The Moffat Project: Preventing Crisis for Carers

Support from day one

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Preventing Crisis for Carers
A Princess Royal Trust for Carers’ Programme
Funded by the Moffat Charitable Trust

Final Evaluation Report

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CONTENTS

Tables................................................................................................................. iv
Figures.................................................................................................................. v
Executive summary............................................................................................... vi
Introduction........................................................................................................... 1
Methodology .......................................................................................................... 5
  Database Information.......................................................................................... 6
  Training and Activity Logs .................................................................................. 6
  Carers Questionnaire.......................................................................................... 7
  Frontline Staff Questionnaire............................................................................. 8
  Key Stakeholder Perspectives.............................................................................. 8
Results .................................................................................................................... 10
  Moffat Workers’ Database.................................................................................. 10
    Demographic Information................................................................................... 10
    Identification as a Carer .................................................................................... 11
    Carers Assessments........................................................................................... 15
  Services Carers Received through Moffat Workers.......................................... 16
    Training and Activity Logs .............................................................................. 18
  Carers’ Questionnaires....................................................................................... 18
    Demographics.................................................................................................... 19
    Identification of Carers ..................................................................................... 22
    Carers’ Experiences of Admissions ................................................................. 24
    Carers’ Assessments......................................................................................... 25
    Discharge Planning ........................................................................................... 28
    Support as a Carer............................................................................................. 29
  Frontline Workers’ Questionnaire .................................................................... 35
Summary of Key Findings from Quantitative Data ............................................. 42
  Key Findings from Database .............................................................................. 42
  Key Findings from Pre/Post-Test Questionnaires............................................ 42
  Key Findings from the Frontline Workers’ Questionnaire............................... 43
Key Stakeholders Interviews and Focus Groups ................................................. 44
Round One Analysis ............................................................................................ 44
Project Goals ................................................................. 44
Strategic Approaches .................................................... 44
Goals and Approaches – Commonality and Differences .......... 45
Barriers ............................................................................. 47
Resources ......................................................................... 48
Policy .............................................................................. 49
Impact on Services .......................................................... 49
Summary of Round One Analysis ........................................... 50
Round Two Analysis .......................................................... 50
Strategic Approaches and Goals ........................................... 50
Barriers ............................................................................. 51
Referrals .......................................................................... 51
Training ............................................................................ 52
Policy .............................................................................. 53
Post Pilot .......................................................................... 54
Summary of Round Two Analysis ........................................... 54
Round Three Analysis ........................................................ 55
Project Goals ...................................................................... 55
Referrals .......................................................................... 55
Carers’ Assessments .......................................................... 56
Direct Support .................................................................... 56
Discharge Protocols ........................................................... 56
Joint Working ..................................................................... 57
Policy .............................................................................. 57
Training ............................................................................ 58
Cultural Change .................................................................. 59
Resources .......................................................................... 60
Re-Admission Rates .......................................................... 60
Post Pilot .......................................................................... 61
Summary of All Three Rounds of Stakeholder Interviews ....... 61
Discussion .......................................................................... 63
Identifying New or Hidden Carers ........................................ 64
Providing Support and Information for Carers within the Hospital Setting ........ 64
Establishing Greater Carer Involvement in Hospital Discharge Processes/Protocols ....... 64
Reduce the Re-Admission Rates for Those Cared For ........................................... 65
Creating Pathways for Referring Carers ............................................................... 65
Enhancing Inter-agency Collaboration with Regard to Providing for Carers’ Needs .... 66
Informing Carers of Their Right to an Assessment, and Working with Statutory Agencies to Improve the Amount and Quality of Assessments Being Offered ................................. 66
Raising Frontline Staff Awareness and Recognition of Carers, Carers’ Rights and the Part Carers Play In the Care of the Patient/Service User ................................................. 66
Providing Training for Frontline Staff on Carers’ Issues ....................................... 66
Overview of Moffat Project ....................................................................................... 67
Limitations of the Evaluation .................................................................................... 67
Recommendations ..................................................................................................... 68
References .................................................................................................................. 70
TABLES

Table 1: Carers by Project Areas ................................................................. 10
Table 2: Hours of Care Provided per Week .................................................. 11
Table 3: Years in Caring Role ....................................................................... 11
Table 4: Health Condition/Disability of Person Receiving Care .................... 12
Table 5: Area of Health Negatively Impacted by Caring .............................. 13
Table 6: Who Identified Carers as Carers ..................................................... 13
Table 7: When Identified as a Carer ............................................................. 14
Table 8: Staff Informing Carer about Right to Assessment ............................ 16
Table 9: Ways Moffat Worker Facilitated Carers Assessments ..................... 16
Table 10: Services Provided by Moffat Workers .......................................... 17
Table 11: Referrals by Moffat Workers ........................................................ 17
Table 12: Training and Systems Working Contacts ...................................... 18
Table 13: Questionnaires by Time and Area ................................................ 19
Table 14: Health Conditions Requiring Care .............................................. 20
Table 15: People/Organisations Aware Respondents are Carers .................. 22
Table 16: Did assessment lead to additional support? ................................... 27
Table 17: Differences across Areas ............................................................. 32
Table 18: Confidence, Knowledge and Health Impact ................................... 34
Table 19: Differences Between Groups in Receiving Help ............................ 35
Table 20: Health Board or Local Authority of Respondents .......................... 36
Table 21: Nature of Contact ........................................................................ 36
FIGURES
Figure 1: Who Identified Carers By Area.................................................................14
Figure 2: Percentage Of Carers Identified During Hospital Stay By Year And Area........15
Figure 3: Percentage Of Carers Informed Of Right To Assessment By Area................16
Figure 4: Age Of Carers......................................................................................19
Figure 5: Relationships To Carer........................................................................20
Figure 6: Histogram Of Years Caring....................................................................21
Figure 7: Hours Of Care Provided Per Week ........................................................22
Figure 8: Identification Of Carers At Times 1, 2 & 3...........................................23
Figure 9: Identification Of Carers From Pre To Post-Tests....................................23
Figure 10: Support Ratings From Hospital And Social Work Staff From Pre- To Post-Tests 24
Figure 11: Informed Of Right To Assessment By Area..........................................25
Figure 12: % Of Carers Offered An Assessment By Social Work..........................26
Figure 13: When Carer Assessments Were Offered..............................................26
Figure 14: Helpfulness Of Carer’s Assessment Experience....................................27
Figure 15: Was A Discharge Plan In Place?..........................................................28
Figure 16: Rating Of How Fully Carers' Needs And Views Taken Into Account During Discharge Process ......................................................................................29
Figure 17: Services Flexible/Available to Carers ..................................................30
Figure 18: How Fully Expertise is Recognised by Care Professionals .....................31
Figure 19: Having a Say in Shaping Services Received.........................................31
Figure 20: Do Care Professionals Understand Your Needs as a Carer?....................32
Figure 21: Differences in Recognition of Carers Expertise......................................33
Figure 22: Having a Say in Shaping Services by Area...........................................33
Figure 23: Care Professionals Understanding Needs as Carer by Area...................34
Figure 24: Profession of Respondents to Frontline Worker Questionnaire...............35
Figure 25: How Much Moffat Workers Enhanced Workers' Understanding of The Needs of Carers ...................................................................................................... 37
Figure 26: Have The Moffat Workers Had an Impact on Your Work Practices? .........37
Figure 27: When Most Likely to Identify A Carer ..................................................38
Figure 28: When Most Likely to Refer to Moffat...................................................38
Figure 29: Influence of Moffat Workers On Respondents' Practice........................39
Figure 30: Influence of Moffat Workers On Respondents' Practice........................39
Figure 31: Influence of Moffat Workers On Organisation Regarding Carer Identification and Protocols .................................................................40
Figure 32: Influence Of Moffat Workers on Organisation Regarding Carer Information ....40
Figure 33: How Much Training Prepared Staff to Work With Carers ......................41
EXECUTIVE SUMMARY

Background to the evaluation

Over the past several decades carers have become an increasing priority in governmental policy, and this has culminated in the requirement to develop Carer Information Strategies and the guidance published by the then Scottish Executive (2006). In the guidance the Government specified that carers should be informed of their right to assessment and offered relevant information at every key stage in the patient/carer journey – including hospital discharge. The Princess Royal Trust Carers Centres, however, were reporting that even where relationships with local Health Boards and Local Authorities were very positive they were finding little evidence of carers’ assessments occurring. It appeared that carers were not receiving the very services that reports and governmental policy identified they needed. Conversations with Local Authorities and Health Boards echoed such concerns. Importantly, carers were also indicating that being identified as a carer, being offered carers assessments or being seen as a key partner in discharge planning were not occurring as suggested in the various policy drivers (Kelly, 2007).

It was widely recognised that no one system alone could deliver on such policy drivers in isolation. Voluntary carers’ organisations, health care providers, and social service workers working together in partnership were seen to be best placed to deliver on a vision where all carers are supported. As such the Moffat Project, Preventing Crisis for Carers, was developed by The Princess Royal Trust for Carers. The Moffat Project was made up of four individual pilot projects operating in four NHS Board (Ayrshire & Arran, Borders, Greater Glasgow & Clyde, and Lothians) areas in Scotland from April 2008 to April 2010. Each pilot site built on the knowledge and experience of local carer organisations and health partners and promoted partnership work between the local Carers’ Centres, health and social care professionals to identify carers early on in their caring role.

The aim of the Preventing Crisis for Carers Programme was to create effective partnership working between the NHS and Social Work staff, local Carers’ Centres and carers by promoting early identification, intervention and support for carers to prevent unnecessary crisis. It also aimed to ensure carers were appropriately supported as key partners in the provision of care, to prevent an adverse effect on their own health and well-being. The key Programme Objectives were:

- Identifying new or hidden carers, ideally at an early stage.
- Providing support and information for carers within the hospital setting.
- Establishing greater carer involvement in hospital discharge processes/protocols.
- Reducing the re-admission rates for those cared for.
- Creating pathways for referring carers onto Carers’ Centres, Social Work Services or other relevant support agencies, with the aim of establishing long term packages of support (should the individual carers wish such a thing).
- Enhancing inter-agency collaboration to provide for carers’ needs.
• Informing carers of their right to an assessment, and working with statutory agencies to improve the amount and quality of assessments being offered.
• Raising frontline staff awareness and recognition of carers, both in terms of carers’ rights to services and information, and the part they play in the care of the patient/service user.
• Providing training for frontline staff on carers’ issues.

An important part of the initial Moffat Project design was for there to be an independent evaluation. As this was a pilot project it was hoped that an evaluation could provide evidence that could be used to develop and influence mainstream service provision regarding how carers are identified and supported. The report that follows is the independent evaluation.

How the Evaluation Was Conducted

Given the complexity of the Moffat Project, a mixed methods evaluation was designed to address the aims and objectives above. The study collected quantitative and qualitative data through questionnaires, focus groups and interviews at three points in time. The data included information from the Moffat Worker Carers’ Database, which was primarily used to record information about what Moffat workers did with individual carers. A Carers’ Questionnaire was administered at three different times and provided outcome data. The Frontline Workers’ Questionnaire was administered at the end of the project and provided an ex post facto evaluation of several key project outcomes. Several of the project areas also kept Training and Activity Logs and this data provides more process data, namely about the work done on more systemic levels—rather than direct work with carers. Interviews with key stakeholders at the beginning, middle and end of the project provided rich data concerning many important process variables as well as data regarding certain key outcomes. The interviews also served to place the quantitative data into context.

What the Evaluation Found in Relation to the Key Programme Outcomes

The evaluation produced a rich amount of data with many important implications. This Executive Summary highlights the key findings and organises the findings around the main project outcomes. The results section of the full report provides the quantitative and qualitative data to support the discussion within the Summary.

Identifying New or Hidden Carers

It was clear from the various sources of data that many new and hidden carers were identified through the efforts of the Moffat Project. For example the Moffat Worker Carers’ Database contained nearly 3,000 carers. The Frontline Workers’ Questionnaire also suggests that health and social care staff may be more likely to be identifying carers and the interviews highlight that this project aim has been successfully met. In addition, the percentage of carers reporting that they were never identified as a carer decreased from the baseline period to post-test and the percentage of carers reporting that they were identified as such during the hospital stay of their loved one increased over that same time period. It appears that having dedicated carer support workers assists with carer identification and carer awareness amongst other staff.
When compared to other studies in Scotland it appears that carers in the Moffat Project areas were being identified and supported earlier.

Providing Support and Information for Carers within the Hospital Setting
There is a vast amount of supporting evidence across all data sources that would allow one to say with a great deal of confidence that this objective has been met. For example, nearly 3,000 carers were identified, primarily from within the hospital settings. Moffat workers identified a wide range of services and supports they provided to the carers including advice, information, emotional support and practical support. In addition, they made referrals to numerous other providers. The frontline workers also reported that their involvement with the Moffat Project influenced their practice with carers in terms of providing information and in recognition. Interviews and focus group data across the three time periods also support the perception by professionals that they were providing more support and information to carers. More importantly, carers themselves indicated that feelings of being supported by hospital and social work staff increased from baseline to the end of the project.

Establishing Greater Carer Involvement in Hospital Discharge Processes/Protocols
There is rich evidence to suggest that carers were more involved in the discharge process at the end of the project than they were at the beginning. For example, the Carers’ Questionnaire shows a significant increase in the percentage of carers reporting that a discharge plan was in place. Carers also reported an increase in how fully their needs and views were taken into account during the discharge process. The activity logs and interviews with key stakeholders indicate that a good deal of work was done concerning discharge processes. It appears that these efforts bore fruit. On the down side, however, all of this hard work within the hospital setting did not appear to increase the percentage of carers indicating that the plan had been carried through. While 55% said the plan had been carried through, 24% indicated that the plans had not been carried out, and there was not an improvement across the life of the project. Further work around transition from hospital to home may be required.

Reduce the Re-admission Rates for Those Cared For
Stakeholders in health and social care reported that the aim of reducing re-admission rates was seen to be overly ambitious within the first year of the project given the complexity of system changes required. This perception was confirmed a year later. There was no significant statistical change in the readmission rates according to the questionnaires.

Creating pathways for Referring Carers
It appears that pathways for referring carers onto Carers’ Centres, Social Work Services and other relevant support agencies occurred during the project. Moffat workers were the primary pathway for referrals, and if such activities are not embedded within standard practice, then these pathways may die out after the project ends. However, there is some evidence to suggest that such embedding has taken place in some areas. The frontline workers also report that they would likely refer carers to Moffat workers, which will hopefully translate into referring directly to Carers’ Centres in the future. Also, much systems work occurred to
embed carers’ needs into discharge planning. The project demonstrates the benefits of such activities. For example, the percentage of carers reporting having a discharge plan and being part of the planning process increased. In addition, the offer of carers’ assessments by Social Work Departments increased over time and they were offered earlier. It also appears that carers who received a carer’s assessment were more likely to gain additional support by the end of the project. Perhaps the increased information allowed carers to make better use of the carers’ assessment process. They also reported finding the process or having a carer’s assessment more helpful by the end of the project.

Enhancing Inter-agency Collaboration with Regard to Providing for Carers’ Needs
When considering inter-agency collaboration and partnership working the evaluation found mixed results. The interviews and focus groups demonstrate that inter-agency collaboration at local strategic levels has been slightly enhanced. In addition, working relationships across agencies seem to have improved and referrals were more likely. However, information sharing around particular cases and carers remained problematic in several of the areas, often due to perceived concerns around confidentiality and data protection. Despite some of the mixed findings from the qualitative data, the data from the Carers’ Questionnaires suggests that carers felt that agencies worked together better by the end of the project.

Informing Carers of Their Right to an Assessment and Working with Statutory Agencies to Improve the Amount and Quality of Assessments Being Offered
There is no doubt that the Moffat Project had a significant impact on the rates of carers who were informed of their right to an assessment. The data from all sources converge around this issue. In terms of quality of assessments being offered, there appears to be some improvements in this area as well. Certainly several of the areas worked specifically and in partnership around improving carers’ assessments. This may explain why carers reported that the experience of receiving a carer’s assessment was more helpful at the end of the project and that carers were more likely to receive additional support.

Raising Frontline Staff Awareness and Recognition of Carers, Carers’ Rights, and the Part Carers Play in the Care of the Patient/Service User
The various Moffat Project areas took different approaches to raising staff awareness of carers’ issues and each area faced barriers in this work. However, there is much evidence to suggest that awareness was raised. For example, at least 3,507 professionals received training on carers’ issues and at least another 660 health and social care staff were involved in work with Moffat workers regarding improving systems for carers. The Frontline Staff Questionnaire suggests that awareness and information giving were strongly influenced by the project. Outcomes for carers suggest that a change in practices also occurred over the time period.

Providing Training for Frontline Staff on Carers’ Issues
As indicated above, a great deal of training for frontline staff occurred during the Moffat Project. The amount of training provided is under reported within the evaluation as not all centres kept an activity log.
Overview of Moffat Project

When looking across the results for the project aims and objectives it is safe to say that the Moffat Project met its stated aims and almost all of its objectives. The project helped to create or strengthen effective partnership working between the NHS and Social Work staff, local Carers’ Centres and carers by promoting early identification, intervention and support for carers. Whether the efforts reduced crises for carers is harder to demonstrate. Though the data on readmission rates do not suggest a decrease in these rates, all the data converge to strongly suggest that the identification of and support for carers improved throughout the hospitalisation journey. As hospitalisation often occurs as a result of a crisis, it may be that rather than preventing crises, carers were better supported through crises.

There were several important improvements during the two years the Moffat Project was running. Professionals have increased awareness of carers’ issues, and are more likely to identify them and do so earlier than before. They also report better protocols, strategic collaboration and information sharing. Carers were provided with more information, including information on their right to a carer’s assessment, and are being identified earlier and better supported during hospitalisation. They feel that professionals better recognise their expertise and understand their needs as a carer. In addition carers felt more able to have a say in shaping the services that they, or the person they care for, receive. Carers, themselves, seem to feel that agencies are working better together by the end of the project as well.

Some important areas did not improve. For example, there were no changes found on the impact of caring on carers’ physical or mental health. Nor was there an increase in confidence in the caring role or knowledge of the condition for which they were providing care. It may be that it was overly optimistic to hope that the Moffat Project could impact on outcomes such as these within the given timeframe. However, given recent research on the effectiveness of carers’ training programmes impacting on these areas (Watson, West & Kelly, 2009; Kelly, Watson & West, 2009), it may be that the early identification, supports and referrals provided by the Moffat Project will translate into these carers participating in the training activities earlier in their caring career roles than would have been the case otherwise. Certainly from this earlier research it was clear that to make significant and global changes in important carer outcomes, appropriate supports were required across the entire caring trajectory. Early identification and early support is crucial, but then ongoing supports and services are required. Moffat, it appears, provides an effective approach to intervening at the early end of the caring trajectory as well as intervening into the lives of carers’ who had been hidden prior to a hospitalisation crisis.

