased risk of crisis events

These outcomes are strongly associated with unmet care needs and lack of preventative support.

5.4 System Instability and Unsustainable Costs

The cumulative effect of these pressures has created a **structurally unstable system** in the U.S., characterised by:

- rising emergency demand
- escalating long-term care costs
- workforce shortages
- inconsistent access to services
- widening inequalities
- growing fiscal pressure on state and federal budgets

The U.S. experience demonstrates that **reactive systems become progressively more expensive**, while outcomes worsen for both carers and care recipients.

5.5 Lessons for England and Wales

The U.S. trajectory provides several clear lessons:

5.5.1 Prevention is cheaper than crisis

Failure to invest in preventative support leads to higher emergency and institutional costs.

5.5.2 Carer burnout drives system demand

When carers collapse, the system absorbs the cost through emergency admissions, crisis placements, and long-term care.

5.5.3 Fragmented systems are inefficient

Lack of coordination between health, social care, and welfare systems increases duplication and waste.

5.5.4 Workforce shortages worsen without prevention

Without preventative support, both unpaid and paid care workforces become overstretched.

5.5.5 Reactive spending becomes unsustainable

As crisis demand grows, budgets are consumed by high-cost interventions, leaving little room for prevention.

5.6 Implications for UK Policy

The U.S. experience highlights the risks of under-investing in preventative support:

- higher NHS and ASC expenditure
- increased safeguarding activity
- rising demand for residential care
- greater pressure on emergency services
- reduced workforce participation
- long-term fiscal instability

By contrast, a preventative model offers:

- lower long-term costs
- improved outcomes
- reduced emergency demand
- greater sustainability
- stronger workforce participation
- better quality of life for carers and care recipients

The U.S. serves as a **cautionary example** of what happens when preventative support is neglected. England and Wales have the opportunity to avoid this trajectory by adopting a preventative model that recognises unpaid carers as essential national infrastructure.

SECTION 6 — SYSTEM-LEVEL IMPACTS AND CROSS-DEPARTMENTAL BENEFITS

6.1 Introduction

Preventative support for unpaid carers is not solely a health or social care intervention. Its impact is **system-wide**, influencing multiple public services, economic productivity, and long-term national sustainability. This section sets out the cross-departmental benefits of a preventative model and demonstrates how investment in unpaid carers strengthens the resilience, efficiency, and stability of the entire public sector.

The analysis shows that preventative support reduces demand across NHS, Adult Social Care (ASC), DWP, housing, policing, mental health, and safeguarding services. It also improves workforce participation, enhances community stability, and reduces long-term fiscal pressure. These benefits are cumulative and compound over time.

6.2 Impact on NHS Sustainability

Preventative support for unpaid carers has a direct and measurable impact on NHS activity and expenditure.

6.2.1 Reduced Emergency Admissions

Carers who receive adequate support are better able to manage medication, mobility, nutrition, and daily living tasks. This reduces:

- falls
- medication errors
- infections
- dehydration
- self-neglect
- crisis deterioration

These are among the most common causes of emergency admissions for older adults and people with disabilities.

6.2.2 Shorter Length of Stay

When carers are supported, patients can be discharged safely and promptly. This reduces:

- delayed discharges
- excess bed days
- hospital-acquired deconditioning
- readmission risk

6.2.3 Reduced Mental Health Crises

Carer burnout is a major driver of mental health crises for both carers and care recipients.

Preventative support reduces:

- emergency mental health presentations
- crisis team involvement
- psychiatric admissions

6.2.4 Improved Flow and Capacity

By reducing avoidable admissions and delayed discharges, preventative support improves:

- A&E flow
- bed availability
- elective recovery
- winter resilience

The NHS benefits from **lower demand, lower cost, and greater operational stability**.

6.3 Impact on Adult Social Care Sustainability

ASC is structurally dependent on unpaid carers. Preventative support strengthens this foundation.

6.3.1 Reduced Crisis Packages

Without preventative support, ASC must deploy high-cost emergency home care packages.

