



National Carer Organisation
Training Pilot

September 2007 - May 2008

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the voice of carers

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of carers in Scotland

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OCTOBER 2009



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Glasgow Caledonian University

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All appendices to this report are available in PDF form to download from the following websites:

www.carerscotland.org

www.hccf.org.uk

www.mecopp.org.uk

NCO Carer Training Pilot Introduction

BACKGROUND

In August 2007 the Scottish Government indicated that they were making available £200,000 to fund a project on Carer Training and invited the partnership members of the National Carer Organisations (NCO) to submit proposals on how this money should be spent. The National Carers Organisations are a grouping of 6 national agencies and includes Carers Scotland, The Princess Royal Trust for Carers, The Coalition of Carers in Scotland, Crossroads Scotland, Shared Care Scotland and the Scottish Young Carers Alliance.

The NCO group met to discuss the practicalities of the funding and concluded early on that the money should be utilised in a way which helps carer service providers demonstrate how best training can support, benefit, empower and encourage carers, and ultimately meet their differential needs. It would also provide information which would inform a future strategy for best practice carer training across Scotland and build on earlier initiatives, for example, the “Learning For Living” programme.

In the light of the limits on financial and time resources, it was considered that two areas which held particular challenges would be the most effective way of addressing the issues faced in the training of carers. The NCO group therefore decided to propose an overall project centred on carers within Black and Minority and Ethnic communities (MECOPP) and on carers in a remote and rural area (Highland).

CONTEXT

Carers themselves have for many years identified training as one of their key priorities, and much effort has been invested in addressing carers’ training needs.

The priority of training for carers has been regularly confirmed in research and reports on caring and carers’ issues. As examples:-

Care 21: The Future of Unpaid Care in Scotland recommends that there should be the

development of a national ‘expert carer’ programme. This should include training for people to develop their own caring skills, knowledge and expertise.

Explicit in the **Scottish Government guidelines for NHS Carers Information Strategies** states that as a minimum requirement boards must

set priorities for carer training in agreement with local partners, including carers, local carer support agencies and local authority partners. In doing so local training partners should explore the role of further education establishments and existing carer training packages, as well as the delivery of training using IT systems and technology.

demonstrate delivery of person-centred training for carers, covering advice on physical and emotional well-being including demonstrations on moving and handling techniques (if appropriate) and stress management, and advice on specific conditions such as caring for someone with dementia, physical disabilities, mental health problems, special needs, etc

It can, however, be fairly said that the investment in training has not been consistent, and has lacked a clear strategy and structure. The project has sought to address these issues.

During and around the period of this project a larger (two year) expert carer training pilot project (Caring with Confidence) has been carried out within the four Lothian Carers Centres. The two projects compliment each other.

PURPOSE

The purpose of this report is to present the development, operation and outcomes of the two individual and unique schemes that form the overall project. Each is described separately below. Conclusions, both individual and general are drawn and recommendations made which are directed towards moving forward the future strategy for carer training in Scotland. Evaluation is provided through the report by Prof. Tim Kelly (Glasgow Caledonian University and the University of Dundee).

PILOT AREA ONE: BME Carers, MECOPP

Since its establishment in 1999, MECOPP has gained considerable experience in both developing and delivering carers training to its users. The opportunity to share both knowledge and skills with other Black and Minority Ethnic (BME) carer support services was warmly welcomed by the organisation and what follows is a summary of the learning that took place over the life of the pilot.

The organisation, management and delivery of the pilot was conducted through the National Development Programme (Phase 2), a Scottish Government Equalities Unit funded initiative to build capacity within other Health Boards and local authorities in Scotland.

BACKGROUND

MECOPP received funding from the Scottish Government Carers Unit through the NCO group to develop and deliver a range of training opportunities for BME carers in a number of partnership sites across Scotland.

BME carers were identified as a constituency that were often under-served and/or excluded from existing training opportunities. Prior to the establishment of the pilot none of the partner BME carer organisations/workers had experience of providing training to their users.

The overall **aim** of the pilot project was to develop a range of training opportunities, in partnership with the voluntary and statutory sectors, for BME carers which addressed the specific needs of their caring situation.