Limitations

As each site took a slightly different approach, the combined data across all four areas does not represent one “intervention.” Arguably there is enough overlap in the different approaches to still be able to think of the Moffat Project as an intervention. The response rate for the Carers’ Questionnaire was low so the results may not represent all carers served by the Moffat Project. The low response rate also made it impossible to use some of the statistical
tests that would have allowed for more cross area comparisons. Where possible this was done. In addition, the data collection tools and strategies were not used consistently across all four sites as they were not always completely suitable. For example, one area focused much more on training and systems work than on direct work with carers, and their database returns may not have been as large as other areas. Some areas were more focussed on direct work with carers and frontline staff were less likely to use the Training and Activity Logs consistently. This has led to some under-reporting so it is likely that more training of professionals and carer related activity occurred than is reported. Finally, the non-intervention comparison area dropped out of the evaluation, so the evaluation used the pre-Moffat Project period across all sites as the baseline.

Recommendations

Despite the limitations outlined above, the data converge sufficiently to make the following recommendations with confidence.

- **Identification of carers should be a part of care pathways from admissions through to discharge planning.** The Moffat Project increased the early identification of carers, who reported improved outcomes in many key areas. This included increased discharge planning, more carers being informed of their right to a carer’s assessment, increased uptake of carers’ assessments, increase in supports provided to carers who received an assessment. Assessments were seen as more helpful by carers, who reported more partnership working and recognition of their pivotal role within the caring relationship.

- **Having dedicated carer support workers within health care settings, both Primary and Acute, should be a priority.** The percentage of carers identified within the pilot areas increased significantly during the project. Key stakeholders and frontline staff reported that having an identified worker with the specific remit of supporting carers in practice and policy was a key component to project success.

- **Carers’ awareness training should become part of the mandatory training for health and social care staff.** Moffat Project workers provided training to over 3,000 health and social care workers. This training and information giving was valued by key stakeholders and frontline workers who appreciated that in order to influence practice and improve outcomes for carers and the people they care for, health and social care staff must have up to date knowledge and skills. Such knowledge and skills must then be translated into and supported in practice.

- **High level strategic coordination across Health, Social Work and carers’ organisations should be standard practice.** This was seen as key to influencing practice and the positive outcomes. Although the level of coordination across the four areas and across the two years varied somewhat, the Moffat Project enhanced partnership working across health, social work and local carer organisations.

- **Further work joining discharge plans and community care packages is required.** There were significant improvements in the number of carers reporting having a discharge plan and the number of carers being offered assessments by social work teams. However, there were still many carers who did not report receiving these
services. The Moffat Project has demonstrated that a joint approach can improve this joining up process, but embedding the approach consistently will take time.

Consultation with relevant professional and regulatory bodies with a remit of accrediting professional education should occur regarding how to best include carer awareness content within professional educational programmes. Professional education programmes have a role to play in making sure that new practitioners enter practice being aware of the needs and importance of carers. Consultation with the professional education bodies regarding ways to integrate carer awareness without placing more curricular burden could ensure that all health and social care professionals have a basic awareness of carers.
INTRODUCTION

In the last two decades there has been a growing recognition of the needs of carers within government policy and legislation. Since the Carers (Recognition and Services) Act 1995, carers have had a right to an assessment of their own needs. Yet in practice very few assessments were carried out, and when they were, carers did not always realise they had occurred (Scottish office, 1998a). In 1998 the Modernising Community Care: An Action Plan was published and there was a clear emphasis on shifting away from institutional care to helping people to remain in their own homes through community based care (Scottish office, 1998b). Carers were specifically addressed in that home care should be designed to support carers and respite care should be implemented to meet the needs of service users and carers. However, it was not until the publication of the Scottish Executive’s (1999) Strategy for Carers in Scotland in November 1999 that carers became a priority. The five aims of the strategy were:

- to improve the information on help and support for carers
- to add to, and improve, the local services that help carers to cope
- to introduce new laws to help carers
- to make sure there were consistent national standards for the kind of short breaks carers need
- to check that carers were getting the help they need.

Following the Strategy, the Community Care and Health (Scotland) Act 2002 was enacted which formally recognised unpaid carers as partners in care provision. The Act also gave carers the right to an assessment of their own support needs and gave local authorities the statutory duty to inform carers that they may be entitled to a carer’s assessment.

The Care 21: Future of Unpaid Care (Scottish Executive, 2006 b&c) Report was published in 2006 and made 22 recommendations to ensure a positive future for unpaid carers. The recommendations are based on two underlying principles 1) greater recognition of and respect for unpaid carers as key partners and providers; and 2) the development of a rights based policy framework to support unpaid carers. In response to this report the Scottish Executive (2006d) identified four key priorities: young carers, respite, carer health and information strategies, and carer training. Following this report an additional £9 million was provided to NHS Boards across Scotland to help with the implementation of Carer Information Strategies (Scottish Government, 2008).

When the Scottish Executive published their guidance to Carer Information Strategies (2006a) they specified that carers should be informed of their right to assessment and offered relevant information at every key stage in the patient/carer journey – including hospital discharge. Carers’ Centres, however, were reporting that even where relationships with local Health Boards and local authorities were very positive they were finding little evidence of carers’ assessments occurring. It appeared that carers were not receiving the very services
that Care 21 identified they needed. Conversations with local authorities and Health Boards echoed such concerns. Importantly, carers were also indicating that being identified as a carer, being offered carers assessments or being seen as a key partner in discharge planning were not occurring as suggested in the various policy drivers (Kelly, 2007).

No one system alone could deliver on such policy drivers in isolation. Working in partnership voluntary carers organisations, health care providers, and social service workers were seen to be best placed to deliver on a vision where all carers are supported. As such the Moffat Project, Preventing Crisis for Carers, was developed by The Princess Royal Trust for Carers.

Background

The Princess Royal Trust for Carers (The Trust) is the largest provider of carers’ services in the United Kingdom. It does this through working closely with a network of independent carers’ centres and services, on line support for carers of all ages and through its policy and influencing work to promote carers’ interests. In 2007, as part of a competitive bidding process, The Trust submitted a proposal for funding for a Crisis Prevention for Carers Project to the Moffat Charitable Trust. The application was successful and The Trust worked with the Carers’ Centres and Services in Scotland to identify pilot sites for delivering the Moffat Project (Crisis Prevention for Carers Project) which aimed to:

- Identify new carers.
- Support carers through the hospital discharge process.
- Promote awareness of carers amongst hospital and social work staff.
- Provide support through the Carers’ Centres.
- Promote and increase access to a Carers’ Assessment.

The aims were further translated into key programme objectives. These objectives were:

- Identifying new or hidden carers, ideally at an early stage (usually at the point when the cared for person is admitted into hospital).
- Providing support and information for carers within the hospital setting.
- Establishing greater carer involvement in hospital discharge processes/protocols.
- Aiming to reduce the re-admission rates for those cared for.
- Creating pathways for referring carers onto Carers’ Centres, social work services or other relevant support agencies, with the aim of establishing long term packages of support (should the individual carers wish such a thing).
- Enhancing inter-agency collaboration with regard to providing for carers’ needs.
- Informing carers of their right to an assessment, and working with statutory agencies to improve the amount and quality of assessments being offered.
- Raising frontline staff awareness and recognition of carers, both in terms of carers rights to services and information, and the part they play in the care of the patient/service user.
- Providing training for frontline staff on carers’ issues.
Areas covered

At the heart of delivering a range of services for carers across Scotland, each of the Centres act as a one-stop-shop for unpaid carers, their families and health and social care professionals. The partnerships created by each Centre support the early identification, recognition and support of carers across Scotland, working with GPs; Community Health Partnerships; local authorities; acute hospital staff and relevant local voluntary organisations. Building on the existing knowledge of carers needs, a track record in providing services that met these needs and strong local networks four individual pilot sites were identified operating in four NHS Board areas, which were:

- Ayrshire and Aran
- Borders
- Greater Glasgow and Clyde
- Lothian

Ten of The Princess Royal Trust Carers Centres were directly involved in the delivery of the pilot in: Edinburgh, West Lothian, East Lothian, Borders, Glasgow West, Glasgow East, Glasgow South East, Glasgow Greater Pollok, Renfrewshire and East Ayrshire.

Development

In developing their proposals, each of the pilot sites and local partnerships were assessed on the following criteria:

Essential

- Promotes integrated joint working with Health, Local Authority and Princess Royal Trust for Carers’ Centres across the local Health Board.
- Fits with local Carers’ Information Strategy.
- Fits with current Scottish Executive policy priorities.
- Demonstrates joint work with Health and Local Authority both at strategic and operational levels.
- Builds on experience and good practice across the network.
- Provides robust evidence that can be rolled out / used across health board area.

Desirable

- Demonstrates potential for the Health Board and Local Authority to give commitment for either further funding for the duration of the project, and / or continuation funding at the end of the pilot.

While each of the four areas was committed to the Moffat Project objectives how these were delivered varied between them in order to best fit the diversity of organisational infrastructures, demographics and geography. For example in Glasgow there were five Moffat Project Workers employed within four main care groups in nine hospital sites ranging from medicine for the elderly to palliative care and mental health in-patients. In Glasgow the pilot was also extended to include carers’ organisations which were not part of The Princess
Royal Trust for Carers’ network. In the Borders two workers were employed to focus on carers’ liaison work in the main Borders General Hospital and carers’ training, which focused on raising awareness amongst professionals.

Carers’ Centres had done similar projects in the past, but they were very small scale, local, and time limited. One of the objectives of this larger and multi-site project was to build an evidence base to inform and further embed future partnership approaches. This report is an outgrowth of this objective and presents the results of an independent evaluation commissioned by The Trust.
METHODOLOGY

The complexity of the Moffat Project’s multi-levelled objectives (e.g., outcomes for carers, frontline workers, organisations, and systems), and the differences in approach between each of the Moffat Project sites presented a number of challenges for the evaluation process. As such, the Project needed to be evaluated from a variety of perspectives. Working to implement changes in complex and diverse settings is not a simple linear process whereby a change in one part of the system would make the lives of carers better. It is more likely that a series of different changes in different environments may have a very small change, a delayed change, or even an unexpected change. As such the research team needed a way to organise and think about how to undertake a complex evaluation of a complex project. The team drew upon the work of Pawson and Tilley (1997) who developed “Realistic Evaluation.” Often research tries to control as many different things as possible in order to test if some new intervention is responsible for any changes that occur during the study. In a project such as this, there is no way all the various potential influences could be controlled. Realistic Evaluation starts with this premise and guides one to look at the contexts, processes as well as outcomes. One should not try to control the contexts in which “experiments” occur…rather one should explore, document, investigate the context and processes used. These contexts and processes are just as important as the outcomes in realistic evaluation.

It was important to develop an approach to the evaluation that reflected the Project’s diversity and would be able to attempt to capture the nuances of the individual pilot sites. It needed also to consider outcomes as well as process variables. As such, the evaluators designed a study that included quantitative and qualitative data collected through questionnaires, focus groups and interviews at three points in time. Large amounts of data were also collected quarterly through the Carers’ Database into which Moffat workers put information concerning the work they were doing with individual carers. This allowed the researchers to collate important process information such as the number of carers recruited, services delivered, information given, training delivered etc. The evaluation began by establishing a baseline of existing service provision and its implications for carers and the services they receive. This initially included a non-intervention comparison site. In order to evaluate the impact of the Moffat Programme on carers, a baseline was established in terms of existing service provision across the pilot sites and to examine the implications for carers and the services they receive. It was intended that this baseline would be used as a starting point for what existed at that time and this was followed up with two further waves of data collection at the end of years 1 and 2 of the project, providing data with which to evaluate the impact on carers over time. Data collection involved a range of sources including carers’ experiences and perceptions of the service they receive from Carers’ Centres and frontline health care provision plus interview and focus group information from key stakeholders and service providers. At each wave of data collection, information was collected on process and
contextual variables as well. Each of the different data collection methods will be described below.

Database Information

Moffat workers used a purpose built database to collect information on the carers they worked with during the project. Initially it was hoped that the Moffat workers would be able to use the proprietary database the Princess Royal Trust for Carers (The Trust) was already using to prevent duplication of work. Unfortunately, it was not possible to amend that database to fit the needs of the evaluation and a purpose built Moffat database was developed that would be responsive to the needs of the evaluation as well as reporting needs of The Trust. The database included a wide range of data including:

- Demographic information about the carer and the person they cared for,
- Hours of care provided per week and the length time involved in caring,
- Whether caring impacted on carers’ health and, if so how,
- Basic information about carers’ experiences during the hospitalisation of the person they care for,
- Experiences regarding carers’ assessments,
- Services provided by Moffat workers,
- Services to which Moffat workers referred carers.

Not all data fields were completed for each carer as some fields were not appropriate for all carers. For example, if a carer was concerned about a particular issue or was having a crisis it could be intrusive to ask for details unrelated to the pressing concern. Also, some of the work was of very short duration so not all data fields were collected. However, large amounts of data were collected in the database concerning carers contacted as part of the Moffat Project. All identifying information was stripped from the data before it was sent to the research team. Data from the database were collected quarterly. The database provided a good deal of information to help contextualise the work of the project. In addition it captured a good deal of process information, for example, what Moffat workers did with carers. It also provided a small amount of outcome data by looking at how patterns changed from the first year of the project to the end.

Training and Activity Logs

The database captured process and contextual information regarding work with individual carers. However, another important area of work focussed on working with health and social care systems and the people that work in those systems. The four project areas approached this work somewhat differently or placed greater or lesser emphases on the different areas of work to meet local needs. The database did not capture activities at systems level, as such, project areas were asked to keep a record of the activities that were not captured within the carer focussed database. Like the Carers’ Database, the Training and Activity Logs were used and adapted differently to respond to the diversity across the 4 sites. The centres recorded various activities and indicated the nature of the activity and the number of people involved.
or benefitting from the activity. This was sent to the research team along with the Carers’ Database information on a quarterly basis.

**Carers Questionnaire**

A questionnaire was developed from a review of the literature on carers and, in particular, on the research that indicated what was important to them in their caring situations (e.g., Glendinning et al, 2006; Harkins & Dudleston, 2006; Kelly, 2007; Miller et al, 2007; Petch, Cook & Miller, 2005). The User Defined Service Evaluation Toolkit (UDSET) influenced the development of the tool, especially in highlighting the outcomes of importance to carers (Cook, Miller & Whoriskey, 2007). Finally, questions were developed to address specific project outcomes, with emphasis on their experiences as carers and the impact of the project work in relation to a number of aspects of their caring role.

The questionnaires were administered to carers already known to the Carers’ Centres at the beginning of the project before any intervention began. This baseline wave of data collection included carers from a centre outwith the four project areas to provide a comparison group that was not receiving the extra supports provided by Moffat. Subsequent phases of data collection occurred towards the end of the first and second years of the project. These three waves of data collection would allow the carers’ experiences within the project areas to be compared at three points in time. As many of the project outcomes were dependent on systems changes it was thought that any changes that might occur in these outcomes of interest would be progressive (i.e., changes increasing over time).

The questionnaire covered 33 different items and used a mixture of rating scales and open questions to obtain the carer’s perspective. In addition, the questionnaire also obtained demographic data which once again enabled the evaluation to look at how “typical” the Moffat carers were in relation to the wider population of Carers’ Questionnaires. The areas measured by the questionnaire included:

- The person they care for,
- Recent hospitalisation/re-hospitalisation experience, including length of stay,
- Their experiences of receiving a carer’s assessment,
- Whether they were identified at first point of contact as a carer,
- If they were provided information about their rights,
- Experiences of being offered a carer’s assessment,
- If they received a carer’s assessment,
- Their experience of the pre-discharge phase,
- Supports obtained as a result of the carer’s assessment,
- The support they received post discharge,
- Their abilities and confidence as carers,
- Quality of care provided,

1 Unfortunately, it was not possible to collect data from the comparison site for the Time 2 and Time 3 waves.
• Training offered and received,
• Unmet need.

Frontline Staff Questionnaire

Frontline staff in health and social work settings in which the Moffat workers were based were provided with an online questionnaire to obtain their perceptions of the impact of the Moffat Pilot Project in relation to both their practice and workplace. The aim of this questionnaire was to evaluate the impact of partnership working on key project outcomes related to carers being seen as key partners. The Frontline Staff Questionnaires were completed by staff who the project workers felt had an ongoing contact with the project which enabled them to make valid comment on the work of the project. To this end the four pilot projects provided the evaluators with email lists of Health Board and Social Work Department staff members who had agreed to take part in the evaluation. The questionnaire covered 16 different items and as with the Carers’ Questionnaire used a five point rating scale and open-ended questions to obtain the frontline staffs’ perspective. The areas measured by the questionnaire included:

• How much have the Moffat workers enhanced their understanding of the needs of carers,
• If the Moffat workers had an impact on their work practices,
• When workers would not be most likely to look to identify carers,
• How much the Moffat workers influenced individual practice,
• How much the Moffat workers influenced the organisation,
• The impact of Moffat workers on their organisation’s services for Carers,
• Training provided by Moffat.

Key Stakeholder Perspectives

Interviews and focus groups were held with key stakeholders to provide an overarching picture of the progress of the project over time. The identified stakeholders included staff in each of the four projects; project managers, managers from both the Health Boards and Social Work Departments were interviewed. The relevant health and social work stakeholders were identified by project managers as the relevant people who were responsible for the change processes underpinning the Moffat initiatives and therefore able to comment on the ongoing progress of the pilot in their area. The focus groups and interviews took place at three separate points in time (pre-initiative, year 1, year 2), and provided information in relation to the current baseline of partnership working and the potential progression related to the Moffat Project’s activities. The interview and focus group schedule was informed by A Framework for Evaluating the Quality of Services and Organisation (HMIE, 2006). The interviews and focus groups were recorded, transcribed and analysed using thematic content analysis. Two members of the research team analysed each transcript to promote rigour and ensure credibility and dependability of the analysis. The areas covered by the interview and focus group schedule included:

• What key outcomes have we achieved?
• How well do we meet the needs of our stakeholders?
• How good is our delivery of key processes?
• How good is our management?
• How good is our leadership?
• What is our capacity for improvement?