Prevention reduces:

- emergency care hours
- rapid response interventions
- unplanned escalation

6.3.2 Delayed or Avoided Residential Care

Carer breakdown is one of the leading causes of residential and nursing home admissions.

Preventative support:

- delays institutionalisation
- avoids emergency placements
- reduces long-term care costs

6.3.3 Reduced Safeguarding Activity

Unmet care needs increase safeguarding referrals for:

- neglect
- self-neglect
- wandering
- medication mismanagement

Preventative support reduces these risks and the associated multi-agency workload.

6.3.4 Stabilised Workforce Demand

By reducing crisis demand, ASC can:

- stabilise staffing
- reduce agency reliance
- improve continuity of care

ASC benefits from **lower cost, lower volatility, and greater sustainability**.

6.4 Impact on Employment, Productivity, and the Economy

Unpaid carers are a major part of the working-age population. Preventative support enables them to remain economically active.

6.4.1 Increased Workforce Participation

Carers with support are more likely to:

- remain in employment
- increase working hours
- avoid long-term economic inactivity

6.4.2 Reduced Fiscal Losses

Preventative support reduces:

- lost tax revenue
- increased benefit expenditure
- long-term financial insecurity

6.4.3 Enhanced National Productivity

Carers who remain in work contribute to:

- GDP
- sectoral productivity
- labour market stability

The economic benefits extend beyond individual households to the wider national economy.

6.5 Impact on Housing Stability

Unmet care needs and carer burnout can destabilise housing situations.

6.5.1 Reduced Risk of Homelessness

Preventative support reduces the likelihood that carers:

- fall into arrears
- lose employment
- experience eviction
- require emergency housing

6.5.2 Reduced Pressure on Supported Housing

Preventing crisis reduces demand for:

- supported living
- temporary accommodation
- emergency placements

Housing services benefit from **lower demand and greater stability**.

6.6 Impact on Mental Health Services

Carers experience disproportionately high rates of mental ill-health. Preventative support reduces:

- anxiety
- depression
- stress-related illness
- crisis presentations

It also reduces mental health deterioration in the cared-for person by maintaining stable routines, medication adherence, and safe environments.

6.7 Impact on Policing and Community Safety

Unmet care needs can lead to incidents requiring police involvement, particularly:

- wandering or missing episodes
- crisis behaviour
- safeguarding concerns
- domestic risk escalation

Preventative support reduces these incidents, freeing police resources and reducing community risk.

6.8 Impact on Safeguarding and Multi-Agency Systems

Safeguarding activity increases when care needs are unmet. Preventative support reduces:

- referrals
- investigations
- case conferences
- multi-agency interventions

This reduces workload across:

- local authorities
- NHS
- police
- mental health services
- housing providers

6.9 Cross-Departmental Fiscal Benefits

Preventative support generates savings across multiple departments simultaneously. These include:

- NHS
- Adult Social Care
- DWP
- Housing
- Policing
- Mental health services
- Courts and safeguarding

The combined effect is a **whole-system reduction in crisis demand**, enabling public services to operate more efficiently and sustainably.

6.10 Summary of System-Level Impacts

A preventative model delivers:

- **Lower emergency demand**
- **Reduced crisis expenditure**
- **Greater workforce participation**
- **Improved mental health**
- **Reduced safeguarding activity**
- **Greater housing stability**
- **Lower long-term care costs**
- **Improved system resilience**

The evidence is clear: preventative support for unpaid carers is not a single-department intervention. It is a **cross-government strategy** that strengthens national infrastructure, reduces public expenditure, and improves outcomes across society.

SECTION 7 — FISCAL IMPLEMENTATION PLAN (3-YEAR NATIONAL ECONOMIC ROLLOUT)

7.1 Purpose of the Fiscal Implementation Plan

This section sets out a **three-year economic rollout plan** for transitioning from the current reactive model to a preventative support model for unpaid carers. It focuses on:

- investment phasing
- cross-departmental budgeting
- sequencing of cost reductions
- timing of fiscal returns
- stabilisation of system demand

This is an **economic implementation plan**, not a policy roadmap. It explains *how the financial transition works*, not what the policy reforms are.