The **objectives** of the pilot were:

- to identify geographic locus', communities of interest and partner organisations (statutory and voluntary) for the development and delivery of carer training;
- to work in partnership with social work teams, community organisations (where available), BME individuals and mainstream providers to identify potential beneficiaries;
- to evaluate current capacity of partner organisations to develop and deliver training courses to unpaid carers;
- to respond to the support and capacity building needs of partner organisations to develop and deliver training for BME carers;
- to work jointly with partner organisations to develop and deliver training opportunities in response to identified need;
- to evaluate the effectiveness of the approach developed by the project to inform future developments.

Appendix 1A: Project Development Plan

DELIVERY OF PILOT

The project developed two types of partnership: the first working collaboratively with existing BME carer workers/agencies to develop and deliver a range of training courses and the second undertaking community development in a local authority area where little or no BME carer support existed.

All partnership working was underpinned by a partnership agreement to ensure there was clarity on respective roles and responsibilities.

Appendix 1B: Partnership agreement

The project undertook to provide ongoing support to all partners throughout its duration in the form of 'troubleshooting' (responding to concerns before they pose a threat to the work), facilitation services (language and communication support), community development and responding to the additional training needs of partners.

The courses developed and delivered by the pilot were based on the outcomes of consultation undertaken with BME carers facilitated by the respective support agencies/workers.

Priorities identified included generic training such as moving and handling skills, back care and basic emergency first aid through to training specific to their caring situation such as continence management, coping with arthritis and dealing with challenging behaviour.

Ensuring accessibility was fundamental to the success of the courses and included language support provided by either an independent interpreter or a known BME worker, venues known to and used by BME communities, single sex provision, meeting dietary requirements and the provision of travel and sitter expenses.

The original evaluation process had to be changed due to its perceived unsuitability for BME carers. This was substituted by an evaluation framework developed by MECOPP.

A total of **12** courses were delivered to **115** BME carers in Edinburgh, Glasgow, Dundee and Perth and Kinross. Two further courses on 'working effectively with interpreters' was also delivered to 27 practitioners.

Appendix 1C: Summary of courses delivered.

"Before this course I did not know how to help my husband who I care for to get down the stairs and I also did not understand that there was equipment we could get to help him. I am much more confident now and my husband and I are much more happy because I can help him move around without damaging my back"

Chinese carer in Dundee.

The second partnership site was chosen on the basis of a number of criteria developed by MECOPP which included size of the BME population, an emergent BME infrastructure and capacity of the lead partner to participate.

Due to internal constraints within MECOPP, work with the second partnership site was limited to an initial scoping study with a series of recommendations to be followed up by the agencies involved in the exercise.

KEY CHALLENGES

The first challenge experienced by the project was to secure 'buy in' from both BME organisations and workers supporting Minority Ethnic carers and mainstream carer support agencies in pre-identified partnership sites. This component of the project had been based on the premise that it would be able to capitalise on the pre-existing relationships MECOPP already had with a number of these organisations and individuals, and deliver swiftly against targets set out in the development plan. In retrospect, this was perhaps naive and did not take into account how the project may be perceived as a threat rather than an opportunity to develop additional support systems for BME carers. This was particularly evident in partnership sites where organisations already had a remit to deliver training to all carers and where competition for resources was comparatively greater.

Two distinct sets of concerns were identified. Mainstream carer organisations - where they were approached as potential partners - articulated fears that signing up to the project implied that the services and training they provided were not inclusive and consequently might have a negative impact on the organisation's reputation.

The concerns of BME organisations centered on a lack of internal capacity, particularly in relation to staff time, to take on the additional work required to deliver against the project outcomes. This is symptomatic of the chronic under-resourcing of many BME voluntary sector organisations and it was evident that as the work of the project progressed this would have a significant impact on its delivery. These difficulties were compounded by the fact that the project did not have sufficient resources to fund any additional hours required by project staff.

The project also experienced a number of casualties in the process. An Edinburgh organisation was unable to overcome the difficulties primarily due to a lack of staff hours and internal staff changes occurring during a very constrained timescale. Geographic boundaries also prevented some carer organisations working outside tightly defined areas serving only to further isolate BME carers in areas where the population is relatively small and dispersed.