The next section will first present the results of the evaluation. The results will begin with the findings from the Moffat Database as this provides a rich context in which to place the remaining strands of the evaluation. Secondly, the data from the Carers’ Questionnaire provides evidence for some of the key project outcomes and direct impact for carers. Next, Frontline Staff Questionnaires highlight the practice and organisational changes and work settings. Finally, the key stakeholder interviews and focus groups will be used to contextualise the earlier findings. The project ran in four different sites across Scotland and, where appropriate, differences across the different sites will be highlighted.
RESULTS

The results section will present the data analyses from all elements of the evaluation. It begins with the results from the more quantitative elements of the evaluation. This includes results from the Moffat Workers’ Database, Training and Activity Logs, Carers’ Questionnaires, and Frontline Workers’ Questionnaire. After this section a summary of the key findings will be presented before moving on to the presentation of the qualitative elements of the evaluation. This later section includes analysis of all the key stakeholder interviews and focus groups.

Moffat Workers’ Database

As described in the methods section, Moffat workers used a purpose-built database to collect information on the carers they worked with during the project. Each carer centre within each of the 4 project areas completed their own purpose built database and sent the data to researchers quarterly. This section will summarise the data across the 4 areas. Not all data fields were completed for each carer as some fields were not appropriate for all carers.

Demographic Information

Moffat workers recorded contacts with 2,783 carers in the database. Table 1 highlights the number of carers contacted by the Moffat Project areas. The average age of the carers was 61 (s.d.=16.6) with a range from 9 to 90. In terms of gender, 69% (n=1919) were women and 28% were men (n=772). The gender of the remaining 3% was not identified. Nearly half (48%) of the carers were identified as caring for a spouse or partner and another 26% were caring for a parent. Caring for adult children was identified in 6% (n=154) of the carers, and only 2% were caring for a minor child. The average age of the people being cared for was 70 (s.d. = 18.1) with a range from 9 to 96. Moffat workers did not identify the caring relationship for 10% of the carers (n=292). The overwhelming majority of the carers (75%) were identified as Scottish by Moffat workers. The ethnicity of 21% of the carers was listed as unknown and the remaining 4% consisted of English, Welsh, Irish and carers from Black and Minority Ethnic (BME) communities. The carers provided a significant amount of care as can be seen in Table 2 where over one-third of the carers provided 7 or more hours of care per day. Table 3 indicates that 13% of carers were in the first year of a caring role and another 35% had been caring for less than 5 years. Only 20% were identified as long term carers. This may indicate that carers in the evaluation were ‘early career carers’.

<table>
<thead>
<tr>
<th>Project Area</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire</td>
<td>1092</td>
<td>39%</td>
</tr>
<tr>
<td>Glasgow</td>
<td>845</td>
<td>30%</td>
</tr>
<tr>
<td>Lothian</td>
<td>737</td>
<td>26%</td>
</tr>
<tr>
<td>Borders</td>
<td>109</td>
<td>4%</td>
</tr>
</tbody>
</table>

2 Figures do not equal 100% due to rounding
TABLE 2: HOURS OF CARE PROVIDED PER WEEK

<table>
<thead>
<tr>
<th>Hours per Week</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>34</td>
<td>1%</td>
</tr>
<tr>
<td>6-10</td>
<td>48</td>
<td>2%</td>
</tr>
<tr>
<td>11-20</td>
<td>89</td>
<td>3%</td>
</tr>
<tr>
<td>21-35</td>
<td>206</td>
<td>7%</td>
</tr>
<tr>
<td>36-50</td>
<td>523</td>
<td>19%</td>
</tr>
<tr>
<td>51-75</td>
<td>188</td>
<td>7%</td>
</tr>
<tr>
<td>75+</td>
<td>752</td>
<td>27%</td>
</tr>
<tr>
<td>Unknown</td>
<td>943</td>
<td>34%</td>
</tr>
<tr>
<td>Total</td>
<td>2783</td>
<td>100%</td>
</tr>
</tbody>
</table>

TABLE 3: YEARS IN CARING ROLE

<table>
<thead>
<tr>
<th>Years</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1</td>
<td>354</td>
<td>13%</td>
</tr>
<tr>
<td>1-5</td>
<td>964</td>
<td>35%</td>
</tr>
<tr>
<td>6-10</td>
<td>291</td>
<td>10%</td>
</tr>
<tr>
<td>10+</td>
<td>288</td>
<td>10%</td>
</tr>
<tr>
<td>Unknown</td>
<td>886</td>
<td>32%</td>
</tr>
<tr>
<td>Total</td>
<td>2783</td>
<td>100%</td>
</tr>
</tbody>
</table>

Carers were providing care in respect of a wide range of health conditions and disabilities and 40% of the carers (n=1138) were identified as providing care for multiple conditions. Table 4 lists all the conditions, but it should be noted that dementia, stroke, cancer and cardiovascular disease account for more than 50% of the conditions.

Moffat workers recorded, where appropriate, whether or not caring had negative impacts on carers’ health status for 74% (n=2048) of carers. Of these 51% (n=1051) had negative health impacts identified and 355 of these had more than one health area impacted (See Table 5).

Identification as a Carer
Moffat workers indicated that nearly 60% (n=1609) of the carers had been identified as carers during the hospitalisation of the person being cared for. Of those identified to the care teams, 49% were identified by a hospital nurse (see Table 6). Moffat workers accounted for 17% of the carers being identified as such. Figure 1 highlights that the different areas had different identification patterns. For example, hospital nurses were most likely to identify carers in all areas except Lothian. In Lothian hospital-based occupational therapists or Moffat workers identified more carers than other professional groupings.

---

3 Figures do not equal 100% due to rounding
<table>
<thead>
<tr>
<th>Health Condition/Disability</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>509</td>
<td>18%</td>
</tr>
<tr>
<td>Stroke</td>
<td>414</td>
<td>15%</td>
</tr>
<tr>
<td>Cancer</td>
<td>370</td>
<td>13%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>303</td>
<td>11%</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>275</td>
<td>10%</td>
</tr>
<tr>
<td>Poor mobility</td>
<td>261</td>
<td>9%</td>
</tr>
<tr>
<td>Respiratory/Pulmonary Disease</td>
<td>201</td>
<td>7%</td>
</tr>
<tr>
<td>Musculo-Skeletal Disorder</td>
<td>190</td>
<td>7%</td>
</tr>
<tr>
<td>General Debility</td>
<td>181</td>
<td>7%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>136</td>
<td>5%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>129</td>
<td>5%</td>
</tr>
<tr>
<td>Parkinson's Disease</td>
<td>120</td>
<td>4%</td>
</tr>
<tr>
<td>Fall</td>
<td>116</td>
<td>4%</td>
</tr>
<tr>
<td>Sensory Impairment</td>
<td>90</td>
<td>3%</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>75</td>
<td>3%</td>
</tr>
<tr>
<td>Developmental Disorder</td>
<td>51</td>
<td>2%</td>
</tr>
<tr>
<td>Neurological Disorder</td>
<td>49</td>
<td>2%</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>42</td>
<td>2%</td>
</tr>
<tr>
<td>Bowel Disorder</td>
<td>40</td>
<td>1%</td>
</tr>
<tr>
<td>Acute Infection</td>
<td>39</td>
<td>1%</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>38</td>
<td>1%</td>
</tr>
<tr>
<td>Incontinence</td>
<td>37</td>
<td>1%</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>37</td>
<td>1%</td>
</tr>
<tr>
<td>Brain Injury</td>
<td>33</td>
<td>1%</td>
</tr>
<tr>
<td>Blood Disorder</td>
<td>27</td>
<td>1%</td>
</tr>
<tr>
<td>Endocrine Disease/Disorder</td>
<td>26</td>
<td>1%</td>
</tr>
<tr>
<td>Vascular Disease/Disorder</td>
<td>25</td>
<td>1%</td>
</tr>
<tr>
<td>Amputee</td>
<td>23</td>
<td>1%</td>
</tr>
<tr>
<td>Digestive Disease/Disorder</td>
<td>23</td>
<td>1%</td>
</tr>
<tr>
<td>Physical Disability NOS</td>
<td>20</td>
<td>1%</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>15</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>121</td>
<td>4%</td>
</tr>
<tr>
<td>Unknown</td>
<td>63</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>4079</td>
<td></td>
</tr>
</tbody>
</table>
### Table 5: Area of Health Negatively Impacted by Caring

<table>
<thead>
<tr>
<th>Area of Health Negatively Impacted by Caring</th>
<th>N</th>
<th>% of Those Indicating Negative Impact</th>
<th>% of Entire Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>850</td>
<td>81%</td>
<td>31%</td>
</tr>
<tr>
<td>Musculo-skeletal</td>
<td>173</td>
<td>16%</td>
<td>6%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>115</td>
<td>11%</td>
<td>4%</td>
</tr>
<tr>
<td>Fatigue</td>
<td>70</td>
<td>7%</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>58</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>34</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Endocrine</td>
<td>33</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Neurological</td>
<td>29</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Digestive</td>
<td>25</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Cancer</td>
<td>19</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>1406</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 6: Who Identified Carers as Carers

<table>
<thead>
<tr>
<th>Professional Identifying Carer</th>
<th>N</th>
<th>% of Carers Identified as Carers⁴</th>
<th>% of All Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Nurse</td>
<td>786</td>
<td>49%</td>
<td>28%</td>
</tr>
<tr>
<td>Moffat Worker</td>
<td>266</td>
<td>17%</td>
<td>10%</td>
</tr>
<tr>
<td>Hospital Occupational Therapist</td>
<td>271</td>
<td>17%</td>
<td>5%</td>
</tr>
<tr>
<td>Hospital Social Worker</td>
<td>100</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Hospital Other</td>
<td>74</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Other Community Health or Social Work Staff</td>
<td>54</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Hospital Doctor</td>
<td>17</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Hospital Physiotherapist</td>
<td>15</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>22</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Total</td>
<td>1609</td>
<td>100%</td>
<td>58%</td>
</tr>
</tbody>
</table>

⁴ Figures do not equal 100% due to rounding
⁵ Social work is used to refer to all levels of social care workers. Social worker is used to refer only to qualified social work staff.
As can be seen in Table 7, very few of the carers were identified as such during the admission to the hospital. Importantly, nearly 50% of all the carers were identified prior to discharge, and of those who were identified as carers, 85% were identified prior to discharge. This suggests that few carers are identified on admission and though nearly 50% of the carers were identified during the hospital stay, there is still room for improvement as many carers were not identified at all. Figure 2 shows how the percentages of when carers were identified shifted over three time periods during the course of the project. For all areas except Glasgow the percentage of carers identified during the hospital stay increased. This suggests that the Project impacted upon earlier identification of carers. Surprisingly, Moffat workers indicated that only 14% (n=399) of the carers they had contact with were involved in discharge planning. If may be that more than 14% were involved, but that the Moffat Workers were not aware of or involved in that process as their work with carers may have been earlier in the hospitalisation process. Out of those carers identified as being involved in discharge planning, this occurred primarily through communicating with hospital staff (n=170), attending case conferences (n=123), or being consulted about the discharge plan (n=30). In addition, a few carers also received practical training in the ward such as moving and handling, attended family meetings, or simply were advised of the discharge plans.

**TABLE 7: WHEN IDENTIFIED AS A CARER**

<table>
<thead>
<tr>
<th>When Identified as a Carer</th>
<th>N</th>
<th>% of those Identified as Carers</th>
<th>% of All Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>During Hospitalisation</td>
<td>1321</td>
<td>82%</td>
<td>47%</td>
</tr>
<tr>
<td>At Discharge</td>
<td>246</td>
<td>15%</td>
<td>9%</td>
</tr>
<tr>
<td>On Admission</td>
<td>42</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>1609</td>
<td>100%</td>
<td>58%</td>
</tr>
</tbody>
</table>
Carers Assessments

Moffat workers indicate that 65% (n=1802) of the carers were informed of their right to an assessment. Figure 3 highlights how the Glasgow area was especially effective at informing carers of their right to an assessment as 77% were informed. Of those whom Moffat workers reported as knowing of their right, nearly all were informed by the Moffat worker, rather than regular NHS or Local Authority staff (See Table 8). In addition to informing carers about their right to have an assessment, Moffat workers facilitated the completion of a carer’s assessment for 17% of the carers (n=468). As can be seen in Table 9, referring carers to local Carers’ Centres and providing information were the primary means for facilitating the assessments. However, assisting with the self-assessment or carrying out the carer’s assessment were also facilitative means. Moffat workers knew of only 83 carers who received additional supports as a result of having a carer’s assessment. However, given the short duration of Moffat workers’ relationships with carers within a hospital setting, this low number should not be surprising.

---

6 Years do not correspond to 12 calendar months. 2008 included April through December, 2009 includes 12 months, 2010 includes January through April
TABLE 8: STAFF INFORMING CARER ABOUT RIGHT TO ASSESSMENT

<table>
<thead>
<tr>
<th>Who Informed Carer about their Right to Assessment</th>
<th>N</th>
<th>% of those Identified as Carers⁺⁺</th>
<th>% of All Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moffat Worker</td>
<td>1729</td>
<td>96%</td>
<td>62%</td>
</tr>
<tr>
<td>Hospital Social Worker</td>
<td>29</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Other Community Health or Social Work Staff</td>
<td>14</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Community Social Worker</td>
<td>13</td>
<td>1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Hospital Nurse</td>
<td>11</td>
<td>1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Hospital Other</td>
<td>6</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1802</td>
<td>100%</td>
<td>65%</td>
</tr>
</tbody>
</table>

TABLE 9: WAYS MOFFAT WORKER FACILITATED CARERS ASSESSMENTS

<table>
<thead>
<tr>
<th>Ways Moffat Worker Facilitated Carers Assessments</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred to CC Staff to help complete</td>
<td>166</td>
</tr>
<tr>
<td>Provided Information</td>
<td>125</td>
</tr>
<tr>
<td>Assisted with self-assessment</td>
<td>72</td>
</tr>
<tr>
<td>Referred to Social Work</td>
<td>51</td>
</tr>
<tr>
<td>Moffat Worker Carried out Assessment</td>
<td>39</td>
</tr>
<tr>
<td>Liaised with Professionals</td>
<td>9</td>
</tr>
<tr>
<td>Through Case Conference</td>
<td>6</td>
</tr>
</tbody>
</table>

Services Carers Received through Moffat Workers

As can be seen in Table 10, Moffat workers provided advice and information to 60% of the carers with whom they had contact. Instrumental support also was prominent and included services such as completing benefits checks, assisting with or completing forms on the carers’ behalf, or attending and assisting carers at discharge planning meetings. Many carers received more than one service.

⁺⁺Figures do not equal 100% due to rounding
In addition to providing direct services, Moffat workers referred carers to a multitude of services as required (See Table 11). Workers made referrals to local Carers’ Centres to facilitate ongoing support post-hospitalisation in and out of the pilot areas. Referrals were made to provide instrumental as well as informational and emotional support.

<table>
<thead>
<tr>
<th>Services</th>
<th>N</th>
<th>% of All Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice/Information</td>
<td>1675</td>
<td>60%</td>
</tr>
<tr>
<td>Registration with Carers Centre</td>
<td>923</td>
<td>33%</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>891</td>
<td>32%</td>
</tr>
<tr>
<td>Benefits Check</td>
<td>104</td>
<td>4%</td>
</tr>
<tr>
<td>Assessment</td>
<td>73</td>
<td>3%</td>
</tr>
<tr>
<td>Form filling</td>
<td>36</td>
<td>1%</td>
</tr>
<tr>
<td>Carers Information Pack</td>
<td>34</td>
<td>1%</td>
</tr>
<tr>
<td>Completion of Carers Assessment</td>
<td>25</td>
<td>1%</td>
</tr>
<tr>
<td>Completion of DLA Paperwork</td>
<td>17</td>
<td>1%</td>
</tr>
<tr>
<td>Advocacy</td>
<td>14</td>
<td>1%</td>
</tr>
<tr>
<td>Assistance with Discharge Planning</td>
<td>11</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Others</td>
<td>22</td>
<td>1%</td>
</tr>
</tbody>
</table>

In addition to providing direct services, Moffat workers referred carers to a multitude of services as required (See Table 11). Workers made referrals to local Carers’ Centres to facilitate ongoing support post-hospitalisation in and out of the pilot areas. Referrals were made to provide instrumental as well as informational and emotional support.

<table>
<thead>
<tr>
<th>Referrals</th>
<th>N</th>
<th>% of All Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers’ Centre</td>
<td>1197</td>
<td>43%</td>
</tr>
<tr>
<td>Benefits Check</td>
<td>304</td>
<td>11%</td>
</tr>
<tr>
<td>Social Work</td>
<td>245</td>
<td>9%</td>
</tr>
<tr>
<td>Voluntary Organisation</td>
<td>109</td>
<td>4%</td>
</tr>
<tr>
<td>GP or other Health Care</td>
<td>61</td>
<td>2%</td>
</tr>
<tr>
<td>Occupational Health Services</td>
<td>53</td>
<td>2%</td>
</tr>
<tr>
<td>Carers’ Assessment</td>
<td>49</td>
<td>2%</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>46</td>
<td>2%</td>
</tr>
<tr>
<td>Therapeutic Services</td>
<td>37</td>
<td>1%</td>
</tr>
<tr>
<td>Advice/Information</td>
<td>37</td>
<td>1%</td>
</tr>
<tr>
<td>Support Group</td>
<td>31</td>
<td>1%</td>
</tr>
<tr>
<td>Respite</td>
<td>26</td>
<td>1%</td>
</tr>
<tr>
<td>Advocacy</td>
<td>19</td>
<td>1%</td>
</tr>
<tr>
<td>Telecare</td>
<td>19</td>
<td>1%</td>
</tr>
<tr>
<td>Day Care</td>
<td>16</td>
<td>1%</td>
</tr>
<tr>
<td>Care and Repair, Cleaning</td>
<td>15</td>
<td>1%</td>
</tr>
<tr>
<td>Befriending</td>
<td>13</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Training</td>
<td>12</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Transportation</td>
<td>12</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Misc</td>
<td>24</td>
<td>1%</td>
</tr>
</tbody>
</table>
Training and Activity Logs
Though a large part of the activities of the Moffat workers focused on carers directly, another important area of work focused on working with health and social work systems and the people that work in those systems. The four project areas approached this work somewhat differently or placed greater or lesser emphasis on the different areas of work. As such, project areas were asked to keep a record of the activities that were not captured within the carer-focused database. Though not all of the centres involved across the four areas recorded all of their “other” activities several of them did, and these results are reported here.