7.2 Principles of the Fiscal Rollout

The fiscal plan is based on four core principles:

1. Early investment unlocks early savings

Preventative support begins reducing emergency demand within months, not years.

2. Costs must be phased to match capacity

NHS, ASC, and voluntary sector capacity must scale gradually to avoid bottlenecks.

3. Savings must be captured cross-departmentally

Savings in NHS and ASC must be recognised jointly, not siloed.

4. The transition must be fiscally neutral by Year 3

By Year 3, preventative investment is offset by reduced crisis expenditure.

7.3 Year 1 — Foundation Phase (Stabilisation and Early Savings)

7.3.1 Investment Focus

- Initial preventative support for high-risk carers
- Early respite and replacement care capacity
- Basic monitoring and early-intervention infrastructure
- Employment-enabling support for carers at risk of leaving work

7.3.2 Expected Economic Effects

- Reduction in emergency admissions begins within 6–9 months
- Reduction in delayed discharges
- Fewer crisis home care packages
- Early stabilisation of carer employment

7.3.3 Fiscal Position

- **Net investment year**
- Savings begin but do not yet exceed investment
- NHS and ASC see the earliest returns

Year 1 establishes the foundation for system-wide savings.

7.4 Year 2 — Integration Phase (Scaling and Cost Substitution)

7.4.1 Investment Focus

- Scaling preventative support to medium-risk carers
- Expanding respite and replacement care
- Strengthening community-based early intervention
- Embedding cross-departmental budgeting mechanisms

7.4.2 Expected Economic Effects

- Significant reduction in emergency admissions
- Reduced readmissions
- Fewer emergency residential placements
- Lower safeguarding activity
- Increased carer employment retention

7.4.3 Fiscal Position

- **Cost substitution year**
- Preventative costs begin replacing crisis costs
- Net savings begin to appear in NHS and ASC budgets
- DWP sees reduced benefit expenditure

By the end of Year 2, the preventative model is financially self-reinforcing.

7.5 Year 3 — Consolidation Phase (Net Savings and System Stabilisation)

7.5.1 Investment Focus

- Full rollout of preventative support
- Integration of NHS, ASC, and DWP savings mechanisms
- Long-term stabilisation of community-based care
- Embedding preventative support into commissioning frameworks

7.5.2 Expected Economic Effects

- Large-scale reduction in emergency demand
- Significant reduction in long-term residential placements
- Lower mental health crisis activity
- Reduced police and safeguarding involvement
- Higher workforce participation among carers

7.5.3 Fiscal Position

- **Net savings year**
- Preventative investment fully offset by reduced crisis expenditure
- Cross-departmental savings become substantial and predictable
- Long-term fiscal pressure decreases

By Year 3, the preventative model becomes the **fiscally dominant** approach.

7.6 Cross-Departmental Budgeting Mechanisms

To ensure savings are realised, the fiscal plan requires:

7.6.1 Joint NHS–ASC Savings Capture

Savings from reduced emergency admissions and delayed discharges must be recognised jointly.

7.6.2 DWP–Treasury Productivity Accounting

Retained employment and reduced benefit expenditure must be captured as fiscal gains.

7.6.3 Multi-Agency Crisis Reduction Accounting

Savings from reduced safeguarding, policing, and mental health crises must be tracked.

7.6.4 Annual Preventative Investment Envelope

A ring-fenced investment envelope ensures stability during the transition.

7.7 Expected Fiscal Trajectory

Year 1:

Investment > Savings (Foundation)

Year 2:

Savings ≈ Investment (Substitution)

Year 3:

Savings > Investment (Net fiscal gain)

This trajectory is consistent with the £1 → £7–£8 return ratio identified in Section 4.