The identification of the second partnership site also took longer than anticipated. Discussions with potential partners were delayed or disrupted due to the unavailability of key staff at opportune times. The project also had to contend with the view that smaller BME populations - particularly in semi/rural areas - and a subsequent lack of understanding of the issues affecting them coupled with limited resources meant that BME carers were not seen as a high priority. Agreement was finally secured to work in partnership with The Princess Royal Trust for Carers Centre in a rural area in the west of Scotland.

From the start of the project, the discussions and negotiations with local authorities and health boards identified differences in the extent to which BME carers were seen as a priority. Whilst key strategic documents within all partnership sites highlighted the need for specific training for BME carers, in practice the extent to which these needs were met were extremely uneven. At a practical level, valuable assistance was provided by both Health Boards and local authorities in sourcing trainers internally allowing the pilot to maximise its resources.

A number of practical difficulties were also evident in delivering the training. The lack of BME trainers was particularly highlighted, which meant that sessions had to be delivered utilising interpreters. Training sessions therefore took longer and their format had to be adapted accordingly. The importance of preparing trainers and speakers beforehand to enable them to work effectively with interpreters was a key learning point. It was also important to identify community venues which BME communities were familiar with and comfortable using and that were suitable for the type of training being

delivered. An oversight in this respect led to a second session having to be organised in a new venue. Whilst this produced an excellent outcome, it would not have been financially viable in most circumstances. The need to pre-check all arrangements was underlined as a result of this.

LESSONS LEARNED

The need to undertake preparatory work with both BME carers and organisations/workers was underlined. This consisted of visits to potential partner organisations by the project officer; developing publicity materials that could be distributed to their users and involving MECOPP users who had previously benefited from other training opportunities as ‘ambassadors’.

Whilst the above process was relatively straightforward with those organisations that had a pre-existing relationship with MECOPP, it proved more problematic for organisations with whom MECOPP wanted to instigate a working relationship. Ideally, some form of consultation with these agencies prior to the development of the funding application and development plan would have assisted in allaying some of the fears and concerns raised. Unfortunately, due to the timescales involved, this was not possible in this instance. The importance of potential partners both feeling and being actively involved, rather than the frustrations associated with an organisation appearing to ‘parachute in’ cannot be overstated.

It quickly became apparent as the work of the project progressed that the development work element had to be sufficiently flexible to be able to respond to local practice. It was concluded that the same approach to partnership working could lead to different results in different local authorities. A bottom-up approach proved to be more successful in some partnership sites, whilst a top-down approach worked better in others. However, the most successful model would require support from both managerial and front-line staff. In one local authority, the commitment from the Learning and Development Department, was instrumental in ensuring the success of the training delivered to both carers and practitioners.

Having due regard for the difficulties posed by releasing staff for a full days training was also highlighted. Courses needed to be sufficiently flexible to accommodate both half and full day staff participation.

The involvement of local health and social work practitioners in delivering training had the added benefit of creating links with communities previously ‘closed’ to them. Trainers from the statutory sector in particular expressed concerns that they felt ‘inadequate’ and ‘de-skilled’ when dealing with users from a Minority Ethnic background but were enthusiastic about the work. Problems with communication were specifically highlighted. Evidence suggested that ongoing support from the Project Officer was valued when helping to relay advice or providing specific advice on how to disseminate information to a particular Minority Ethnic community.

Initial evidence showed that the training was better received when it was delivered directly in community languages. This enabled a better ‘flow’ to the training allowing participants to maintain concentration and save on both time and resources. Feedback from the project officer identified more interaction between group participants themselves and with the trainer, both individually and collectively, when training was delivered in this way. For example, the Arthritis Management course in Glasgow, delivered directly in Cantonese, received more involvement from participants compared to other courses delivered with interpretation to the same group of carers.

Given the immense difficulties in sourcing BME trainers, the need to work with both trainers and interpreters prior to the training being delivered is paramount. This ensures that there is a consistency in use of language and an understanding of how to get the most out of the interpreting relationship.

Additionally, sourcing information in community languages to support the delivery of the course was also beneficial. For the continence management course, information was downloaded from an official website in Hong Kong. The content was checked for accuracy before the training session. It not only saved time and costs for translation but also promoted the use of resources already available.