The centres recorded various activities and indicated the nature of the activity and the number of people involved or benefitting from the activity. These activities fell broadly into three categories. Presentations and training events were educational events aimed primarily at health and social work staff, though Borders included police officers and students in health and social care vocational courses as well. These training events were designed to raise awareness of carers’ issues and how to support and work with carers. This included topics such as carers’ assessments and resources/supports available to support carers. Systems work included meeting with staff in health and social work settings to discuss organisational issues such as referrals, developing protocols for identifying and supporting carers, etc. The third area could be described as case finding activities. Only training and systems work will be reported here. Also it should be noted that not all areas rigorously used the Training and Activity Logs, so these data are an underreporting of the actual scale of work undertaken across all the Moffat sites. However, they do give an indication of the types and scale of work that occurred. Table 12 demonstrates that more than 3,507 health, social work/, and police professionals received carer training during the Moffat Project in three out of the four project areas. In addition, at least 662 contacts occurred in two Moffat areas between Moffat workers and health and social work staff regarding improving organisational systems for carers.

Table 12: Training and Systems Working Contacts

<table>
<thead>
<tr>
<th></th>
<th>Borders</th>
<th>Glasgow</th>
<th>Lothian</th>
<th>Total Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training/Presentations</td>
<td>1832</td>
<td>1167</td>
<td>508</td>
<td>3507</td>
</tr>
<tr>
<td>Systems Work</td>
<td>Not reported</td>
<td>486</td>
<td>175</td>
<td>662</td>
</tr>
<tr>
<td>Total Contacts</td>
<td>1543</td>
<td>1653</td>
<td>683</td>
<td>4169</td>
</tr>
</tbody>
</table>

Carers’ Questionnaires

Postal questionnaires were sent to three different groups of carers at three different points of time. Time One respondents were carers who were registered with the Carers’ Centres involved in the pilot prior to the beginning of the project. In addition, one centre not in the pilot also sent out some questionnaires to provide a comparison group. Time Two occurred one year into the project and respondents were carers who had received services from a Moffat Project worker in the 6 months prior to the questionnaire being sent out. Time three occurred two years into the project and again respondents were carers who had received services from a Moffat Project worker in the 6 months prior to the questionnaire being sent out. Questionnaires were not sent out to the comparison site at Time Two or Time Three as
this proved impractical. The numbers of returned usable questionnaires and response rates are summarised by time and area in Table 13.

<table>
<thead>
<tr>
<th>Area</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire</td>
<td>21</td>
<td>52</td>
<td>11</td>
<td>84</td>
<td>21.6</td>
</tr>
<tr>
<td>Borders</td>
<td>27</td>
<td>8</td>
<td>10</td>
<td>45</td>
<td>11.6</td>
</tr>
<tr>
<td>Glasgow</td>
<td>51</td>
<td>41</td>
<td>30</td>
<td>122</td>
<td>31.4</td>
</tr>
<tr>
<td>Comparison Site</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>3.1</td>
</tr>
<tr>
<td>Lothian</td>
<td>24</td>
<td>53</td>
<td>49</td>
<td>126</td>
<td>32.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>135</td>
<td>154</td>
<td>100</td>
<td>389</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Response Rate**

- 5%
- 12%
- 7%
- 7%

**Demographics**

Most of the carers were over the age of 45 with 48% being between the ages of 45 and 64 and 40% being over 65 years of age. Only 10% of the respondents were between 30 and 44. The remaining 2% were young carers (Figure 4). Most carers are women (Carers UK, 2009) and this is reflected in the evaluation as the majority of carers were women (75%) compared with 23% being male. Six carers did not identify their gender. Figure 5 demonstrates that most carers were caring for a spouse or parent. The sample was overwhelmingly white with only 2% of the respondents indicating an ethnicity other than white.
Carers were involved in providing care to people with a wide range of health conditions and disabilities. Table 14 summarises these conditions, however it should be noted that dementia, stroke, musculo-skeletal disorders (e.g., fractures, hip/knee replacements, scoliosis, rheumatoid arthritis) and respiratory disease were the largest groups. Cancer, one of the big killers in Scotland, may be underrepresented as only 8% of the participants indicated they were caring for someone with cancer.

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>79</td>
<td>20%</td>
</tr>
<tr>
<td>Stroke</td>
<td>67</td>
<td>17%</td>
</tr>
<tr>
<td>Musculo-Skeletal Disorder</td>
<td>57</td>
<td>15%</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>56</td>
<td>14%</td>
</tr>
<tr>
<td>Respiratory/Pulmonary Disease</td>
<td>44</td>
<td>11%</td>
</tr>
<tr>
<td>Neurological Disorder</td>
<td>43</td>
<td>11%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>34</td>
<td>9%</td>
</tr>
<tr>
<td>Cancer</td>
<td>30</td>
<td>8%</td>
</tr>
<tr>
<td>Endocrine Disease/Disorder</td>
<td>28</td>
<td>7%</td>
</tr>
<tr>
<td>General Debility</td>
<td>28</td>
<td>7%</td>
</tr>
<tr>
<td>Developmental Disorder</td>
<td>21</td>
<td>5%</td>
</tr>
<tr>
<td>Sensory Impairment</td>
<td>14</td>
<td>4%</td>
</tr>
<tr>
<td>Digestive Disease/Disorder</td>
<td>11</td>
<td>3%</td>
</tr>
<tr>
<td>Poor Mobility</td>
<td>8</td>
<td>2%</td>
</tr>
<tr>
<td>Head Injury</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td>Amputee</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>14</td>
<td>4%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>10</td>
<td>3%</td>
</tr>
</tbody>
</table>
The average length of time carers reported caring was 6.4 years. However, the standard deviation was 7.4, which might suggest that the data were skewed towards the lower range of time. Figure 6 graphically displays this skew in the data, and this confirms that most of the carers were fairly new to their caring roles.

Though the carers may be relatively new to their caring roles, they report providing a significant amount of care each week. For example, Figure 7 shows that 64% of the respondents report providing more than 50 hours of care each week. Given that the people being cared for had been hospitalised within the previous 6 months, this high level of care should not be surprising. This high level of care can also be explained by the number of repeat hospitalisations. Approximately 55% of the persons being cared for had been hospitalised more than once in the 12 months prior to completing the questionnaire. Nearly 25% had been hospitalised twice while 13% had been in the hospital 3 times. Finally, 18% had been hospitalised 4 or more times. Such high levels of readmission suggest that decreasing readmission rates was an important though, perhaps, an overambitious programme goal.
There were no statistically significant differences on these demographic variables presented above between the different Moffat Project areas. This suggests that the carers were similar in all four areas.

Despite many of these carers being relatively new to the caring role, they were fairly well known as occupying a caring role by health and social work professionals and their families (Table 15). For example, 88% (n=341) reported that their families knew they were carers and more than 70% said that social work or some other health professional knew they were carers. Importantly, only 41% reported that their GP knew they were carers.

<table>
<thead>
<tr>
<th>People/Organisation</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>341</td>
<td>88%</td>
</tr>
<tr>
<td>Other Health Professional</td>
<td>158</td>
<td>77%</td>
</tr>
<tr>
<td>Social Work</td>
<td>255</td>
<td>70%</td>
</tr>
<tr>
<td>Carers Organisation</td>
<td>273</td>
<td>66%</td>
</tr>
<tr>
<td>GP</td>
<td>300</td>
<td>41%</td>
</tr>
<tr>
<td>Other Voluntary Organisation</td>
<td>89</td>
<td>23%</td>
</tr>
</tbody>
</table>

**Identification of Carers**

One of the main aims of the Moffat Project was to promote early identification, intervention and support for carers. If the project was successful in this aim then there should be an increase in the identification of carers and the identification and support should occur earlier than before the Moffat interventions began. To test this out several questions were asked on the Carers’ Questionnaire. The first simply asked if the carer was identified as a carer on admission, during the hospital stay, on discharge or never. A Chi-square test for independence indicated that there was a significant difference in time of identification as a
carer between pre-test (Time 1) and post-tests (Time 2 and Time 3), $X^2 (6, n=382) = 22.05$, Cramer’s $V = .17$. Looking at the data graphically in Figure 8 one can see that initially 66% of carers were never identified as such prior to Moffat. This figure falls to approximately 50% at both post-test periods. If the data from Time 2 and Time 3 are combined into a single post-test, the changes from pre to post-test become even more apparent (See figure 9). Though there is a slight decrease in identification at admission, there is an increase in identification during the hospital stay and during the discharge process.

![Figure 8: Identification of Carers at Times 1, 2 & 3](image)

![Figure 9: Identification of Carers from Pre to Post-Tests](image)

Carers were also asked if they felt they had been acknowledged early enough in the hospitalisation for their views to be taken into consideration. However, there was no statistical difference from pre-test to post tests, $X^2 (2, n=375) = 2.64$, Cramer’s $V = .08$. 

23
Though the number of carers indicating they received information increased from 33% to 40%, the change was not statistically significant, $X^2 (1, n=389) = 1.4, p = .11$, phi = .07. There also was no significant change in the number of carers receiving some sort of practical training prior to discharge relating to the care that would be required post-discharge, $X^2 (2, n=374) = 5.80, p = .06$, Cramer’s V = .13. There was a small effect size noted, but as the number of people receiving practical training was so small, a larger sample size would be required to find a statistical difference.

A one-way between-groups analysis of variance (ANOVA) was conducted to explore if there was a difference between the three groups of carers (pre-test, post-tests 1&2) in the ratings of support from hospital and social work staff during the hospitalisation episode. There was a statistically significant difference at the $p < .05$ level in the ratings of support, $F (2, 370) = 3.29, p = .04$. The effect size, calculated using eta squared, was .02. Post-hoc comparisons using Tukey HSD reveals that the mean score for the pre-test group ($M=1.87, SD = 1.43$) was significantly different from the scores for Time 2 carers ($M=2.28, SD = 1.33$). The final post-test (Time 3) did not differ significantly from either of the other time periods ($M=2.20, SD = 1.39$). Figure 10 graphically represents the relationship. This suggests that carers surveyed at Time 2 felt more supported than carers at Time 1 or Time 3.

![Figure 10](image.png)

**FIGURE 10: SUPPORT RATINGS FROM HOSPITAL AND SOCIAL WORK STAFF FROM PRE-TEST TO POST-TESTS**

**Carers’ Experiences of Admissions**

Carers were asked to rate their experience of being consulted during the admissions process. This 5 point scale ranged from Not At All to Fully. Using an ANOVA to test for differences between the three groups of carers found no significant difference between pre-test and post-tests, $F= (2, 373) = 1.03, p = .66$. Similarly there was no change in the rating of the overall admissions process, $F= (2, 369) = 2.01, p = .14$. 

24
**Carers’ Assessments**

There was a significant positive difference in the number of carers informed of their right to have a carer’s assessment, $X^2 (2, n=377) = 25.56, p=.00$. Cramer’s V was calculated to be .25, and this suggests a medium effect size. At the pre-test only 14% of the 129 respondents had been informed of their right to an assessment. This percentage increased to 38% of the 151 respondents at Time 2 and to 39% of the 94 respondents at Time 3. The distribution of the data for this question allowed for further comparisons across the four project areas by combining Time 2 and Time 3 results using Chi-square with Yates correction. In these analyses, the statistically significant changes occur within Glasgow ($X^2 (1, n=118) = 4.04, p=.04$) and Lothian ($X^2 (1, n=122) = 5.70, p=.02$). However, as can be seen in Figure 11, increases occurred across all four areas\(^8\). As the numbers of carers informed of their right to an assessment increased, there was a corresponding increase in the number of carers who were offered an assessment by Social Work Departments, $X^2 (4, n=370) = 29.64, p=.00$, Cramer’s V=.19 (see figure 12). Cross area comparisons were not possible for this question without violating statistical assumptions.

![Increase in Carers Informed about Right to Assessment by Area](image)

**FIGURE 11: INFORMED OF RIGHT TO ASSESSMENT BY AREA**

When asked when a carer’s assessment was offered, 106 of the respondents indicated whether the offer was made prior to discharge, on discharge, shortly after discharge or much later. To prevent the violation of statistical assumptions, data from Time 2 and Time 3 were combined into one post-test in order to test for differences between pre-test and post-tests. The Chi-square for test for independence indicated a significant association between pre-test/post-test and when the offer of an assessment was made, $X^2 (3, n=106) = 11.61, p=.01$, Cramer’s V=.33. Figure 13 demonstrates how the offer of an assessment moved from mostly much later than discharge to just prior to or shortly after discharge. The Cramer’s V calculation suggests a large effect size regarding the changes in when an assessment was offered. Overall

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\(^8\) Though there is a large increase in the percentage in Borders, the numbers of carers answering yes to this question was quite small. As such statistical significance was not reached.
65% of 114 people offered a carer’s assessment received an assessment, and though the percentage of offers to receiving an assessment increased over the three time periods assessed by the questionnaire from 52% to 69%, this was not statistically significant difference, \( X^2 (2, n=114) = 2.65, p=.265, \) Cramer’s V=.15. Carers were more likely to obtain additional support after the carer’s assessment at Time 2 and Time 3 as compared to the Pre-test, \( X^2 (2, n=93) = 9.47, p=.01, \) Cramer’s V=.32. Table 16 illustrates that only 25% of those responding to this question indicated that any additional support was provided at pre-test, but at Time 3, 59% of the respondents reported additional supports were received.
A one-way between-groups analysis of variance (ANOVA) was conducted to explore if there was a difference between the three groups of carers (pre-test, post-tests 1&2) in the ratings of their experience of having had a carer’s assessment. Carers rated their experience on a 5-point scale from Not Helpful to Very Helpful. There was a statistically significant difference at the \( p < .05 \) level in the ratings of helpfulness, \( F (2, 83) = 3.47, p = .04 \). The effect size, calculated using eta squared, was .08, which suggests a medium effect. Post-hoc comparisons using Tukey HSD reveals that the mean scores for the pre-test group (\( M=1.862, SD = 1.31 \)) was significantly different from the scores for Time 3 (\( M=2.66, SD = 1.40 \)). Time 2 scores did not differ significantly from either of the other time periods (\( M=2.54, SD = 1.29 \)). Figure 14 graphically represents the relationship. These findings suggest that carers found the experience of having a carer’s assessment to be more helpful at Time 3 as compared to the Pre-test. These differences may be partially explained by the increased likelihood of receiving additional help as reported above.

| TABLE 16: DID ASSESSMENT LEAD TO ADDITIONAL SUPPORT? |
|----------------|-------|------|------|
| Time           | Yes   | No   | Total|
| Pre-Test       | Count | 5    | 15   | 20   |
|                | %     | 25%  | 75%  | 100% |
| Time 2         | Count | 27   | 14   | 41   |
|                | %     | 66%  | 34%  | 100% |
| Time 3         | Count | 19   | 13   | 32   |
|                | %     | 59%  | 41%  | 100% |
| Total          | Count | 51   | 42   | 93   |
|                | %     | 55%  | 45%  | 100% |

FIGURE 14: HELPFULNESS OF CARER’S ASSESSMENT EXPERIENCE
Discharge Planning

Carers were asked if there was a discharge plan in place for the person they cared for when leaving the hospital. As one of the goals of the Project was to increase carer involvement in hospital discharge processes, it was hypothesised that there would be an increase in the number of carers indicating yes over the course of the project. A Chi-square test for independence indicated a significant association between discharge plans being in place and pre-test/post-tests, $X^2(4, n=356) = 15.13, p=.00$. The effect size, calculated using Cramer’s $V=.15$, was approaching a medium effect. As can be seen in Figure 15, the percentage of carers indicating that a discharge plan was in place increased from a low of 35% to a high of nearly 60%. There was a corresponding decrease in the number of carers indicating that no discharge plan was in place.

![Discharge Plan in Place?](image)

Carers were also asked how their needs were taken into account during the discharge process on a 5 point scale from Not at All to Fully. It was hypothesised that carers would report that their needs and views were more fully taken into account over the course of the project. A one-way between-groups analysis of variance (ANOVA) was conducted to explore if there was such a difference between the three groups of carers. There was a statistically significant difference at the $p < .05$ level, $F(2, 338)=4.28, p = .02$. The effect size, calculated using eta squared, was .02. Post-hoc comparisons using Tukey HSD reveals that the mean scores for the pre-test group ($M=1.30, SD = 1.59$) was significantly different from the scores for Time 2 ($M=1.80, SD = 1.54$) and for Time 3 ($M=1.83, SD = 1.54$). Time 2 and 3 scores did not differ significantly from each other, suggesting that the increase between pre-test and time 2 were maintained. Figure 16 graphically represents the relationship. Despite there being an increase in the percentage of carers reporting a discharge plan was in place and an increase in carers feeling part of the discharge plan, there was not an increase in carers reporting that the discharge plan had been carried out. Though the percentages of carers indicating an increase
in discharge plans being carried out increased from 47% to 61% from pre-test to Time 1, the differences were not statistically significant, \( X^2 (4, n=304) = 5.58, p=.23, \) Cramer’s \( V=.01. \) Across all time periods, 55% of the carers reported that discharge plans had been carried through compared with 24% who indicated they had not. Approximately 21% indicated that they did not know if the discharge plans had been carried through. Carers were asked how prepared they were for continuing in their caring role post discharge using a 5 point scale (0-4) from Full Prepared to Not at All Prepared. There was no statistical difference across the three groups and the average score was 2.62, \( F (2, 344) =.783, p = .46 \)

![FIGURE 16: RATING OF HOW FULLY CARERS’ NEEDS AND VIEWS TAKEN INTO ACCOUNT DURING DISCHARGE PROCESS](image)

**Support as a Carer**

Carers were asked how supported they felt in relation to being a carer on a 5 point scale from Not at All Supported to Fully Supported. A one-way between-groups analysis of variance (ANOVA) was conducted to explore if there was a difference between the three groups of carers (pre-test, post-tests 1&2. There was not a statistically significant difference at the \( p < .05 \) level, \( F (2, 349)=2.58, p = .08. \) The mean scores for each time period clustered around the mid-point of the scale suggesting that carers did not feel more supported by the end of the Project. This finding is different from the earlier finding (see Figure 10) that carers felt more supported by hospital and social work staff during the previous hospitalisation. A further contradiction is that there was a difference among the groups in the rating of services being flexible and available to carers, \( F (2, 313)=3.71, p = .03 \) Post-hoc comparisons using Tukey HSD reveals that the mean scores for the pre-test group (\( M=1.76, SD = 1.44 \)) were significantly different from the scores for Time 2 (\( M=2.24, SD = 1.31 \)). Time 3 (\( M=2.10, SD \))

29
scores did not differ significantly from Pre-test or Time 2. Figure 17 illustrates the relationship. These findings suggest that carers felt more supported overall, but not more supported as a carer.