7.8 Long-Term Fiscal Stability

By Year 3, the preventative model:

- reduces emergency demand
- reduces long-term care costs
- increases workforce participation
- lowers safeguarding and policing activity
- stabilises NHS and ASC budgets
- reduces long-term fiscal pressure

The preventative model becomes the **default economic model**, not an optional enhancement.

7.9 Summary of the Fiscal Implementation Plan

The three-year fiscal rollout demonstrates that:

- preventative investment is affordable
- savings appear early and grow over time
- cross-departmental benefits are substantial
- the transition is fiscally neutral by Year 3
- long-term savings are significant and sustainable

This plan provides a clear, economically robust pathway for transitioning to a preventative model without duplicating the policy content of the Blueprint.

SECTION 8 — INVESTMENT SCENARIOS AND RETURNS

8.1 Purpose of the Investment Scenarios

This section presents three investment scenarios that model the financial implications of different levels of preventative support for unpaid carers. The scenarios are designed to:

- illustrate the fiscal consequences of under-investment
- quantify the returns from moderate and full preventative investment
- support cross-departmental decision-making
- demonstrate the scalability and affordability of the preventative model

These scenarios are **economic models**, not policy recommendations. They show how different investment levels affect system costs, savings, and long-term fiscal stability.

8.2 Scenario A — Minimal Investment (Status Quo Plus)

8.2.1 Description

This scenario represents a continuation of the current reactive model with only marginal increases in preventative support. Investment is limited to small-scale pilots, short-term grants, and targeted interventions for the highest-risk carers.

8.2.2 Investment Level

- Low, fragmented, and inconsistent
- Primarily short-term funding
- No structural change in service provision

8.2.3 Expected Outcomes

- Small reductions in emergency admissions
- Limited impact on delayed discharges
- Minimal reduction in crisis placements
- No significant change in carer employment retention
- Accident-related harm remains high

8.2.4 Fiscal Impact

- **Savings: Low**
- **Costs: High and recurring**
- **Net position: Continued fiscal pressure**

This scenario **does not alter the long-term trajectory** of NHS, ASC, or DWP expenditure. It is the **least cost-effective** option.

8.3 Scenario B — Moderate Investment (Targeted Preventative Model)

8.3.1 Description

This scenario introduces structured preventative support for carers with medium-to-high needs. It includes planned respite, early intervention, and employment-enabling support, but does not fully scale the preventative model.

8.3.2 Investment Level

- Moderate, predictable funding
- Targeted at high-risk and medium-risk carers
- Partial integration across NHS and ASC

8.3.3 Expected Outcomes

- Significant reduction in emergency admissions
- Reduced delayed discharges
- Fewer crisis home care packages
- Lower safeguarding activity
- Improved carer employment retention

8.3.4 Fiscal Impact

- **Savings: Moderate to high**
- **Costs: Moderate and predictable**
- **Net position: Positive by Year 3**

This scenario delivers **meaningful fiscal returns** and stabilises system demand, but does not capture the full potential savings of a comprehensive preventative model.

8.4 Scenario C — Full Preventative Investment (Comprehensive Model)

8.4.1 Description

This scenario represents full implementation of a preventative support model for unpaid carers. It includes:

- universal access to preventative support
- planned respite and replacement care
- early intervention and monitoring
- employment-enabling support
- integrated NHS–ASC commissioning
- accident prevention programmes

8.4.2 Investment Level

- High initial investment
- Stable, long-term funding
- Fully integrated cross-departmental approach

8.4.3 Expected Outcomes

- Large-scale reduction in emergency admissions
- Major reduction in delayed discharges
- Significant reduction in long-term residential placements
- Lower mental health crisis activity
- Reduced safeguarding and police involvement
- High carer employment retention
- Substantial reduction in accident-related harm

8.4.4 Fiscal Impact

- **Savings: Very high**
- **Costs: High initially, then stable**
- **Net position: Strongly positive from Year 3 onward**

This scenario delivers the **£1 → £7–£8 return ratio** identified in Section 4 and provides the **greatest long-term fiscal stability**.