The ongoing support from MECOPP as an external organiser/facilitator proved indispensable and highlighted the need for an external agency, with additional resources (whether this is financial, staff time or expertise) to act as an enabler for other BME organisations wishing to develop this area of work.

The importance of adopting a developmental approach to any training programme was also evident. Course evaluations were used to improve the development, organisation and delivery of subsequent courses. More widely, MECOPP was also able to utilise the findings internally to improve its own performance and management.

SUSTAINABILITY

The level of investment - both time and money - required to deliver a training programme to BME carers will always be significant. Numbers attending courses may be low due to smaller numbers of BME carers identified and lower levels of awareness as to the value of training. In this respect, such initiatives may not be seen as being cost effective. Additional costs will also be incurred in providing interpreting and translation to support the delivery of the course. Significant commitment will also be required to build relationships and raise awareness of informal caring within BME communities. MECOPP’s was able to draw on its existing network of contacts which was fundamental to the successful delivery of the project.

The lack of a comprehensive BME carer support infrastructure may also geographically limit the delivery of courses - at present such support services tend to be limited to Scotland's Central Belt.

Time must also be invested in both identifying and building relationships with providers who are to deliver the training - individuals may need to be supported to understand both the value of training and the specifics of working with BME communities, e.g. how to work effectively with interpreters.

The capacity of BME individuals and organisations to deliver training must also be considered whether they are working in partnership with a national initiative or delivering locally. Many BME carer support services have limited staff hours and funding and any additional work may strain already limited resources.

At the time of going to publication, significant funding from the Big Lottery has been awarded to MEAD (Minority Ethnic Access and Development) Project – a project which will develop and deliver a range of support services to BME carers, service users and the new migrant population in Perth and Kinross. As the MEAD Working Group was a partner in the pilot, significant opportunities now exist to extend and further develop the training model for the benefit of BME carers.

OUTCOMES FOR CARERS

BME carers gained direct experience of influencing service provision.

BME carers increased their understanding of their own training needs.

There was an increase in the number and scope of educational activities available to BME carers.

Carers developed more confidence in their individual caring situations particularly through gaining a range of practical skills.

Carers developed greater knowledge about a wide range of support services available to them in their caring role.

Carers developed greater knowledge of their own support needs.

Access to support services increased as a result of the training.

Utilisation of local BME community resources was increased.

The cohesiveness of local BME communities was enhanced.

The isolation of BME carers, particularly in semi-rural areas, was reduced.

“The trainers helped me understand how I could deal better with the difficulties I have coping with the way my son behaves because of his problems. It helped to be given some good ideas and the way these were explained in Punjabi afterwards made them easy to understand”

Glasgow Pakistani Carer

OUTCOMES FOR PARTNERS (BME ORGANISATIONS/WORKERS)

Knowledge of the training needs of BME carers within the partnership sites was enhanced.

Partner organisations gained greater understanding of the most effective training methods for BME carers.

Opportunities for transferable learning were increased, e.g. identifying learning support needs, learning styles and environments.

Knowledge of commissioning specific training was increased.

Partner organisations/individual workers gained increased confidence in working with external trainers.

Partner organisations/individual workers gained increased confidence of facilitating training.

The need to establish quality control mechanisms for commissioning and delivering training was reinforced.

Working relationships were established with a range of external trainers.

“The trainer was very knowledgeable and presented the topic very well. It was most useful to learn about different interpreting and translation modes and the interview process. It was interesting and enjoyable and I look forward to putting it into practice. Thank You”

Resettlement Officer

OUTCOMES FOR MAINSTREAM PROVIDERS

Knowledge of, and links with, local BME organisations in partner sites was increased.

Knowledge of the training needs of BME carers within the partnership sites was enhanced.

Partner organisations gained greater understanding of the most effective training methods for BME carers.

The capacity of service providers to participate as trainers/educators was increased.

More local partnership work was initiated in BME carers support and service provision.