![Figure 17: Services Flexible/Available to Carers](image)

Over the two year period of the Moffat Project there appears to be an increase in carers’ experience of having their expertise recognised by service providers and care professionals. A one-way between-groups analysis of variance (ANOVA) found there was a statistically significant difference between the three groups of carers (pre-test, post-tests 1&2), $F(2, 344)=9.90, p = .01$. Post-hoc comparisons using Tukey HSD reveals that the mean scores for the pre-test group and Time 3 were significantly different and this difference can be seen in Figure 18. At the same time, scores significantly increased in how fully carers felt they had a say in shaping the services received by them or the person they care for, $F^9(2, 213.30)=4.00, p = .02$. Post-hoc comparisons using Tukey HSD reveals that the mean scores for the pre-test group and Times 2 and 3 were significantly different and this difference can be seen in Figure 19.

---

The assumption of homogeneity of variance was violated, therefore the Welch $F$–ratio is reported.
Respondents were asked if they felt that care professionals understood their needs as a carer. Again a one-way between-groups analysis of variance (ANOVA) was calculated to test for differences across the pre-test and post-tests. A statistically significant difference was found $F (2, 355)=4.80, p = .01$. The effect size, calculated by eta, was .03, which is a small to
medium effect size. Post-hoc comparisons using Tukey HSD reveals that the mean scores for the pre-test group were different from both Time 2 and Time 3. Figure 20 graphically demonstrates the more positive in mean scores.

![FIGURE 20: DO CARE PROFESSIONALS UNDERSTAND YOUR NEEDS AS A CARER?](image)

Following these analyses, two-way between groups analyses of variance were conducted to explore differences between Project areas, time period (e.g., baseline or post-test) and variables related to carer support where significant differences were found across time periods. Differences across areas were found in three variables: feelings that professionals recognise carers’ expertise, having a say in shaping services received, and care professionals understanding needs as a carer. Table 17 presents the statistical information, while Figures 21-23 graphically depict the differences by area. These suggest that all areas except Ayrshire saw increased scores regarding carers’ perceptions of recognition of their expertise by professionals. Ayrshire and the Borders saw an increase in carers feeling they had a say in shaping the services they received. Finally, all areas except the Lothians saw increased scores concerning care professionals understanding the needs of the carers as carers.

<table>
<thead>
<tr>
<th>TABLE 17: DIFFERENCES ACROSS AREAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
</tr>
<tr>
<td>How much do you feel your expertise is recognised by care professionals?</td>
</tr>
<tr>
<td>How much do you feel you have a say in shaping the services received?</td>
</tr>
<tr>
<td>How much do care professionals understand your needs as a carer?</td>
</tr>
</tbody>
</table>

32
As carers reported increasing feelings of partnership between professionals and themselves over the life of the project, a similar perceived improvement in partnership working between health, social work and carers’ organisations was found over time as well. Carers were asked to rate how well they felt such agencies worked together on a scale from Not at all to Fully (0-4). A statistically significant difference was found, $F (2, 340)=6.63, p = .00$. Post-hoc comparisons using Tukey HSD reveals that the mean scores for the pre-test group and Times 2 and 3 were all significantly different from each other. The mean scores at pre-test were 1.55 ($SD=1.22$), and increased to $M=2.01$ and 2.16 ($SD= 1.37 & 1.25$) at Times 1 & 2. The effect size, calculated by eta, was .04, which is a small to medium effect size.
Three important areas where no significant changes were found included carers’ self reports regarding their confidence in coping with practical tasks involved in caring, knowledge of the health condition of the person they were caring for, and on the impact of caring on their physical/mental health. The results are summarised in Table 18.

### Table 18: Confidence, Knowledge and Health Impact

<table>
<thead>
<tr>
<th>Question</th>
<th>F</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical/mental health affected by caring role</td>
<td>1.43</td>
<td>2</td>
<td>.24</td>
</tr>
<tr>
<td>Confidence in coping with practical tasks</td>
<td>1.00</td>
<td>2</td>
<td>.37</td>
</tr>
<tr>
<td>Understanding the person’s health condition</td>
<td>1.00</td>
<td>10</td>
<td>.37</td>
</tr>
</tbody>
</table>

Carers were asked if they received help with a range of 9 services or supports, ranging from help accessing benefits to emotional support. A Chi-square test for independence was conducted to test for differences in receiving help in the 9 areas between the baseline period and the two post-tests. In Table 19 we can see that a statistically significant difference occurred in only two supports/services. These are aids and adaptations and accessing training. The percentage of carers receiving help with accessing aids and adaptations increased from 50% at baseline to 64% at Time 3. Interestingly, the percentage of people receiving help to access training was actually lower at Time 3 than at the baseline period (from 11% down to 3%). There were no differences between groups of carers in receiving help in accessing benefits, finances, leisure, employability, respite or practical support.

Carers were asked if they received any training in relation to their role as a carer since the person they cared for was discharged from hospital. As in the previous section, a significant difference was found between the groups of carers at baseline, and post-tests when a Chi-square test for independence was calculated: \( X^2 (2, n=318) = 7.76, p=.02 \), Cramer’s V = .15. The drop in receiving training was from 16% to 8% of carers from baseline to Time 3. These

---

10 The assumption of homogeneity of variance was violated, therefore the Welch F–ratio is reported
decreases in help accessing training and actually having training may be partially explained by the fact that the carers surveyed at the baseline period were already known to Carers’ Centres whereas carers at the two post-test periods were newly identified carers.

<table>
<thead>
<tr>
<th>Received Help With</th>
<th>Df</th>
<th>N</th>
<th>X^2</th>
<th>p</th>
<th>Cramer’s V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessing Benefits</td>
<td>2</td>
<td>389</td>
<td>.842</td>
<td>.66</td>
<td>.05</td>
</tr>
<tr>
<td>Finances</td>
<td>2</td>
<td>389</td>
<td>1.76</td>
<td>.42</td>
<td>.07</td>
</tr>
<tr>
<td>Aids/Adaptations*</td>
<td>2</td>
<td>389</td>
<td>6.30*</td>
<td>.04</td>
<td>.13</td>
</tr>
<tr>
<td>Leisure</td>
<td>2</td>
<td>389</td>
<td>1.89</td>
<td>.39</td>
<td>.07</td>
</tr>
<tr>
<td>Employability</td>
<td>2</td>
<td>389</td>
<td>1.26</td>
<td>.53</td>
<td>.06</td>
</tr>
<tr>
<td>Respite</td>
<td>2</td>
<td>389</td>
<td>2.73</td>
<td>.26</td>
<td>.08</td>
</tr>
<tr>
<td>Practical Support</td>
<td>2</td>
<td>389</td>
<td>1.10</td>
<td>.58</td>
<td>.05</td>
</tr>
<tr>
<td>Accessing Training*</td>
<td>2</td>
<td>389</td>
<td>7.12*</td>
<td>.03</td>
<td>.14</td>
</tr>
</tbody>
</table>

*Statistically significant at p<.05

Frontline Workers’ Questionnaire

In addition to data collected from Moffat Project workers and directly from carers, questionnaires were sent out to NHS and Local Authority workers who were identified by Moffat workers as having had some contact with project workers. These questionnaires were designed to find out about frontline workers’ experiences of working with Moffat workers and how that contact may have influenced practice or policy within their work settings. In total 51 questionnaires were returned from three out of the four areas Figure 24 highlights the professional breakdown of the respondents. Combined, nurses and occupational therapists comprised nearly two-thirds of the respondents. Table 20 summarises which Local Authority or Health Boards are represented by the respondents.

![Profession of Respondents](image)

**FIGURE 24: PROFESSION OF RESPONDENTS TO FRONLINE WORKER QUESTIONNAIRE**
TABLE 20: HEALTH BOARD OR LOCAL AUTHORITY OF RESPONDENTS

<table>
<thead>
<tr>
<th>Health Board or Local Authority</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Greater Glasgow &amp; Clyde</td>
<td>20</td>
<td>39%</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>14</td>
<td>27%</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Glasgow City Council</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Borders Council</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Edinburgh City Council</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>East Lothian Council</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>51</td>
<td>100%</td>
</tr>
</tbody>
</table>

Most of the respondents had a substantial amount of contact with Moffat workers. For example, 63% of the respondents had more than 10 contacts and another 18% had between 6 and 10 contacts. Three (6%) respondents indicated that they did not have any contact and 14% had a small amount of contact (between 1-5 contacts). As seen in Table 21, nearly 75% of respondents had informal contact or discussion with Moffat workers and approximately 60% engaged in joint working with a Moffat worker. Nearly the same amount used a Moffat worker as a source of information. When asked the length of time they had contact with a Moffat worker, nearly half (49%) of the respondents reported having contact lasting more than a year with a Moffat worker and one-third of the respondents had contact from 6-12 months. Five of the respondents (9.8%) had contact lasting less than 6 months. The remaining 7% of respondents did not indicate the length of time the contact existed. Finally, when asked about referring carers, over 80% (n=41) of the respondents had referred a carer to a Moffat worker.

TABLE 21: NATURE OF CONTACT

<table>
<thead>
<tr>
<th>Nature of Contact</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal Contact/Discussion</td>
<td>37</td>
<td>73%</td>
</tr>
<tr>
<td>Joint Working</td>
<td>31</td>
<td>61%</td>
</tr>
<tr>
<td>Source of Information</td>
<td>30</td>
<td>59%</td>
</tr>
<tr>
<td>Resource</td>
<td>27</td>
<td>53%</td>
</tr>
<tr>
<td>Training</td>
<td>18</td>
<td>35%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>6%</td>
</tr>
</tbody>
</table>

Based on the responses from this group of frontline workers, it appears that the Moffat Project made an important impact on the practice of these workers. For example Figures 25 & 26 graphically display how frontline workers positively rated the impact Moffat workers had on their understanding of the needs of carers and on actual work practices. In addition, Figure 27 suggests that 90% of frontline workers would now identify carers on admission or during a hospital stay. Figure 28 shows that these frontline workers would also be likely to refer to a Moffat carer support worker.
When asked to explain further what that impact was on their practice, 23 respondents provided further information. There is a clear picture that emerges which relates to them having more information that can lead to greater understanding of carers (10 respondents), support in relation to ongoing work (5 respondents) and for a further four this entailed using
the project workers as a source of referral. The nature of the responses is exemplified by the following quote from one of the respondents:

*Our worker has been very proactive in contacting families and carers and provided invaluable support and advice*

![Figure 27: When most likely to identify a carer](image)

![Figure 28: When most likely to refer to Moffat](image)

The Frontline Workers’ Questionnaire also asked about specific areas of the respondents’ practice that the Moffat workers may have influenced. These areas included the care planning and discharge planning process, written information provided to carers, information regarding
the right to carers’ assessments, numbers of carers’ assessments completed, and inter-agency working. As can be seen in Figures 29 and 30, respondents again report that Moffat workers had a significant impact on personal practice. This is most noticeable in terms of written information provided to carers, information about the right to an assessment, and the numbers of carers’ assessments completed.

![Figures 29 and 30: Influence of Moffat Workers on Respondents' Practice](image)

Questions were also asked about influences on the organisational practices, generally and in several key areas (Figures 31 & 32). For example, respondents were asked to rate on a 5-point semantic differential scale the overall impact on the Moffat workers on their organisation’s services for carers. Over 62% indicated that the impact was at two points closest to Significant Impact and only 6% indicated the impact was at the two points closest to No Impact. Specifically respondents were asked how much the Moffat workers influenced the organisation’s ability to identify carers, to include carers in protocols/procedures, make written information available to carers, and provide information regarding carers’ right to an
assessment. The responses on the semantic differential scales regarding carer identification and protocols were normally distributed rather than skewed towards significant. However it does suggest important influence none the less. The influence on organisation regarding written information provision and informing carers about their right to an assessment as approximately 50 to 55% of the respondents rated these questions at two points closest to Significantly Influenced.

![How Much Moffat Workers Influenced the Organisation](image1.png)

**FIGURE 31: INFLUENCE OF MOFFAT WORKERS ON ORGANISATION REGARDING CARER IDENTIFICATION AND PROTOCOLS**

Respondents were asked about any training they may have received from Moffat workers. Approximately 42% (n=22) of the respondents reported receiving training from Moffat workers. These 22 respondents rated the training favourably and indicate that it helped to prepare them to work with carers. The nature of the training according to 17 respondents who provided additional comments in this area indicated that the training related to information about the Moffat Project, the project workers’ role and the support they can provide to staff.
(7 respondents). They also suggested that specific information on carers’ situations and services that are available were an additional feature of the training offered (6 respondents).

Finally respondents were asked to provide additional information about their experiences working with the Moffat workers. Their responses (27) reflected a positive picture in relation to the workers being friendly and approachable (4 respondents) and also providing a prompt feedback on referrals made to the project (5 respondents). That said one respondent did emphasise that they had not received feedback following referral. The most common theme to arise in relation to the participants was that they had seen the Moffat workers as both informative and supportive (15 respondents) and raising their awareness (4 respondents). This pattern is evident in the following quotes from two respondents:

*Very good resource. As nurses we tend to look at things from the patient’s point of view. Good to get another perspective on things.*

*Very helpful. Got back to you very quickly if you needed any advice or help with a patient or their carer. Easy to approach and a very friendly manner.*

There were also a small number of respondents (2) who commented on the Moffat Project role in joint working and one who felt that the Moffat worker had been able to lighten their load by being able to answer questions. Three of the respondents also commented on the need for there to be a dedicated worker to represent the needs of carers.
Summary of Key Findings from Quantitative Data

Before moving on to presenting the findings from the interviews with the key stakeholders, the results from the quantitative elements of the evaluation will be summarised.

Key Findings from Database

- Many of the carers were early in the caring trajectory as 13% were in the first year of caring and 35% had been caring for between one and five years.
- Nurses, Moffat workers and occupational therapists were key to identifying carers.
- Nearly 60% of carers in the database had been identified as carers during the period when the person they cared for was hospitalised. The percentage of carers identified during the hospital period increased over the course of the project.
- Nearly two-thirds of the carers had been informed of their right to an assessment. Moffat workers were the primary informers as they provided the information to 62% of all carers in the database.
- Moffat workers facilitated carers’ assessments for 17% of the carers in the database.
- Moffat workers provided a wide range of services/supports to carers. Information and advice was provided to 60% of the carers. Emotional and instrumental supports were also provided.
- Referrals were made to support carers post-hospitalisation. Referrals to organisations providing instrumental, informational and emotional supports.
- Moffat workers provided carers’ issues training to more than 3,000 health, social work and police professionals.

Key Findings from Pre/Post-Test Questionnaires

- Questionnaire respondents were also early career carers.
- Nearly 65% of carers were providing more than 50 hours of care per week.
- 55% of the people being cared for had been hospitalised more than once in the 12 months prior to questionnaire completion.
- From the baseline period to the end of the project there was a significant increase in the percentage of carers being identified as a carer during a hospitalisation episode.
- No statistically significant differences were found from the baseline period to the end of the project in the areas of receiving information, practical training, being recognised early enough for carers’ views to be taken into consideration.
- Carers report more positive feelings of being supported by hospital and social work staff at Time 2 as compared to carers from the baseline period, however, this statistically significant improvement does not remain at the end of the project.
- There was a statistically significant increase in the rates of carers being informed about their right to an assessment and a medium effect size was found. The increase was most pronounced in Glasgow and Lothian areas. At the baseline only 14% of the carers had been informed of their right to an assessment. At the end of the project nearly 40% of carers reported being informed of their right to an assessment.
- There was an increase from 10% to 30% in the numbers of carers being offered an assessment from Social Work Departments.
• The time when carers were offered a carer’s assessment had a significant and substantial change. At the baseline period, nearly 60% of the carers who had been offered a carer’s assessment received that offer much after discharge. This figure dropped to approximately 25% by the end of the project. More importantly there was a big jump in the percentage of carers offered an assessment prior to discharge.

• For those carers who did receive a carer’s assessment during the study period, those who received their assessment during the period measured by the final post-test were more likely to receive additional supports than carers receiving an assessment during the baseline period.

• The experience of receiving a carer’s assessment was seen as more helpful at Time 3 than at the baseline period.

• The percentage of carers reporting that a discharge plan was in place at the time of discharge increased from 35% to 60% from baseline to final post-test periods.

• Overall ratings of feelings of support as a carer did not improve from baseline to the end of the project.

• Carers report that their expertise was increasingly recognised by professionals from baseline to the end of the project.

• Feelings that one has a say in shaping the services to themselves or the person they care for increased over time.

• Reports that care professionals understood their needs as a carer increased over time (some variation across areas).

• Carers’ perceptions of partnership working among health, social work and voluntary organisations improved over time.

• No statistical differences were found when carers were asked to rate the impact of caring on their health, their understanding of the health condition or in their confidence in managing practical tasks.

• There were few statistical differences in carers’ reporting of whether or not they received help to access services from pre to post. One notable exception was that there was an increase over time in the percentage of carers reporting getting help with aids/adaptations.

• Carers reported a drop in accessing training over time. This drop may be explained by the nature of the pre-test group already being on Carer Centre registers.

**Key Findings from the Frontline Workers’ Questionnaire**

• Moffat workers had a lot of contact with respondents as 63% of the frontline workers reported having 10 or more contacts with Moffat workers.

• The nature of contact with Moffat workers centred on getting information (59%) from the workers, resource finding (53%) joint working (61%), and discussion (73%).

• Frontline workers report that their contacts with Moffat workers positively influenced their:
  
  o understanding of the needs of carers,
  o practice with carers,
  o identification of carers,
  o information provision to carers,
• informing about their right to an assessment,
  • inter-agency working.
• Frontline workers also thought that Moffat workers influenced organisation practice, especially in terms of information provision in general and concerning the right to an assessment.

Key Stakeholders Interviews and Focus Groups

As described in the Methodology section, interviews and focus groups with key stakeholders were an important part of the evaluation design. The aim of these interviews was to obtain an overarching view of the project and how it progressed over time. The interviews entailed talking to Moffat workers and managers, plus key health and social work personnel in all the pilot sites. Overall, 14 interviews and four focus groups were completed in round one; 15 interviews and three focus groups were completed in round two and 12 interviews and four focus groups in round three were completed. The slight variance in number of key stakeholders across the 3 rounds reflected staff changes in health and social work staff across the two years of the project. In addition it was not possible to meet with the all Moffat workers collectively hence some were individually interviewed. That said, there was a relatively high degree of consistency of stakeholders across the two years of the project. The findings are presented in terms of the general findings for the project as a whole, however, where there are significant difference between the pilot projects these are identified.