8.5 Comparative Summary of Scenarios

Scenario	Investment Level	Savings	Net Fiscal Position	System Impact
A — Minimal	Low	Low	Negative	High crisis demand, no structural change
B — Moderate	Medium	Moderate–High	Positive by Year 3	Reduced crisis demand, partial stabilisation
C — Full	High	Very High	Strongly positive	System-wide transformation and long-term stability

8.6 Returns on Investment

Scenario A — Low Return

- Limited impact
- Crisis demand remains high
- No long-term fiscal benefit

Scenario B — Medium Return

- Strong returns in NHS and ASC
- Moderate returns in DWP and wider public services
- Fiscal neutrality achieved by Year 3

Scenario C — High Return

- Maximum cross-departmental savings
- Significant reduction in long-term care costs
- Strong productivity gains
- Sustainable fiscal trajectory

8.7 Strategic Interpretation

The investment scenarios demonstrate that:

- **Minimal investment is the most expensive option long-term**
- **Moderate investment delivers strong returns and stabilises demand**
- **Full preventative investment delivers the highest returns and long-term fiscal sustainability**

The economic evidence is clear: preventative investment is not a cost pressure — it is a **cost-avoidance strategy** that strengthens national infrastructure and reduces long-term public expenditure.

SECTION 9 — ECONOMIC RISKS AND SENSITIVITIES

9.1 Introduction

All economic models contain uncertainties. This section identifies the key economic risks, sensitivities, and variables that may influence the financial outcomes of the preventative support model. The purpose is to ensure transparency, demonstrate robustness, and provide decision-makers with a clear understanding of the assumptions that underpin the national cost model.

The risks outlined here are **economic and structural**, not policy or operational. They relate to modelling assumptions, system behaviour, workforce capacity, and cross-departmental financial flows.

9.2 Modelling Risks

9.2.1 Variability in Prevalence of Unmet Needs

The proportion of carers with unmet or partially met needs may be higher or lower than assumed.

Impact:

- Higher prevalence increases reactive costs and strengthens the case for prevention.
- Lower prevalence reduces total savings but does not change the direction of benefit.

9.2.2 Uncertainty in Accident Rates

Accident estimates rely on risk ratios and national activity data. **Impact:**

- Higher accident rates increase potential savings.
- Lower accident rates reduce accident-related savings but do not affect core NHS/ASC savings.

9.2.3 Unit Cost Variability

NHS and ASC unit costs vary by region and over time. **Impact:**

- Rising unit costs increase the value of avoided crises.
- Falling unit costs reduce savings but do not eliminate them.

9.2.4 Data Gaps

The UK does not publish a unified dataset on unmet care needs. **Impact:**

- Some assumptions rely on triangulation across multiple datasets.
- Conservative assumptions mitigate this risk.

9.3 System Behaviour Risks

9.3.1 Workforce Capacity Constraints

NHS, ASC, and voluntary sector capacity may limit the speed of preventative rollout. **Impact:**

- Slower rollout delays savings.
- Does not affect long-term savings potential.

9.3.2 Variation in Local Authority Implementation

Local authorities differ in commissioning capacity and financial resilience. **Impact:**

- Variation may lead to uneven savings across regions.
- National averages remain stable.

9.3.3 Behavioural Response of Carers

Carers may take time to engage with preventative services. **Impact:**

- Slower uptake delays early savings.
- Long-term savings remain unaffected.

9.3.4 Provider Market Stability

Respite and replacement care markets may require time to scale. **Impact:**

- Short-term bottlenecks possible.
- Medium-term stabilisation expected.

Breakdown of unpaid care also triggers high-cost commissioned alternatives such as Shared Lives placements, creating additional volatility in ASC budgets during the transition period.

9.4 Cross-Departmental Financial Risks

9.4.1 Misalignment of Savings and Investment

Savings may accrue in one department (e.g., NHS) while investment is required in another (e.g., ASC).

Impact:

- Without cross-departmental mechanisms, savings may not be captured effectively.
- Joint budgeting mitigates this risk.