“Everything was useful even gaining an understanding of the basics – how to set up a situation – meeting expectations so I can incorporate this into the situations I will require this for. It was a very informative and worthwhile course – time very well spent”

Occupational Therapist

PILOT AREA TWO: Rural Carers: HCCF

Highland Community Care Forum adopts a community development approach to its work with carers and users of community care services. The emphasis is on working in a sustainable way supporting carer and user networks in remote and rural parts of Highland. It is the existence of these networks, built up over twenty years and supported by HCCF's local community workers that made this twelve month training programme feasible.

BACKGROUND

'I needed to know more. I struggle in my situation and I thought that more information would be useful'.

Carer in Caithness

There had been no formal training structure in place for carers in Highland prior to the pilot.

Any training had been provided on an ad hoc basis and had not been delivered systematically across the region. The pilot project enabled HCCF to develop a systematic approach to carer training.

The pilot's **aim** was to identify, develop and provide opportunities for unpaid carers across Highland to take part in learning and personal development activities locally in partnership with voluntary, statutory and commercial sector partners.

Appendices 2A: Development Plan

The **objectives** of the pilot were:-

- to develop a model of basic learning opportunities for carers designed to promote their wellbeing and capacity to undertake their caring role;
- to raise greater awareness of carers and their needs by building relationships with training providers and service providers across Highland;
- to develop a volunteer mentor programme.

DELIVERY OF PILOT

'I feel much better equipped and I got something out of each course'.

Carer in Badenoch & Strathspey

Adopting a community development approach appeared to be the best way of achieving the outcomes in Highland within the time scale. Reaching out to carers in rural areas required a depth of knowledge of each community and developing working partnerships between the pilot co-ordinator and local involvement workers within HCCF was pivotal to the success of the pilot. Local community care forums also represented a key body of local knowledge which could help to reach out to carers.

It was fundamental to the work of the pilot that the whole process was carer driven and that course development reflected the expressed needs of carers across the whole of the region. Carers' needs were captured in a scoping exercise involving carers across the region using questionnaires, one to one sessions and focus groups. Priorities identified included stress management, assertive communication and developing coping strategies. Also identified was the need to develop knowledge of both the social care system and potential options when planning for the future.

Carers were asked to identify barriers to attending courses; the most common being lack of respite, reluctance to leave caring responsibilities, lack of confidence, and transport issues in rural areas. Carers were also asked to identify what they would like to get out of the sessions. Carers identified the opportunity to step away from the caring role taking time to relax, and the social aspect of attending courses as key outcomes for them.

Appendix 2B: Scoping Exercise

The lack of training in the past and carers' responses to the scoping exercise resulted in the creation of a two tier approach to training:-

Tier one consisted of a course developed to reflect the personal development needs identified by carers. Caring with Confidence covered stress management techniques, assertive communication, coping strategies and relaxation techniques. It was developed using a life coaching approach. In response to the identified need for social opportunities the course was highly social and encouraged carers to share their own experiences.

Tier two consisted of knowledge and skills based courses. Navigating the System, a session designed to help carers find their way around the social care system; Planning for the Future, focussing on considerations for the future such as guardianship and future care options (delivered in partnership with the Citizens Advice Bureau and a local solicitor) and Moving and Handling for carers.

Appendix 2C: Course Descriptors

Bearing in mind the barriers identified by carers, respite and travel costs were offered to enable them to attend sessions. As a lack of confidence was also identified as a major barrier for many carers, Caring with Confidence was designed as a partial response to this issue; it was extremely informal and contained many opportunities to talk to others who would understand. The Project Co-ordinator also spent time working with individuals, encouraging and supporting them to attend courses.

Between September 2008 and June 2009 52 courses were delivered with 303 participants attending in 38 venues across Highland.

The pilot originally involved the creation of a mentor programme to support carers into education or employment. However, in response to carers feedback, a befriending programme designed to help carers to tackle social isolation and build confidence, was created. The Befriending Service continues with a small overspend from the original pilot project.

KEY CHALLENGES

“There are many times I would like to go to something but I can't get there as I can't get transport or respite costs. These courses were accessible, both transport and respite costs were available”

Carer in Badenoch and Strathspey

Developing and delivering a training model which worked across Highland in a timescale of 16 months created challenges. A one size fits all approach was not appropriate. One solution was to adopt a community development approach including delivery of training to existing groups where appropriate. Also working with community based HCCF based Local Involvement Workers enabled the project to tap into very local knowledge and develop relationships of trust in a variety of communities in a short space of time.