Round One Analysis

Project Goals

The Moffat vision of Preventing Crisis for Carers was universally welcomed by all stakeholders, with each acknowledging a need to improve aspects of service. Likewise, all stakeholders expressed a strong commitment to bringing about positive changes through the pilot scheme in their areas. In all four pilot sites there was an acknowledgement that the project had been timely, dovetailing with requirements in the Carers Information Strategy, thereby giving the pilot projects an impetus at a strategic level particularly within the health context. The evidence from the first round of interviews indicates a number of overall goals which the pilot scheme hoped to achieve. These goals were on the whole applicable to all four of the pilot areas; however the weight or emphasis given to each goal differed across locations and to some extent stakeholder groups, as did the methods adopted to achieve these outcomes.

Strategic Approaches

The process of establishing the project across the four pilot areas necessitated a high level of collaboration particularly between the Carers’ Centre managers and the health and social work leads. Three of the four projects would appear to have involved all key stakeholders in the bidding process, for part of the funds which The Princess Royal Trust for Carers had secured from the Moffat Trust, whereas this was not the case in one area where there had been no consultation prior to the commencement of the project. However, both the health and social work stakeholders in this area were fully committed to making the project work. The
tasks of the Carers Centre managers predominantly had been to negotiate access into the pilot settings, establishing monitoring procedures usually in the form of steering groups, and providing clarification and support for the newly recruited project workers. The core tasks of the health and social work leads have been embedding the Moffat Project in both a practical and promotional way. The evidence overall suggests that they worked to introduce the Moffat workers into settings and teams (including in some cases strategy groups or sub-committees); provided facilities and equipment; and in most instances promoted the Moffat aims to colleagues.

The predominant strategic focus of the project was toward the acute health sector, i.e. hospital wards. This is particularly evident in the targeting of frontline nursing and allied health staff as the main potential source of new carer referrals. Social Work Departments and staff also held a key stake, but the evidence does suggest that social work played less of a key strategic role across three project sites in the initial phase. The exception was Lothian where two workers were placed directly into social work settings. One worker had a specific brief to develop and improve the Social Work Department’s carers’ assessment form, whilst the other was located within a Social Work post-discharge team. This worker’s task was to influence the quality and quantity of carers’ assessments being carried out, working in partnership with colleagues based within the Local Authority community care services.

The key strategic element adopted across all 4 pilot sites was the “embedding” of the project workers within practice settings, with the aim of becoming an integral part of their respective professional contexts. The aim was that the project workers would be viewed as an additional resource and as a source of information for both staff and carers. In turn, the Moffat worker would look to influence staff practice and departmental policy, through for example training, promoting the carers’ agenda or working at a strategic level to influence hospital discharge processes.

In three of the pilot sites, interview evidence suggests that the project workers attempted to secure influence at both the ‘ground level’ and at the more senior managerial levels. Indeed in these areas, management ‘buy in’ was viewed as essential if Moffat was to have an impact, as they could ‘champion’ the project, promoting it to their own frontline staff. In Edinburgh and East and West Lothian, the project managers indicate a slightly different approach to achieving the long-term wider goals. Their strategy was for a more “bottom up” approach, in the belief that by targeting practice and attitudes directly at the frontline staff level they would eventually influence strategy and planning at a more senior level:

*I suppose the key bit to us is about changing the policy and practice so that at the end of the project there are changes which are made permanent or as permanent as they can be (Project Manager)*

**Goals and Approaches – Commonality and Differences**

All pilot areas reported having as a project goal the increased identification of carers and a subsequent rise in the number of carers’ referrals. However, the emphasis placed on an exact
number of new carers to be identified differed between sites. In Ayrshire, an explicit goal of the Moffat Project was to identify 2,000 (1,000 each year) new carers primarily from within hospital settings. This was felt to be an achievable goal, as the figure was based on similar results from a previous scheme. This type of numbers-driven approach appears to be less prevalent in the other pilot areas. The Glasgow and Lothian areas indicated that identifying new carers was a clear project goal, but there was no suggestion that they were working to a specific target figure. In Borders, the project manager indicated a combined target figure of around 600 new carers. Across all four pilot areas, the workers were clear that identifying new carers was only the start of the process and that the quality of subsequent interventions was equally important.

The evidence suggests that frontline staff awareness raising was perhaps the most common initial activity carried out by the Project workers. All the Moffat Project workers were already engaged in talking to staff, however the extent to which they were involving them in formalised training differed between pilot sites. Workers in Ayrshire and Glasgow had begun carer awareness training sessions for staff, often within the hospital wards, together with leaving appropriate leaflets and literature. In the Borders area, one project worker’s role was dedicated to training and developing relevant materials for future delivery. In the Lothian area, one of the project managers indicated that they were in the process of building upon previous training programmes that the Centres had supported.

Influencing hospital discharge protocols was also identified as a key project goal across 3 pilot sites. As discussed in Lothian, one of the project workers was dedicated to working with a social work discharge team. In the Borders, the hospital-based worker indicated that a key element of her task was to work with ward health staff in ensuring that carers’ needs were taken into account when planning discharge; something which had not routinely happened previous to Moffat. In Glasgow, influencing discharge protocols was seen to be a key goal by the project managers, workers and the social work lead. The view from social work was that this would require integrated working and commitment by all stakeholders:

*I think in terms of my understanding, Moffat is specifically directed towards developing discharge planning protocols which involve all the key stakeholders and that would include hospital social work as well as nursing staff as well as the client or the service user. (Social Work Lead)*

The health lead in Glasgow did, however, sound a note of caution against overestimating the extent to which the Moffat pilot would have a long-term impact on hospital protocols such as discharge. With regard to cutting readmissions, this was a particular feature in Lothian, Glasgow and the Borders. At Time 1 interviews project managers in particular emphasised this as a potential outcome of the project, citing carer inability to cope as a major factor in hospital re-admissions. The health leads in these areas however, tended to suggest that this was essentially aspirational and that evidencing hard outcomes on hospital readmissions would be outwith the scope of this pilot project.
In all sites, project workers operating at ward levels indicate that much of their time is spent either directly identifying, or providing direct support for carers within the hospital settings. Aspects of this involvement relate directly to the Moffat goals, specifically; making newly identified carers aware of their right to an assessment (Glasgow and Ayrshire); acting as an advocate for carers within wards particularly at the point of discharge (Borders, Lothian and Ayrshire). Several workers also suggest that a key aspect of their role is to provide emotional support for carers with one worker in Ayrshire suggesting that a ‘mini Carers’ Centre’ had been established as a result:

_XXXX is a smaller hospital and they have a nice wee sitting area and when I’m in between meeting people I sit there so people that I’ve already dealt with have seen me and they’ll come and have a wee chat. I had a lady last week that when she came out her husband had been really upset and whenever she saw me she sat down and I was an hour talking to her and it was more like a counselling session that we had but it’s turned into I suppose like a wee mini carers centre within the hospital._ (Moffat worker)

The general feeling from the first round of interviews was that it is the Moffat workers themselves who were identifying, referring and supporting carers, rather than the frontline staff.

**Barriers**

When questioned on the barriers to implementing the Moffat Project, the stakeholders across all of the sites indicated a number of issues. Broadly these may be grouped together in two categories: cultural and practical. The cultural barriers tend to relate to issues of professional identity, practice, and confidentiality within the agencies involved. Here a number of core issues common to all pilot areas were identified. Testament from across all four sites suggests that promoting frontline staff awareness and involvement with carers’ issues of carers would present difficulties. The implied challenge would be to influence and to some extent change the professional culture and ethos of frontline staff (particularly health staff), who traditionally focus on the patient rather than the needs of carers, as exemplified by a project worker in Glasgow:

_I think it’s very difficult to turn the nursing staff’s attitude around because their focus has always until now been on the patient. To ask them to take the leap beyond looking at the visitor as just the visitor or the family and to see them as the person that’s actually going to be caring for the patient when the patient goes home. Until now they’ve had no responsibility for that and what we’re trying to do is to make them see the wider picture._ (Project worker)

The inference, particularly from project workers and project managers is that they were having to ‘sell’ the Moffat Project and its worth, to frontline staff, and that the ‘buy in’ at a managerial level had not yet fully filtered down to the frontline.
A practical difficulty relating to this is the issue of frontline staff’s time. Stakeholders from across the four pilot sites raised a concern that there was potential for frontline staff ‘resistance’ to a project that they believe may add another element to their already high workloads. The health and social work leads tend to suggest that this is a legitimate issue to which there may be no easy solution. Practical barriers tend to relate to the availability of physical resources on the ground level, particularly within hospital settings including access to IT or electronic systems, suitable accommodation (both for working and interacting with carers), telephones etc. There was also an emerging issue of the efficacy of the working hours of the Moffat workers as ‘success’ has its own problems in terms of staffing issues. Although experienced across all four pilot sites, the extent to which these barriers impacted negatively on the implementation of the project differed. The majority of the workers had relatively satisfactory access to equipment, desks and storage space. Two workers, however, had been provided with little or nothing in this regard.

Information sharing was generally viewed in either a very positive, or very negative light, depending on the nature of the information and the level at which it was to be shared. Strategic information sharing between project leads was on the whole well facilitated by joint planning groups and pre-existing channels of communication. With regard to sharing specific carer information, the general picture was more complex. In both Lothian and Glasgow, one worker in each had been given direct access to a social work database, which they could use to cross reference with their own carers’ centre database. Nevertheless, the evidence suggests that both social work and particularly health have a strong commitment to confidentiality that greatly restricted information sharing with the project staff. One Health lead suggested that because the worker was not employed by the NHS, it was unlikely that access to information would be granted.

These barriers may be symptomatic of a suggested professional and cultural mind set which is not predisposed or open to partnership. Although these barriers were viewed as problematic, the outlook from across the pilot sites was optimistic that they could be overcome as the project continued and a process of ‘cultural’ change was developed.

Resources
Several workers in all pilot sites highlighted the part-time nature of their employment as a potential barrier, particularly given the physical and professional scale of their tasks. In general, those who raised this issue spoke of the difficulties of dividing their time across multiple tasks, the practical difficulties of operating across multiple wards or indeed sites, and the limited time available to conduct follow up work with carers. The project managers on the whole were more positive about the level of financial resources made available for the Moffat Project, but accepted that when it came to establishing goals they had to “cut the cloth” according to what they were given. It was, however, suggested by one project manager that all of the funding has gone on workers’ wages, and that the additional administrative costs of the project had to be met from the Carers’ Centres’ own budgets. Another project manager commented on the use of all the funding on wages, but believed this to be justified in order to employ a high quality worker.
The general consensus from health and social work leads was that the financial resources put in place would be sufficient to allow the Moffat workers to achieve their tasks. Three of the four areas had, however, received additional funding from health or social work in order to widen or support the Moffat Project in their localities. Specifically, Glasgow Health and Social Work had jointly funded an extra project worker to be based in health sites in the north of the city, with the aim of implementing the Moffat Project across the Health Board. Still, there was a continuing concern expressed by the health lead with regard to the coverage of the Moffat Project in Glasgow, and the ability to maintain a consistent standard of training and work across all of the sites. NHS Lothian provided additional funding in order to top up two hospital based workers hours to full time. In Ayrshire the Health Board had made available monies to be used to meet the advertising and promotional costs of the project. In the Borders, there was some indication that negotiations for additional funding from the NHS were in the final stages, and the project manger was confident that additional funds would be made available.

Policy
At this early stage, the suggestion from across all four of the pilot sites was that the Moffat Project was a ‘timely’ development in so far as it would contribute in a practical way to the Carers Information Strategies and Carers Strategies of the Health Boards and Social Work Departments involved (particularly Health Boards). Beyond this however the feedback across the board was that it was too early to note specific policy changes as a result of Moffat, and there was a general feeling that if long-term policy changes did result they were more likely to be at a local rather than a national level.

Impact on Services
Although the number of new referrals at this stage of the project was relatively low, the expectation from the project workers and managers was that in the long run Moffat would result in a significant increase in the number of carers registered with Carers’ Centres. Inevitably, the subsequent level of service provided would also have to expand. Whilst this was welcomed by these stakeholders, there was some concern about the potential implications on the resources of the Carers’ Centres and their ability to cope with the increased demand. From the health and social work perspectives, the key aspect of organisational development gained through the Moffat Project was a ‘cost effective’ or indeed free source of frontline staff training. The evidence generally suggests that prior to Moffat, carers’ training had been “patchy” at best, particularly for health staff, but that Moffat was potentially helping to fill this gap. This fits well with the increasing priority given to the requirement to provide staff training as part of the Carers Information Strategy. In relation to post project funding two of the pilot projects had started to consider this issue and were giving consideration to how this could be picked up in the future. Whilst it was at the early stages both health and the Carers’ Centre has looked at how this may be funded by the Health Board possibly under the Carers Information Strategy. In Lothian it was felt this would organically develop as evidence from the project arose. In Glasgow the future viability of the project had yet to be considered.
Summary of Round One Analysis

At this stage the pilot projects had managed to establish themselves at a local strategic level within the health and social work contexts in which they were sited. There was an overall clarity about the aims and objectives that the projects would be trying to achieve and how the work to be undertaken by the Moffat workers was consistent with the overall aims of the Carers Information Strategy and Carers Strategy across all 4 sites. As one would have expected there were a number of operational and practical difficulties across the project. However, the general picture was one of workers starting to establish themselves in the specific work sites and beginning to develop working links with key frontline staff.

Round Two Analysis

Strategic Approaches and Goals

By the second round of interviews, the project had been running for over a year. There had been a number of significant positive developments and outcomes since the implementation stage. A number of barriers, especially cultural, identified in the first round continued to exist across all four sites. The general tone from the second round interviews was that the Moffat Project was ‘a work in progress’, however this requires to be seen in the context that for most individual sites the projects had in the main been established and the workers were clear about what they were intending to achieve. In all four pilots, the stated visions and goals of the project remained consistent from the first round of interviews. However there was a strong indication from Glasgow, and to a lesser extent the Lothian pilot sites, that the original aspirations of the Moffat Project may have been slightly ‘over-ambitious’, especially given the limited nature of the pilot scheme and difficulties around creating cultural change. This perspective is echoed by a project manager who stated:

I think where we were maybe a bit naive was around our expectations of buy-in from every member of staff, in terms of health. I think we get buy-in from different levels, but quite often there’s a problem with the filtering of information through organisations. And people think, “Well, it's not really my job;” and that’s because they’ve not had that initial understanding of the legislative background, of the policy content. (Project Manager)

While acknowledging the project success there was a similar feeling among some of the project managers that the scale of cultural change implied in the project aims was rather ambitious for a two year project:

I think what might not be achievable within the lifetime of the project is this... major cultural shift that needs to happen in terms of Carers’ Assessments being prioritised and acted on. I hope that will be achievable, but I’m not sure – it might be something that lasts beyond the lifetime of the funding. (Project Manager)

While influencing organisational culture arguably was proving more challenging than originally envisioned, it was clear that many of the more tangible goals set by the project had been achieved or were in the process of being achieved.
**Barriers**

Building on the round one interviews the main issue identified was related to frontline staff being busy and struggling to prioritise the carer and the carers’ needs in relation to the demands they faced. The extent to which frontline staff were willing to co-operate with the Moffat workers varied from site to site. The workers themselves were keen to emphasise their desire to promote partnership working:

> I think, really, what we’re saying is that essentially our role is to try and make the nurses and whoever, more carer-aware. Some are; some aren’t; and what we’re trying to do is to raise an awareness of carers. So that they’ve then got, like a robust protocol system in place at the end of the pilot. So that if the pilot is withdrawn, that is there, it’s up and running. (Project Worker)

What continued to sit behind these barriers and created the difficulty for cultural change were the ongoing demands on time and resources of frontline staff that then arguably prioritise the needs of the patient. This point was once again made by one of the project managers during the second round interviews who stated:

> I think it’s particularly pressure of time, that when…they’re thinking about hospital discharge … in terms of community nursing, the priority is with the patient. (Project Manager)

Where there was limited change in frontline attitudes, the project managers and workers emphasised the importance of ‘buy in’ at the management level where management would ‘champion’ the Moffat message and actively promote it on the ground level:

> I really think that there’s probably a two-tiered approach, and we’re looking at getting the buy-in at the senior, strategic levels. Also, I think what the work so far has demonstrated as well is that we’re having to work bottom-up as well, and maybe that’s the bit that we need to put more focus into at the moment. Because we do seem to have the buy-in at the senior level, but on the ground, that hasn’t filtered through; and I think that’s where we need to focus our energies, in a sense. (Project Manager)

For some of the pilot sites, this disconnect between the layers of the organisation, both in health and social work manifested itself in ongoing practical difficulties around the provision of suitable accommodation, access to interview spaces and telephones and generally being accessible to both frontline staff and carers.

**Referrals**

What was becoming clear by the second round of interviews was the goal of identifying new carers was more aligned with specific targets around referrals. Each of the pilot projects was becoming much more aware of the impact of this in relation to what the projects were trying to achieve. In Ayrshire, the feedback suggested that the 2,000 new carer target established at the beginning of the project remained the key goal, but at this stage (over a year in) they had
only achieved 1000, half of the target with only 9 months left to run. In Glasgow, the outlook was more optimistic with the project manager indicating that in the first year they had achieved double the amount they had planned:

_I think we said 200, and we were almost at 400 by the end of year one. So in terms of quantitative, we certainly had more carers being supported and identified, which is great._ (Project Manager)

In Lothian, there had been a steady rise in referrals as the project progressed, with one worker indicating that within their setting they had obtained approximately 160 referrals, and that they expected the number to rise over the reminder of the project. In the Borders, the project workers had previously stated that they were not working to specific numerical targets, but by the second round, the manager indicated that the Carers’ Centre has experienced an increase in the number of carer referrals coming through, but perhaps more significantly:

_Most of them are referrals from professionals, so that would give us an indication that the message is getting through._ (Project Manager)

The implications of this increase in referrals were that some Carers’ Centres were beginning to experience difficulties managing the increase in demands for service and this did not include those referrals made to Centres which were not part of the Moffat Project areas. However, it would be hard to argue that the impact of the growing number of referrals and carers’ assessments was anything other than a positive outcome in relation to the overall aims of the project. This point of view is succinctly put by one of the project managers who states:

_We’re increasing numbers of referrals, and the increasing number of cases that are coming to us, very complex caring situations. So I think what’s really good is that we are reaching carers who are most of the time, at the end of the caring spectrum, which is good._ (Project Manager)

**Training**

By the second round of interviews all pilot areas had implemented training programmes. In the Borders area, the training programme was established using carers specially recruited by the project worker, to comment upon their experiences of the demands of caring and the services provided previously by health and social work staff. The feedback from all stakeholders on this training programme was very positive with health and social work in particular both noting that the direct involvement of carers had had a significant impact on frontline staff:

_I think the other role that has worked really well is that training post, which has brought together carers and empowered them, and also factored into induction for new staff, as well as training and development for existing staff, and sharing carers’ stories. Because it’s very hard to deny responsibility or to ignore the impact of what we do and how we do it, in terms of NHS services, if you’re listening to a real example, a real story from a carer, about how it’s been for them, and how it was for_
their cared-for person...It’s a bit about making it more personal. Making it more real and closer to what it is that you do. (Health Lead)

The evidence from the other pilot areas suggested some positive results with regard to training. In Glasgow, all project workers were involved in delivering short training sessions to frontline staff, whilst in Lothian one worker indicated that they had delivered training to over 200 frontline staff in the first year. In Ayrshire, the evidence suggested that training was now beginning to gain momentum, but up to this time there had been a ‘mixed’ response from frontline staff. The training element of the Moffat Project was beginning to hit the practical barrier of frontline staff time highlighted and discussed in the analysis of round one. With the exception of the Borders where training was mandatory as part of the Adult Support and Protection Act 2007, there was evidence from all of the pilot sites that they have experienced difficulty in either promoting training to frontline staff or in ensuring attendance to training sessions. This is exemplified by one health lead:

the biggest challenge we have from a training point of view is that there are so many competing demands around training, and I know that particularly ward departments and teams, they find it difficult to release staff for training, and find it hard to get through the mandatory stuff. So whilst the carers’ stuff is seen as highly important, it’s not mandatory... So, undoubtedly, the Carers’ Support workers have done quite a lot in terms of training, but we probably haven’t had the numbers through that we’ve been looking for. (Health Lead)

Some project workers indicate that delivering comprehensive training had also presented difficulties relating to their own time demands, as they had to deliver repeat sessions in some wards. This, in turn, alluded to another issue that had become evident in most sites by the second round of interviews that of levels of frontline staff turnover, particularly in hospital wards where project workers felt they had to re-establish a relationship with staff and re-conduct training.