9.4.2 Fiscal Timing Differences

Savings may appear later than investment in some departments. **Impact:**

- Creates short-term fiscal pressure.
- Year-3 neutrality mitigates long-term risk.

9.4.3 Benefit System Sensitivities

Employment-related savings depend on carer retention. **Impact:**

- Lower retention reduces DWP savings.
- NHS/ASC savings remain unaffected.

Statutory employment protections for unpaid carers reduce this sensitivity by stabilising workforce participation and improving retention.

9.5 Economic Sensitivity Analysis

The model tests variations in key assumptions to assess robustness.

9.5.1 Accident Preventability

- Lower bound: 30%
- Upper bound: 60% **Impact:**
- Lower preventability reduces accident-related savings.
- Core savings remain strong.

9.5.2 Carer Employment Retention

- Lower bound: modest retention
- Upper bound: strong retention **Impact:**
- Affects DWP/tax savings.
- Does not affect NHS/ASC savings.

9.5.3 Crisis Placement Avoidance

- Lower bound: modest reduction
- Upper bound: substantial reduction **Impact:**
- Strong influence on ASC savings.
- NHS savings remain stable.

9.5.4 Emergency Admission Reduction

- Lower bound: modest reduction
- Upper bound: substantial reduction **Impact:**
- Strong influence on NHS savings.
- ASC savings remain stable.

9.6 External Economic Risks

9.6.1 Inflation and Cost Pressures

Rising costs in NHS and ASC increase the value of avoided crises. **Impact:**

- Inflation strengthens the economic case for prevention.

9.6.2 Demographic Change

An ageing population increases demand for care. **Impact:**

- Increases reactive costs.
- Increases potential preventative savings.

9.6.3 Labour Market Conditions

Labour shortages in care sectors may affect rollout speed. **Impact:**

- Slower rollout delays savings.
- Does not affect long-term savings potential.

9.7 Overall Risk Assessment

Across all tested sensitivities:

- The preventative model **remains cost-saving**
- The direction of benefit **does not change**
- The magnitude of savings varies but remains positive
- The model is **robust under conservative assumptions**
- The economic case for prevention is **strong across all scenarios**

No plausible sensitivity scenario reverses the conclusion that preventative support for unpaid carers is significantly more cost-effective than the reactive model.

9.8 Summary of Economic Risks and Sensitivities

The key findings are:

- Economic risks relate primarily to timing, not direction
- Conservative assumptions ensure credibility
- Cross-departmental mechanisms are essential for capturing savings
- Workforce and market capacity influence rollout speed
- External pressures (inflation, demographics) strengthen the case for prevention
- The preventative model remains fiscally superior under all tested conditions

The economic evidence is clear: while uncertainties exist, they do not undermine the fundamental conclusion that preventative investment in unpaid carers delivers substantial and reliable fiscal benefits.

SECTION 10 — ECONOMIC CONCLUSION

The economic analysis presented in this report demonstrates that the current reactive approach to supporting unpaid carers generates substantial and avoidable costs across the NHS, Adult Social Care (ASC), DWP, housing, policing, mental health, and safeguarding services. These costs arise from emergency admissions, delayed discharges, crisis placements, carer withdrawal from employment, and preventable accidents linked to unmet or partially met care needs.

The modelling shows that preventative support for unpaid carers is a **high-value investment** that delivers significant fiscal returns. Across all scenarios, preventative investment reduces crisis demand, stabilises system pressures, and improves long-term financial sustainability. The evidence consistently indicates that **every £1 invested in preventative support avoids £7–£8 in reactive expenditure**, with savings emerging early and compounding over time.

The national cost model demonstrates that:

- The reactive model is **structurally high-cost**, driven by emergency responses and long-term institutional care.
- The preventative model is **predictable, affordable, and fiscally efficient**, with investment offset by reductions in crisis activity.
- Savings accrue across multiple departments, making preventative support a **cross-government economic strategy**, not a single-sector intervention.
- The preventative model becomes **fiscally neutral by Year 3**, with strong net savings thereafter.
- Long-term fiscal pressures are significantly reduced when carers are supported to maintain safe, stable, and sustainable caring arrangements.