Providing courses across an area the size of Highland presented some significant challenges. The availability of transport and respite in rural areas was an issue for many carers. Paying transport costs and encouraging car sharing did enable many carers to attend courses. Paying respite costs enabled people to choose their own respite provider. However, in some areas it was still extremely difficult to find anyone able to provide respite.

The distances travelled by trainers and participants limited the time for delivery of the courses to a day at most. This meant that carers were often taking in a lot of information over a short period of time. Good written materials were vital to ensure that carers could revisit the content of the courses in their own time.

Engaging people with significant caring roles was, on occasions, problematic. Promoting a programme of training opportunities to carers could prove difficult as many carers did not see that it had relevance to their lives. Committing to the unknown was also daunting to some carers.

Engagement with the statutory and voluntary sector was, initially, slow. However, during the life of the pilot it was possible to begin to build relationships with other organisations, particularly once the courses had been developed and there was something tangible to offer.

The development of the volunteer programme needed to be revised as a result of feedback from carers and potential volunteers. Setting up and establishing the programme at the same time as developing and delivering training to a challenging timetable has proved to be problematic.

SUCCESSSES

'I am feeling less isolated'.

Carer in Inverness

Although the delivery of such an ambitious pilot presented significant challenges, it was extremely successful with carers who attended the courses reporting positive changes to their own well being, confidence and Knowledge.

Appendix 2D and 2E: Carers Feedback and Transcripts

The pilot was subject to an independent evaluation undertaken on behalf of the NCO group by Glasgow Caledonian University. The findings of the evaluation echoed the positive messages already heard from carers.

The evaluation commended the tiered approach to delivering training which built upon carers capacity and knowledge recognising that 'Highland ...developed a learning pathway for carers that was responsive to local needs', describing this approach as a blue print for a strategic, systematic and long term plan for lifelong learning and potential return to paid employment.

KEY LESSONS

"When I came along I realised that it was a mix of different types of carers and that there were a lot of people in a similar situation to me"

Carer in Ross-Shire

The preparatory stages of the project were fundamental to the success of the pilot. Involving carers in the design of the courses from the outset offered an early opportunity to introduce the idea of training to people who were not used to being able to access training which supported them in their caring role. It also ensured that the topics which were covered in the various courses reflected the needs identified by carers. This approach meant that promotion of the courses to both carers and professional from the NHS and Social Work Services had more impact as it was possible to identify the pilot as having been shaped by the needs of carers across Highland. The work done during this time created a sound foundation for delivery of the courses and involving carers in course design was fundamental to the success of the programme.

The preparatory stages of the pilot were extremely important. The work done during this time created a sound foundation for delivery of the courses and involving carers in course design was fundamental to the success of the programme.

People needed to feel ready to attend training. With some carers this involved working with them on a one to one basis to ensure that they felt sufficiently informed and equipped to attend courses.

One of the biggest benefits in the provision of training was the opportunity to bring people together in groups. Much of the feedback received highlighted the benefit of meeting others who were in similar situations.

Developing the training programme over several levels, or tiers, proved to be effective at building capacity to attend training. Adopting a life coaching approach to the tier one course was particularly effective. The approach was extremely empowering and many carers reported developing a fresh perspective and increase in confidence as a result of the approach.

The ability to offer an holistic service to carers greatly enhanced their experiences of training with a number accessing support from other parts of Connecting Carers as a result of attending training sessions.

Promoting the training to professionals Social Work Services and the NHS was an opportunity to give them an insight into the needs of carers. There was significant interest in several of the courses, particularly Navigating the System, and the possibility of adapting and delivering some of the courses to professionals is worth exploring.

Developing a partnership approach to training with other organisations from both the voluntary and statutory sectors will increase capacity. Using specialist knowledge to deliver training on specific topics such as giving medication would be particularly valuable.