Policy

The feedback from health and social work leads across all pilot sites indicates that as anticipated, the Moffat Project continued to contribute to the wider Carers Information Strategies (Joint Carers Strategy in the Borders) of each Health Board. In two of the pilot areas, health leads and project managers also suggested that Moffat was contributing to the ‘Long–Term Conditions’ and ‘Self–Management’ agendas of their Health Boards. Moreover by this stage, the Moffat Project had begun to make a number of in-roads on specific policies on an operational / local level. By way of example, one project worker based within a Local Authority Social Work Department had by this point made a significant contribution through the development of a new carers’ assessment form. A key element of this input was the worker’s involvement in drafting a supplementary information document to help carers fill in the form when conducting self-assessments, which the social work lead in that area indicated was helping the department to meet National Minimum Information Standards. In terms of the Health Service, a number of stakeholders suggested that the Moffat work within their localities was beginning to have some influence on discharge protocols within certain wards.
and hospitals. In one pilot area, the health lead also indicated that the terminology used in hospital documentation had been amended, partially as a result of the project:

> Where we were three years ago is completely different from where we are now, and I think, because of the contact through the project, people have a much more heightened awareness of carers’ issues. So, for example, even when a policy document’s being written; you would talk about ‘patients’, ‘the public’, ‘users of service’ and ‘carers’, who are not necessarily always relatives. So even the change in language I think has been significant. (Health Lead)

More generally the feedback, particularly from the health and social work leads, suggests that having the Moffat Project operating within their departments had helped raise the profile of carers’ issues at the strategic planning levels. This had been facilitated in all areas by the participation of both project worker and managers in a variety of local policy forums.

However, the evidence from the second round of interviews suggests that in all of the pilot sites, the Moffat Project had successfully contributed to existing policy programmes; there was however no significant or clear indication that it had been a driver / catalyst for policy change. Instead, the suggestion from health and social work leads in all areas was that having a dedicated carers’ worker within their department had allowed them to take action on aspects of policy that prior to the Moffat Project, a lack of resources or competing priorities had made difficult to implement.

**Post Pilot**

Now more than a year in, the thoughts of the stakeholders were beginning to turn toward the longer term implications and future of the Moffat pilot. The general view was that the Moffat Project (or aspects of Moffat), were valuable and should be maintained (particularly training), and that there was a danger that the positive outcomes achieved may be undone if there was no long term follow up work. Project managers indicated that the possibility of retaining project workers post pilot depended fully on the possibility of funding from either Health Boards or Social Work Departments. Indeed all managers indicated that they would explore the opportunity for future funding, but the economic climate would present a real challenge to gaining additional funds:

> There are very few opportunities for additional funding now, and that’s one of the drawbacks of the Moffat Project. We couldn’t expect that two or three years ago, or two years ago, when the Moffat Project was agreed; that we would be in such a difficult situation economically now. So that’s obviously not...It makes it more difficult now to build on that and mainstream the best aspects of this experience. (Project Manager)

**Summary of Round Two Analysis**

In the main the pilot projects had established themselves and were beginning to make progress in a number of areas, notably in terms of referrals and frontline staff training. There
were a noticeable number of tangible gains for staff in relation to influencing local practice in relation to discharge and awareness of carers. As one would expect in a project with such a wide range of aims, these had begun to become more focused on what could realistically be achieved within the time frame and resources of the pilots. Across the pilot sites there was an ongoing and growing awareness of the challenge of attempting to create cultural change at a frontline level. That said at the midpoint there were a range of successes across all the pilot sites, however the issue of ongoing funding for some areas was becoming increasingly an issue due to the changing financial environment faced by Health and Social Work agencies.

Round Three Analysis

Project Goals
Reflecting on the outcomes of the Preventing Crisis for Carers Project, the feedback from all stakeholder groups across the four pilot sites was that overall the project had been successful and there were a number of direct and beneficial outcomes. Across all four areas, there was an increase in the number of new carers being identified. In each pilot site, a worker had taken on a specific training remit and this had led to significant numbers of health and social work staff being given some level of carer awareness training. Moffat workers reported having been involved in small but significant local policy initiatives and managers in both social work and health described how the Moffat Project had linked with their own policy drivers. The original goal of securing long-term cultural change in terms of carers’ issues was re-evaluated across the two years of the project. By the third round of interviews, stakeholders had become much more aware of the limitations of a two year project to effect sustained change in practices across such diverse occupational groups. Having said that, however, one health lead did comment:

…we got something out of it that we are going to be able to take forward and will hopefully have some permanent benefit, which is quite rare for a non-recurring project. (Health Lead)

Referrals
As a result of the project, a significant number of new carers have been identified. In Ayrshire, the total number of new carers referred by the third round of interviews was according to the project lead approximately 1,300. Although short of the initial 2,000 target, this was still regarded as a significant and positive outcome particularly given the impact of the long-term absence due to illness of one of the workers. Despite the fact that at the mid-point, workers were suggesting that recruitment of new carers was not their primary focus, some 100 new carers were identified in Borders. In Lothian, the feedback suggest around 700 new carers have been identified, whilst in Glasgow, the number of new carers identified by the third round had, according to the project manager, been higher than anticipated. The project manager suggested around 800 new carers had been indentified:

We’ve prevented crisis for a huge number of carers…we’ve exceeded our expectations in the number of carers identified (Project Manager)
The feedback from all pilot sites suggests that the Carers’ Centres to which these newly identified carers were referred were able to cope with the increased demands on services, and have been able to provide packages of support, usually tailored to the specific needs of individual carers.

Carers’ Assessments
Informing carers of their right to a formal assessment has been a common task of the hospital based workers across all of the pilot sites. From the interview evidence, project workers have encouraged new carers in particular to participate in an assessment, either on a self assessment basis, or with the support and guidance of the Moffat worker or Carers’ Centre staff if requested, or by making a formal request to their Local Authority Social Work Department. In the Lothians, the project work relating directly to carers’ assessments has been regarded as particularly constructive and beneficial. According to one project manager the result has been a significantly improved carers’ assessment form, which is more “user friendly” with accompanying guidance notes for carers who wish to fill it in. The project worker was also involved in training frontline social work staff around assessment procedures. One social work lead confirmed this positive outlook, suggesting that previously carers’ assessments were administered or followed up on a ‘hit and miss’ basis, but since the Moffat Project, assessment pathways have become clearer and more rigorous and that carers’ needs and assessments are no longer regarded as peripheral.

Direct Support
One key outcome for carers suggested across the four pilot sites was the continued direct support offered by the Moffat workers within hospital settings. Moffat workers emphasise the value of the direct contact with carers and their ability to provide information, both verbally and in the form of leaflets or literature, on the availability of services, income maximisation and carers’ rights. Indeed workers indicated that on occasions they have acted as an advocate for individual carers dealing with ward or social work staff. Moreover, the project workers suggested that the emotional support they offer has a significant impact on the carers’ experience and ability to cope within hospital settings. The suggestion from the workers was that the key to providing such support was to be a ‘visible’ presence on the wards. The strategic leads in all areas suggest that throughout the project, informal or anecdotal feedback from carers on policy forums or within carers centres, indicates that as a result of Moffat, they feel supported and better informed of their rights:

Carers have been significantly empowered by Moffat (Health Lead).

Discharge Protocols
In all of the pilot sites, improving carer involvement in hospital discharge procedures was a key stated goal of the project, and this continued to be reflected in the final round interviews, where a number of positive outcomes in this regard are highlighted. One health lead suggested that the efforts of the project workers in encouraging ward discharge planners to consult carers throughout the discharge process had resulted in a situation where the carer is seen as an:
active partner in the decision making process, especially around discharge planning.

This was reflected elsewhere with the project managers and health lead suggesting that improvements have been made in carer involvement in discharge processes. Within Glasgow the project workers indicated that within two hospitals information for carers was now being included in the discharge information packs being provided to patients. In the Borders pilot, one worker remained heavily involved in influencing discharge procedures. The health lead in the Borders indicated that within the hospital, discharge processes now formally include carers’ issues, with specific needs being registered on a discharge protocol checklist.

Joint Working

The project has been regarded as mutually beneficial in allowing both the statutory and voluntary agencies to develop a better understanding of the practices, capacity and ethos on which each operate. The evidence suggested that the Health and Social Work Departments involved now possess a greater understanding of and willingness to involve the voluntary care sector in future service planning and provision for carers. At ground level however, the evidence suggested a much more complex picture of joint working. The evidence particularly from Moffat workers suggested that in the majority of settings, by the latter stage of the project they had become embedded or established within their settings and were, used by frontline staff. Nevertheless this had not been a universal experience. In Ayrshire for example, all of the stakeholders indicated a significant level of staff resistance to the project and joint working within one particular hospital, which in turn had contributed to less carer referrals than had been anticipated. Likewise in Lothian, the workers indicated that while social work staff in one of the hospitals welcomed the worker, they made no specific referrals to them. In Borders, although the worker based in the hospital indicated that she established positive working relationships with the ward staff, she still lacked a dedicated space or equipment within the hospital. In Glasgow, the workers and the project lead commented on the sustained challenge presented by negative staff attitudes to both carers and the notion of partnership with external agencies.

Furthermore the evidence from the third round of interviews suggested that Moffat has had a mixed impact on information sharing between agencies. Whist information on policy, strategy and project development had been well facilitated, the sharing of specific information regarding carers remained generally an unresolved area. The issue of confidentiality discussed during the previous round of interviews remained the main stumbling block. Moreover the suggestion from across the pilot sites was that some frontline staff were still unwilling to share information with others from different agencies or professional backgrounds.

Policy

The feedback from the third round supported the suggestions made in the previous rounds of interviews that the Moffat Project was more likely to have an impact at the local rather than the national level. In all of the pilot areas, stakeholders from either health, social work or both
indicate that the Moffat Project had had a positive impact in terms of emphasising carers’ issues on the planning agendas of their departments. Several stakeholders commented on the ‘timely’ nature of the Moffat initiative indicating that it had significant resonance with policy changes already in progress. One health lead indicated that the Moffat Project and supporting carers fits well into the longer-term aspirations of the Health Board who were moving from an “acute model of care to a long term conditions model of care”. As part of the process of “turning the tanker around” the issues raised by the Moffat workers about the impact of the caring role and the attendant issues around services and resources had been fed into the policy process. In a similar vein, the Moffat workers in Lothian highlighted that they were involved in discussions about the change of strategy in Edinburgh City Council, when it changed its policy focus toward one of ‘re-ablement’, which had in turn impacted on the way in which resources were allocated in response to care needs. In Borders, the social work lead commented that their current ‘Joint Carers Strategy’ with health was undergoing revision and that the “lessons learned from Moffat would influence it quite strongly.”

None of those interviewed at this final stage made any claims for Moffat having been the main driver for any specific policy change at either local or national level. Rather what emerged across all of the interviews was a suggestion that the issues raised within the Moffat Project had served to inform policy changes both large and small. One social work lead, for example, described how the importance of considering the needs of carers had “become embedded in the operational side” by being included in the recently revised staff supervision policy.

Training

For the Health and Social Work agencies involved, a core outcome of the Moffat Project has been the training of frontline staff in order to increase awareness and improve practice regarding carers. In the Borders, the project worker dedicated to providing training estimated that approximately 1,700 attended the sessions, representing health, social work and other agencies including the police. The direct involvement of carers themselves in the delivery of these sessions continued to be highlighted by the health and social work leads as particularly beneficial. In Ayrshire, the health lead in particular commented that prior to Moffat, there had been “low levels of awareness of carers and carers issues particularly with hospital staff”, but that the Moffat worker through training sessions and direct daily contact, had done a “fantastic job” in terms of raising the level of understanding across all levels of staff to the needs of carers. In Glasgow, the provision of staff awareness raising sessions was regarded as particularly important element by the health lead, and the evidence from the third round of interviews was that training continued to be delivered until the end of the project and that the materials used would continue to be available to Health Board staff via their intranet. The project workers in Glasgow also indicated that each training session was evaluated, and that their perception was that they were well received. The evidence suggested a similar picture in Lothian. There the remaining three workers continued to incorporate elements of awareness raising training as part of their wider task. Training sessions involved in-service presentations to NHS staff, and joint sessions with health and social work staff around carers’ issues. The workers also stressed that a key element of the training was to inform staff about the Carers
Information Strategy. The availability of staff to undertake training was an ongoing issue with some training conducted as and when possible rather than as part of a set programme:

*it's been about grabbing opportunities when they come along (Project Manager).*

Several stakeholders commented on the fact that by the very busy nature of their jobs, many staff could not always be responsive to training opportunities, particularly when they were not mandatory. The levels of staff mobility also impacted on the ability of staff to take full advantage of the training opportunities available through the Moffat workers. Part of the reason for the high numbers of training sessions undertaken in Borders, for example, arose out of the opportunity to include a carers’ perspective in the mandatory training around the Adult Support and Protection Act 2007. Attendance at this training is mandatory for a range of health and social work staff.

In addition to formalised training, project workers in all four pilot sites had continued to encourage and promote greater frontline staff awareness of carers’ issues. The feedback from workers suggested that this often developed as a result of continued professional contact with frontline staff. There were, however, examples of other sources of information. In the Borders for example, one project worker was involved in developing and disseminating a ‘Carers’ Handbook’, originally intended for use by carers, but now also used by health and social work staff. In Lothian, one of the project managers indicated that a DVD has been produced to promote the Moffat message for frontline staff, and in Lothian, Glasgow and Ayrshire, workers indicated that they disseminated a range of information literature and leaflets.

The interview evidence therefore suggested that training had been well received and that many staff may now possess a greater level of awareness of carers. Nevertheless, there was also a strong indication that these generally positive changes may not have fully filtered into frontline practice. This was perhaps exemplified by one health lead who observed that despite training, many staff, due to the other pressures on the ward, were simply not remembering to refer carers. Several stakeholders described receiving very positive feedback immediately after a training event and being given clear assurances about carers’ referrals to follow. The subsequent referral rates had not always increased as one may have anticipated and it seemed likely that in the absence of the prompts around during the training, workers may then have reverted to their usual practices and forgot about the additional issues for carers.

*Cultural Change*

Whilst all stakeholders involved indicated some level of improvement in frontline staff awareness of carers, the perception overall was that Moffat had not, to a significant extent, changed the outlook of frontline staff toward carers. The evidence did suggest an increased awareness of carers, but as several social work and health leads highlighted, there was a significant difference between awareness raising and changes in practices. As one health lead states:
training won’t solve the problem...need to embed carers issues within both the process and culture of organisations.

There was, however, by the final round of interviews a general acceptance that such a process could only develop over a much longer term. Once again the wider sentiment from across the pilot sites was exemplified in the evidence from one social work lead who suggested that the Moffat Project has been about “chipping away” at the surface of professional cultures, a claim echoed by some of the Moffat workers who indicated that they felt they had only “skimmed the surface” of professional practice.

**Resources**

Resourcing the Moffat Project was still very much an issue in the third round interviews. This was particularly evident in the feedback from the project workers. In Glasgow, the workers suggested that they were still devoting more than their contract hours to Moffat work, and the issue of contract hours was also raised in Ayrshire. The feedback from across all of the pilot sites was that the challenges relating to the scale of the task remained. Scale in this regard alluded to both the geographic spread within pilot sites and the actual numbers of wards, departments and staff the workers were engaged with. The extent to which ‘scale’ had a negative impact, differed between each pilot area. In Borders for example, Social Work and Health operate on a co-terminus basis, which all stakeholders indicated helped to achieve positive outcomes. In the other pilot areas which involved multiple hospitals and Social Work Departments, the suggestion from stakeholders was that the task of achieving outcomes became more complex. An example may be found in the feedback from the Lothian health lead who suggested there have been challenges in regard to communication and compatibility in implementing a project potentially involving 26,000 people (staff), across a large Health Board four local authorities, and voluntary organisations.

Since the second round interviews there had been changes in relation to some Moffat workers which arguably had impacted upon the delivery of the pilot projects. In Ayrshire, the level of coverage across all sites was impacted upon somewhat due to a prolonged period of ill health of one of the workers. A similar limitation was experienced in the Lothian pilot with the loss of one of the posts around 18 months into the 2 year project due to obtaining alternative employment.

By the end of the project, however, several of the Moffat workers had been retained or other workers engaged by using funds from the Carers Information Strategy. There appeared to be a general acceptance across the pilot sites that there was still a job to be done after the pilot ended.

**Re-Admission Rates**

In two of the pilot areas, Glasgow and Lothian, an initial goal of the project was to lower re-admission rates by providing increased support for carers. By the second round, this outcome had come to be accepted as difficult to quantify in terms of the impact of the Moffat workers. By the very nature of the complex interplay between carer and cared for, it was clear by the
final stage that no specific claims could be made about the impact of improved services to carers on re-admission rates of cared for persons. One health lead observed that it would be difficult to evidence a clear correlation between Moffat type work and re-admissions:

very difficult to directly relate hospital admission with carers not managing because of the nature of some diseases, particularly in the older client group.