Breakdown of unpaid care also triggers high-cost commissioned alternatives such as Shared Lives placements, reinforcing the structural inefficiency of the reactive model.

Statutory employment protections for unpaid carers further strengthen the preventative model by reducing workforce withdrawal, stabilising caring arrangements, and lowering long-term fiscal pressure.

The international comparison with the United States provides a clear warning: failure to invest in preventative support leads to escalating crisis costs, workforce withdrawal, system instability, and long-term fiscal strain. England and Wales have the opportunity to avoid this trajectory by adopting a preventative economic model that recognises unpaid carers as essential national infrastructure.

The conclusion of this report is unambiguous: **preventative support for unpaid carers is not an optional enhancement — it is a strategic economic necessity**. The financial evidence is clear, robust, and consistent across all modelling scenarios. A preventative model delivers lower costs, better outcomes, and greater long-term sustainability for the entire public sector.

The economic case for action is compelling. The question is no longer whether preventative investment is affordable, but whether the UK can afford to continue without it.

APPENDIX Y — DEFINITIONS AND TERMINOLOGY

This appendix provides clear definitions of the key terms, concepts, and categories used throughout the economic analysis. Definitions are written for analytical clarity and consistency across NHS, ASC, DWP, and cross-government modelling.

Y.1 Care-Related Definitions

Unpaid Carer

An individual providing care or support to a family member, friend, or neighbour with illness, disability, frailty, or mental health needs, without financial remuneration.

High-Needs Caring Situation

A caring arrangement involving:

- complex health conditions,
- high dependency,
- multiple daily care tasks, or
- significant supervision requirements.

Unmet Care Needs

Essential care tasks that are not being provided, leading to risk of deterioration, harm, or crisis.

Partially Met Care Needs

Care needs that are met inconsistently or insufficiently, increasing the likelihood of accidents, instability, or emergency intervention.

Preventative Support

Low-level, early, or stabilising interventions designed to prevent deterioration, crisis, or escalation into high-cost services.

Reactive Support

High-cost, crisis-driven interventions delivered after deterioration has occurred.

Shared Lives Placement

A commissioned care arrangement in which a trained, matched non-family carer provides support to a vulnerable adult. Shared Lives placements operate at 3–6 times the cost of supporting unpaid carers and represent a reactive expenditure triggered by breakdown of unpaid care.

Y.2 NHS Definitions

Emergency Admission

An unplanned hospital admission resulting from acute deterioration, accident, or crisis.

Delayed Discharge

A patient medically fit for discharge but unable to leave hospital due to unsafe home conditions or lack of support.

Excess Bed Day

A hospital bed day beyond the expected length of stay, often caused by delayed discharge.

Readmission

A return to hospital within a short period following discharge, often due to unresolved or preventable issues.

Y.3 Adult Social Care Definitions

Crisis Home Care Package

An urgent, unplanned package of care deployed to stabilise a deteriorating situation.

Emergency Residential Placement

A rapid admission to residential or nursing care following carer breakdown or unsafe home conditions.

Long-Term Residential Care

Ongoing placement in a residential or nursing home, typically following crisis escalation.

Safeguarding Intervention

A statutory response to concerns about neglect, self-neglect, or risk of harm.

Y.4 Accident and Harm Definitions

Falls

Accidental loss of balance resulting in injury, often requiring A&E attendance or hospital admission.

Medication Error

Incorrect, missed, or duplicated medication doses leading to harm or deterioration.

Self-Neglect Injury

Harm arising from inability to maintain personal care, nutrition, hydration, or hygiene.

Wandering Episode

An incident where a vulnerable adult leaves home unsafely, often requiring police or emergency response.

Y.5 Economic Definitions

Unit Cost

The cost of a single service activity (e.g., A&E attendance, bed day, home care hour).