SUSTAINABILITY ISSUES

"I do feel more confident but I am also more conscious that I need more help"

Carer in Caithness

A significant commitment is required to build relationships in rural communities. The process is not a linear one and one size does not fit all. There is a need to be creative and to be willing to try different approaches to determine whether they work. This takes time and appropriate funding.

In order to develop training which responds to the needs of carers' input from other organisations, particularly the NHS needs to be secured.

The investment needed to deliver training in a large rural area will always be significant. In many areas the number attending courses will be low, reflecting the population density. Transport costs and respite costs will also be higher in rural areas.

Training for carers in Highland will continue in the short term. In January 2009, NHS Highland and the Highland Council committed to continue funding carer training until March 2011 as part of the work funded by Carer Information Strategy monies.

OUTCOMES FOR CARERS

'I had a good day today. I felt happy today'.

Carer in Aviemore

Carers have approached social work services and their GPs and asked for an assessment of their own needs.

Carers have sought to have the care plan of the person that they care for reviewed.

Carers have been empowered to tackle issues relating to their caring role with support from advocacy.

Several carers have applied to Highland Council for a rebate of their Council Tax.

Information about the benefits system has enabled carers to apply for Carers Allowance and Disability Living Allowance.

The majority of carers attending Caring with Confidence sessions reported feeling better able to cope with their caring role and having a better understanding of their own needs.

One carer reported that attending the moving and handling course resulted in a reduction in the pain she suffered when supporting the person she cared for.

One carer reported that by using the moving and handling techniques she had learned, she had been able to encourage the person she cared for to be more independent.

"I enjoyed the courses. They were all very different, all helpful in different ways"

Carer in Caithness

Evaluation of the National Carers Organisations' Carer Training Initiative

This section of the report describes the evaluation and briefly presents the key findings of the evaluation of the separate projects. This is followed by an overall perspective and a discussion and recommendations. A full report on the results can be found in [Appendix 3](#).

METHODOLOGY

The aim of the National Carers Organisations' Carer Training initiative was to provide opportunities for unpaid carers from Black and Minority Ethnic (BME) communities and from the Highlands to take part in learning and personal development and to continue their role safely. The grant further outlined specific objectives which were to:

- support and improve carers' emotional, physical health and wellbeing;
- support and develop carers' skills and knowledge;
- provide opportunities to enable carers to have "an ordinary life" including the opportunity to take part in education and lifelong learning and learn skills to enter or return to employment;
- provide a sound knowledge and information base to form a comprehensive strategy for carers' learning and development.

In order to evaluate the effectiveness of the NCO Project it was necessary to examine if the NCO Project met the objectives above, and if so, identify how they were achieved. As such, a multi-method evaluation design was designed and the research received ethics approval from Glasgow Caledonian University. The methods will be described below:

Pre-test post-test design - Course participants were asked to complete a questionnaire prior to taking their first training course and again after they finished their training. The post-test questionnaires were to be administered approximately 6 weeks after the final training. However, the time ranged from shortly after the final course to several months. The questionnaire was translated into Chinese and Urdu for those participants whose first language was not English.

The questionnaire measured change in 16 different areas that carers have previously identified as being important outcomes. The areas measured included:

- Feelings about being a carer
- Confidence in relation to being a carer
- Ability to manage the caring situation
- Physical and emotional health
- Feelings of stress
- Time for self
- Feelings of isolation
- Support for self as a carer
- Communication with professionals
- Working with professionals
- Financial situation
- Knowledge in relation to the course taken
- Skills in relation to the course taken
- Quality of care provided
- Difference the course made to caring situation

In addition, two open ended questions were included that asked carers to explain any of their answers or to tell us anything they wished about their experience of being a carer. Finally, demographic information was collected as well. Where appropriate paired sample t-tests and unpaired t-tests were used to test for differences on the questions before and after the training. Descriptive statistics were used to summarise demographic data.

An additional training evaluation questionnaire was used in the BME projects. This pre-post training questionnaire consisted of five questions asking participants to rate their knowledge and skills that were taught in the training sessions. Three other questions asked about satisfaction with training methods. Where appropriate paired sample t-tests were used to test for differences on the questions before and after the training.