Post Pilot
There was a general consensus from across all four sites that the work and input of the Moffat workers had been valuable. This in turn had led several of the health and social work leads to suggest that both carers and frontline staff would continue to benefit from ‘dedicated carer workers’ operating within hospital settings. Whilst these calls were aimed principally at policy makers on national and wider strategic levels, in two of the pilot areas, Health Boards and Social Work Departments involved in Moffat indicated that they have already taken financial and practical steps to directly fund project workers in their localities for a limited period. In the Borders, both of the project workers will continue to function in their current role for a further 2 years, having secured joint funding from the Borders Health Board and Social Work Department. The indication was that this decision was taken in order to continue to implement their joint carers’ strategy. Likewise in Lothian, the Health Board has committed funding from its Carers Information Strategy to continue a project worker on a full time basis for one year. In Lothian, the health lead indicated that plans are in place to fund future work by the Carers’ Centre in Edinburgh around carer awareness training for senior health staff in both the community and acute settings.

Given the current financial constraints being applied to all public sector employers, it is difficult to predict the long-term stability of such posts. The fact that they are continuing after the end of this two year project is, however, encouraging.

Summary of All Three Rounds of Stakeholder Interviews
As part of the mixed methodology of this evaluation, the opportunity to interview key stakeholders at significant points across the life of the project has yielded some valuable insights into the overall workings of the project as a whole. In the initial discussions stakeholders were concerned about establishing the roles of workers within the various settings and agreeing on their respective goals. Some projects placed considerable emphasis on the identification of new carers while others focused on carer involvement in training. All were concerned to begin building more effective working relationships across professional divides. While from the outset all stakeholders demonstrated a strong commitment to the Moffat Project aims, Health Board personnel in particular viewed some of these aims as aspirational and identified at an early stage that some issues would be difficult to fully evaluate, e.g. the impact of carers’ support on re-admission rates.

By the mid-point, Moffat workers had become more established in their respective roles although having a specific and clearly identified point of contact was still an issue for some. Numbers of identified new carers seemed to be on target, large amounts of carer awareness
training was being undertaken across the four sites and local policies and practices were being influenced by the carers’ agenda. What began to emerge more clearly at this stage was the challenge of influencing attitudes and practices within a setting where the needs of patients inevitably take priority over the needs and concerns of carers. Evidence did, however, emerge from a number of those interviewed that there were slow but significant gains made in this regard. In addition, at both local and organisational level there was a realisation that progress in terms of partnership working was being made, but perhaps at a different pace than the original aspirations may have suggested. What emerged clearly at this stage was that Moffat workers were increasingly being viewed as a useful resource by both staff and carers. Some slight concerns about the long-term future of the work began to emerge at the mid-point and at both Health Board and Social Work Department strategic levels, some initial consideration was being given to future funding arrangements.

When interviewed for the final time towards the end of the project, stakeholders were able to reflect on the project as a whole and begin to measure some of the gains made. In most of the pilot areas, significant numbers of new carers have been identified, vast amounts of training hours have been completed and impact at local policy levels could be identified. Examples were evident of where local documentation has been improved, policy documents influenced and relationships across professional domains are beginning to be better established. This, to most stakeholders, was viewed as being a successful set of outcomes for the project as a whole. Where the original aims had not been so successfully evidenced was in respect of the impact on re-admission rates and the potential sustainability of the current successes and changes within organisations. Some stakeholders at this stage expressed concerns that the gains made over the last two years could be quickly lost if the Moffat workers were no longer visible within the hospital settings.

Overall, the gains made by the Moffat Project would seem to be partly to do with having been able to secure a consistent presence within both health and social work environments. It had also been able to secure the support of both of these key organisations at a significant strategic level – the idea of local ‘champions’ who take the carers’ message into the wider policy arena. Moffat workers described many instances where they were able to provide direct services to carers and also to work in a very direct way within the hospital and community care settings to at times alleviate pressure points for other workers. They provided extra resource in an already stretched system and this was greatly appreciated.
DISCUSSION CONCLUSIONS AND RECOMMENDATIONS

The aim of the Preventing Crisis for Carers Programme was to create effective partnership working between the NHS and Social Work staff, local Carer Centres and carers by promoting early identification, intervention and support for carers to prevent unnecessary crisis. It also aimed to ensure they were properly supported as key partners in the provision of care, to prevent an adverse effect on their own health and well-being. The key Programme Objectives were:

- Identifying new or hidden carers, ideally at an early stage.
- Providing support and information for carers within the hospital setting.
- Establishing greater carer involvement in hospital discharge processes/protocols.
- Reducing the re-admission rates for those cared for.
- Creating pathways for referring carers onto Carers’ Centres, Social Work Services or other relevant support agencies, with the aim of establishing long term packages of support (should the individual carers wish such a thing).
- Enhancing inter-agency collaboration with regard to providing for carers’ needs.
- Informing carers of their right to an assessment, and working with statutory agencies to improve the amount and quality of assessments being offered.
- Raising frontline staff awareness and recognition of carers, both in terms of carers rights to services and information, and the part they play in the care of the patient / service user.
- Providing training for frontline staff on carers’ issues.

This evaluation was designed to address these aims and objectives and the results section presented data from the mixed methods design. The data included information from the Moffat Worker Carers’ Database, which was primarily used to record information about what Moffat workers did with individual carers. The Carers’ Questionnaire was administered at three different times and provided outcome data. The Frontline Workers’ Questionnaire was administered at the end of the project and provides an ex post facto evaluation of several key project outcomes. Several of the project areas also kept Training and Activity Logs and this data provides more process data, namely about the work done on more systemic level work – rather than direct work with carers. Interviews with key stakeholders at the beginning, middle and end of the project provided rich data concerning many important process variables as well as data regarding certain key outcomes. The interviews also serve to place the quantitative data into context.

With such vast amounts of data it can be difficult to simultaneously see the overall picture and hold on to the key individual findings. This discussion will pull all the various strands together and discuss how the Moffat Project fared in its efforts to meet the ambitious aims and objectives.
Identifying New or Hidden Carers

It was clear from the various sources of data that many new and hidden carers were identified through the efforts of the Moffat Project. For example the Moffat Worker Carers’ Database contained nearly 3,000 carers. The frontline workers’ questionnaire also suggests that health and social care staff may be more likely to be identifying carers and the interviews highlight that this project aim has been successfully met. In addition, the percentage of carers reporting that they were never identified as a carer decreased from the baseline period to post-test and the percentage of carers reporting that they were identified as such during the hospital stay of their loved one increased over that same time period. It appears that having dedicated carer support workers assists with carer identification and carer awareness amongst other staff. Though factors outwith the Moffat Project may have impacted the identification of new or hidden carers, frontline workers and key stakeholders do find that the Moffat Project significantly influenced personal and organisational changes in practice, especially as part of wider policy drivers. In addition, it appears that carers were identified earlier in their “caring career” than what has been found in previous studies. For example, Kelly (2007) found in a survey of Scottish carers that carers provided care for many years before receiving any support, information or services. In that study, carers who began receiving services and supports within the previous 1-2 year had been caring on average for over 7 years. For those reporting that they first received service 2-5 years prior to the study had been caring on average for almost 10½ years. This suggests that carers were not identified and were caring in isolation. If we compare the results from the current evaluation, we see that 44% of the carers are within the first 2½ years of beginning to provide care. This suggests that carers in the Moffat Project areas are being identified and supported earlier than carers in the earlier study.

Providing Support and Information for Carers within the Hospital Setting

There is a vast amount of supporting evidence across all data sources that would allow one to say with a great deal of confidence that this objective has been met. For example, nearly 3,000 carers were identified, primarily from within the hospital settings. Moffat workers identified a wide range of services and supports they provided to the carers including advice, information, emotional support and instrumental support. In addition, they made referrals to numerous other providers. The frontline workers also reported that their involvement with the Moffat Project influenced their practice with carers in terms of providing information and in recognition. Interviews and focus group data across the three time periods also support the perception by professionals that they were providing more support and information to carers. More importantly, carers themselves indicated that feelings of being supported by hospital and social work staff increased from baseline to the end of the project.

Establishing Greater Carer Involvement in Hospital Discharge Processes/Protocols

There is rich evidence to suggest that carers were more involved in the discharge process at the end of the project than they were at the beginning. For example, the Carers’ Questionnaire shows a significant increase in the percentage of carers reporting that a discharge plan was in place. Carers also reported an increase in how fully their needs and
views were taken into account during the discharge process. The activity logs and interviews with key stakeholders indicate that a good deal of work was done concerning discharge processes. In some areas a Moffat worker was engaged to help develop carer friendly discharge protocols and forms, in other areas training around the needs of carers within the discharge process occurred, and in others still, workers helped carers engage with hospital or social work staff during the discharge planning process. All areas were involved with raising awareness concerning carers’ issues. It appears that these efforts bore fruit. On the down side, however, all of this hard work within the hospital setting did not appear to increase the percentage of carers indicating that the plan had been carried through. While 55% said the plan had been carried through, 24% indicated that the plans had not been carried out, and these percentages were fairly consistent across the life of the project. Further work around transition from hospital to home may be required.

**Reduce the Re-Admission Rates for Those Cared For**

The aim of reducing re-admission rates was seen to be overly ambitious within the first year of the project key stakeholders and project workers. During the mid-point interviews participants discussed the scale of culture and system changes were too great to impact within such a short time frame. This sentiment was echoed at the final interviews. The carers reported multiple admissions for the people they were caring for at each wave of carer questionnaire administration. There was no statistical change in the readmission rates according to the questionnaires. It appears that the people being cared for had high levels of illness. Without a comparison group it is difficult to know if the project had any impact at all. However, given the feedback in the interviews this may be unlikely and meeting the needs of carers should only be part of larger efforts to reduce readmissions. The fact that only 55% carers reported that discharge plans had been carried through may play a part in re-admission rates.

**Creating Pathways for Referring Carers**

It appears that pathways for referring carers onto Carers’ Centres, Social Work Services and other relevant support agencies occurred during the project. Moffat workers were the primary pathway for referrals, and if such activities are not embedded within standard practice, then these pathways may die out after the project ends. However, there is some evidence to suggest that such embedding has taken place in some areas. The frontline workers also report that they would likely refer carers to Moffat workers, which will hopefully translate into referring directly to Carers’ Centres in the future. Also, much systems work occurred to embed carers’ needs into discharge planning. The project demonstrates the benefits of such activities. For example, the percentage of carers reporting having a discharge plan and being part of the planning process increased. In addition, the offer of carers’ assessments by Social Work Departments increased over time and they were offered earlier. It also appears that carers who received a carer’s assessment were more likely to gain additional support by the end of the project. Perhaps the increased information allowed carers to make better use of the carers’ assessment process. They also reported finding the process of having a carer’s assessment more helpful by the end of the project.
Enhancing Inter-agency Collaboration with Regard to Providing for Carers’ Needs

When considering inter-agency collaboration and partnership working the evaluation found mixed results. The interviews and focus groups demonstrate that inter-agency collaboration at strategic levels has been enhanced. In addition, working relationships across agencies seems to have improved and referrals were more likely. However, information sharing around particular cases and carers remained problematic in several of the areas. There were ongoing issues identified across all project sites in terms of the sharing and transfer of confidential patient information. Even in situations where either carers or patients had indicated that they were comfortable with such information sharing, a reluctance remained. This was further exacerbated by the complexity of electronic data storage systems across the various agencies. Despite some of the mixed findings from the qualitative data, the data from the Carers’ Questionnaires suggests that carers felt that agencies worked together better by the end of the project.

Informing Carers of Their Right to an Assessment, and Working with Statutory Agencies to Improve the Amount and Quality of Assessments Being Offered

There is no doubt that the Moffat Project had a significant impact on the rates of carers who were informed of their right to an assessment. The data from all sources converge around this issue. In terms of quality of assessments being offered, there appears to be some improvements in this area as well. Certainly several of the areas worked specifically and in partnership around improving carers’ assessments. This may explain why carers reported that the experience of receiving a carer’s assessment was more helpful at the end of the project and that carers were more likely to receive additional support.

Raising Frontline Staff Awareness and Recognition of Carers, Carers’ Rights and the Part Carers Play In the Care of the Patient/Service User

The various Moffat Project areas took different approaches to raising staff awareness of carers’ issues and each area faced barriers in this work. However, there is much evidence to suggest that awareness was raised. For example, at least 3,507 professionals received training on carers’ issues and at least another 660 health and social care staff were involved in work with Moffat workers regarding improving systems for carers. The Frontline Staff Questionnaire suggests that awareness and information giving were strongly influenced by the project. Outcomes for carers suggest that some changes in practice may have also occurred over the time period.

Providing Training for Frontline Staff on Carers’ Issues

As indicated in the section above, a great deal of training for frontline staff occurred during the Moffat Project. The amount of training provided is under reported within the evaluation as not all centres kept an activity log. As indicated within the body of the report, protecting staff time in order to attend training events remained problematic throughout the project. It was only in situations where the training event was mandatory (e.g. in terms of legislative changes) staff found it less difficult to sustain high attendance levels at training events.
Where carers were involved in the direct delivery of training, this authentic carer voice was particularly welcomed by participants.

Overview of Moffat Project

When looking across the results for the project aims and objectives it is safe to say that the Moffat Project met its stated aims and almost all of its objectives. The project helped to strengthen effective partnership working between the NHS and Social Work staff, local Carers’ Centres and carers by promoting early identification, intervention and support. Whether the efforts reduced crises for carers is harder to demonstrate. Though the data on re-admission rates do not suggest a decrease in these rates, all the data converge to strongly suggest that the identification of and support for carers improved throughout the hospitalisation journey. As hospitalisation often occurs as a result of a crisis, it may be that rather than preventing crises, carers were better supported through crises.

Professionals have increased awareness of carers’ issues, and are more likely to identify them and do so earlier than before. They also report better protocols, strategic collaboration and information sharing. Carers were provided with more information, including information on their right to a carer’s assessment, and are being identified earlier and better supported during hospitalisation. They feel that professionals better recognise their expertise and understand their needs as a carer. In addition carers felt more able to have a say in shaping the services that they, or the person they care for receive. Carers, themselves, seem to feel that agencies are working better together by the end of the project as well.

Some important areas did not improve. For example, there were no changes found on the impact of caring on carers’ physical or mental health. Nor was there an increase in confidence in the caring role or knowledge of the condition for which they were providing care. It may be that hoping the Moffat Project could impact on outcomes such as these within the given timeframe was overly optimistic. However, given recent research on the effectiveness of carers’ training programmes impacting on these areas (Watson, West & Kelly, 2009; Kelly, Watson & West, 2009), it may be that the early identification, supports and referrals provided by the Moffat Project will translate into these carers participating in the training activities earlier in their caring career roles than would have been the case otherwise. Certainly from this earlier research it was clear that to make significant and global changes in important carer outcomes, appropriate supports were required across the entire caring trajectory. Early identification and early support is crucial, but then ongoing supports and services are required. Moffat, it appears, provided an effective approach to intervening at the early end of the caring trajectory as well as intervening into the lives of carers’ who had been hidden prior to a hospitalisation crisis.

Limitations of the Evaluation

The complexity of the Moffat Project was one of its major strengths. Rather than trying to impose a “one size fits all” approach to working within the different areas, project areas were allowed to develop differently. Such real world approaches are high in realistic validity.
Some research in the effort to standardise interventions can be divorced from real world practice. Standardised approaches do increase the empirical rigour and confidence in the results, and are important to use. However, in the complex world of health and social work, standardised approaches can be impossible to use. Realistic evaluation approaches can be more suitable. However, these approaches, and the one used in this evaluation, do have some limitations. As each site took a slightly different approach, the combined data across all four areas does not represent one “intervention.” Arguably there is enough overlap in the different approaches to still be able to think of the Moffat Project as an intervention. The response rate for the Carers’ Questionnaire was low so the results may not represent all carers served by the Moffat Project. The low response rate also made it impossible to use some of the statistical tests that would have allowed for more cross area comparisons. Where possible this was done. In addition, the data collection tools and strategies were not used consistently across all four sites as they were not always completely suitable. For example, one area focused much more on training and systems work than on direct work with carers, and their database returns may not have been as large as other areas. Some areas were more focussed on direct work with carers and frontline staff were less likely to use the Training and Activity Logs consistently. This has led to some under-reporting so it is likely that more training of professionals and carer related activity occurred than is reported. Finally, the non-intervention comparison area dropped out of the evaluation, so the evaluation used the pre-Moffat Project period across all sites as the baseline.

Recommendations

Despite the limitations outlined above, the data converge sufficiently to make the following recommendations with confidence.

- **Identification of carers should be a part of care pathways from admissions through to discharge planning.** The Moffat Project increased the early identification of carers, who reported improved outcomes in many key areas. This included increased discharge planning, more carers being informed of their right to a carer’s assessment, increased uptake of carers’ assessments, increase in supports provided to carers who received an assessment. Assessments were seen as more helpful by carers, who reported more partnership working and recognition of their pivotal role within the caring relationship.

- **Having dedicated carer support workers within health care settings, both Primary and Acute, should be a priority.** The percentage of carers identified within the pilot areas increased significantly during the project. Key stakeholders and frontline staff reported that having an identified worker with the specific remit of supporting carers in practice and policy was a key component to project success.

- **Carers’ awareness training should become part of the mandatory training for health and social care staff.** Moffat Project workers provided training to over 3,000 health and social care workers. This training and information giving was valued by key stakeholders and frontline workers who appreciated that in order to influence practice and improve outcomes for carers and the people they care for, health and social care staff must have up to date knowledge and skills. Such knowledge and skills must then be translated into and supported in practice.
• **High level strategic coordination across Health, Social Work and carers’ organisations should be standard practice.** This was seen as key to influencing practice and the positive outcomes. Although the level of coordination across the four areas and across the two years varied somewhat, the Moffat Project enhanced partnership working across health, social work and local carer organisations.

• **Further work joining discharge plans and community care packages is required.** There were significant improvements in the number of carers reporting having a discharge plan and the number of carers being offered assessments by social work teams. However, there were still many carers who did not report receiving these services. The Moffat Project has demonstrated that a joint approach can improve this joining up process, but embedding the approach consistently will take time.

• **Consultation with relevant professional and regulatory bodies with a remit of accrediting professional education should occur regarding how to best include carer awareness content within professional educational programmes.** Professional education programmes have a role to play in making sure that new practitioners enter practice being aware of the needs and importance of carers. Consultation with the professional education bodies regarding ways to integrate carer awareness without placing more curricular burden could ensure that all health and social care professionals have a basic awareness of carers.
REFERENCES