Preventable Incident

An accident or harm event that could reasonably be avoided with preventative support.

Fiscal Loss

Lost tax revenue or increased benefit expenditure resulting from carer withdrawal from employment.

Net Savings

The difference between reactive model costs and preventative model costs.

APPENDIX Z — DATA TABLES AND MODELLING ASSUMPTIONS

This appendix provides the core data tables, ranges, and assumptions used in the national economic model. Values are expressed as ranges where appropriate to maintain conservative modelling.

Z.1 NHS Unit Costs

Cost Category	Unit Cost Range
A&E attendance	£150–£400
Emergency admission	£3,000–£5,000
Readmission episode	£3,000–£5,000
Excess bed day	~£400
Mental health crisis intervention	£1,000–£3,000

Z.2 Adult Social Care Unit Costs

Cost Category	Unit Cost Range
Crisis home care (weekly)	£800–£1,500
Emergency residential care (weekly)	£1,200–£1,800
Long-term residential care (annual)	£45,000–£70,000
Regular respite (annual)	£3,000–£5,000
Low-level home support (annual)	£2,000–£4,000
Carer support services (annual)	£500–£1,000

Z.3 DWP and Tax System Assumptions

Category	Value Range
Lost tax revenue per carer leaving work	£3,000–£7,000
Increased benefit expenditure	£5,000–£10,000
Total fiscal loss per carer leaving work	£8,000–£17,000
Employment-enabling support cost	£2,000–£4,000
Net fiscal benefit per retained working carer	£4,000–£15,000

Z.4 Accident and Harm Modelling Assumptions

Z.4.1 Preventability Ranges

Accident Type	Preventability Range
Falls	30–50%
Medication errors	40–60%
Self-neglect injuries	40–70%
Burns/scalds/choking	30–50%
Wandering/missing	30–50%

Z.4.2 Cost Components Included

- A&E attendance
- Emergency admission
- Bed days
- Follow-up care
- Community nursing
- Social care response
- Safeguarding activity

Z.5 Population Assumptions

Variable	Description
Total unpaid carers	National estimate (England & Wales)
High-needs caring situations	Subset requiring intensive support
Proportion with unmet/partially met needs	Conservative estimate
Adults with significant functional limitations	Population requiring daily support
Accident incidence rates	Derived from national activity data

Z.6 Scenario Modelling Inputs

Scenario	Investment Level	Savings Profile
Scenario A — Minimal	Low	Low
Scenario B — Moderate	Medium	Moderate–High
Scenario C — Full	High	Very High

Z.7 Fiscal Timeline Assumptions

Year	Economic Position
Year 1	Investment > Savings
Year 2	Savings $\approx$ Investment
Year 3	Savings > Investment

Z.8 Sensitivity Analysis Variables

Variable	Lower Bound	Upper Bound
Accident preventability	30%	60%
Carer employment retention	Low	High
Crisis placement avoidance	Low	High
Emergency admission reduction	Low	High

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GLOSSARY OF ABBREVIATIONS

A&E — Accident and Emergency

ADASS — Association of Directors of Adult Social Services

ASC — Adult Social Care

APPG — All-Party Parliamentary Group

CQC — Care Quality Commission

DLUHC — Department for Levelling Up, Housing and Communities

DHSC — Department of Health and Social Care

DWP — Department for Work and Pensions

HES — Hospital Episode Statistics

HM Treasury / HMT — His Majesty's Treasury

ICB — Integrated Care Board

ICP — Integrated Care Partnership

ICS — Integrated Care System

JRF — Joseph Rowntree Foundation

KFF / KFF (US) — Kaiser Family Foundation

LGA — Local Government Association

NAO — National Audit Office

NHS — National Health Service

NICE — National Institute for Health and Care Excellence

ONS — Office for National Statistics

PAC — Public Accounts Committee

PHE — Public Health England

RPB — Regional Partnership Board (Wales)

SCW — Social Care Wales

UKG — UK Government

WG — Welsh Government

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