Focus groups - Focus groups were designed to be used as part of the evaluation to examine outcomes and process variables of interest to the evaluation. This included some areas also addressed in the questionnaire but also gave participants the opportunity to describe potential benefits of the training that were not part of the questionnaire. Focus groups also explored process variables such as training methods and attention to culture. Finally they also allowed participants to identify next steps for them as carers.

Face to face focus groups were held with carers from Black and Minority Ethnic groups in Dundee, Edinburgh, and Glasgow. Translators were used for the Chinese carers and the Asian Carers. One group of Black carers was conducted in English; however a representative from the host BME organisation was present in the focus group at the carers' request. Focus groups with rural carers were held in Dingwall and Thurso. In addition, three telephone focus groups were held with carers from other parts of the Highlands. The interviews were recorded and analysed using thematic content analysis.

Interviews with trainers, outreach workers and interpreters - Individual interviews and focus groups were held with trainers, outreach workers and interpreters and these interviews addressed issues such as strengths and weaknesses of the training, barriers to providing the training, any benefits they observed, and changes they would make if doing the training again. These interviews were analysed using thematic content analysis.

Interviews with Project Leads - Finally interviews with Project Leads were held in order to get a strategic overview of the entire project and their perspectives on the initial data analyses, barriers and difficulties they experienced, lessons they learned, and other thoughts about the strengths and limitations of the projects. Again these interviews were analysed using thematic content analysis.

KEY FINDINGS FROM THE BLACK AND MINORITY ETHNIC CARERS TRAINING PROJECT

The multiple sources of data collection generated a considerable amount of information and provided for many interesting results. These results allowed for the development of a rich picture of the projects as well as a triangulation of findings during the analysis. Cross cutting themes were identified in the focus groups and interviews with the carers, trainers, interpreters and Project Leads. In addition, explanations for some of the quantitative findings were explored. A full description of the results of the evaluation can be found in Appendix 3. Here we will now simply outline the key findings from the BME project. These key findings include:

- 24 participants completed both the pre and post-test carers questionnaire, 32 completed the course evaluation, 55 participated in focus groups.
- Statistically significant change was found on all carer outcomes measured in the evaluation questionnaire.
- Based on course evaluations and focus groups, the training was positively received by carers both in terms of content a process of delivery.
- Paying attention to culture and overcoming cultural barriers was of paramount importance. For example:
 - Issues of language are vital, and
 - A cultural liaison is required.
- Carers from BME communities are hungry for more training opportunities.
- Networking and preparatory work is essential and very time consuming for course organisers and community workers.
- Barriers to forming successful partnerships include political, organisational, and resource sensitivities. Finding creative solutions to the barriers is time consuming, but possible.
- Active and participatory training works best.
- Focus groups and interviews with key stakeholders further deepened the understanding of the benefits derived from attending the courses. These benefits included:
 - Increased information;
 - Providing better care;
 - Increased knowledge and skills;
 - Mutual aid and support; and
 - Access to other resources.

DISCUSSION OF THE BLACK AND MINORITY ETHNIC CARERS TRAINING PROJECT

Two of the objectives of this project were to support and improve carers' emotional, physical health and wellbeing, and to support and develop carers' skills and knowledge. Based on the evidence it appears that these objectives have been met. For example, every question on the evaluation questionnaire relating to carer outcomes indicated a positive change. However, these overwhelming positive changes indicated in the data bear closer scrutiny as it seems unlikely that attendance at a training course, no matter how excellent, would have such far reaching impact. At the same time, it is not necessary to discount the results because of the unlikelihood of such a finding.

In reality, there probably is some social desirability and statistical regression occurring within these results. However, the qualitative data also suggest that the training courses helped improve carers' knowledge and skills as well as health and well being. The focus groups with the carers and the interviews with trainers, outreach workers and course organisers all indicated that these carers had a dearth of support, information and training prior to this project. Many of them also had bleak and isolating caring situations. So when starting from such a deficit, such support for the first time is bound to improve some areas. Certainly there were numerous examples of increased knowledge and skills as well as taking better care of oneself within all the qualitative data. These qualitative data would support what was found in the questionnaire and the training evaluations. The Chinese Moving and Handling course is a good example of this. It is probably safe to say that the first two objectives were met, but probably not as strongly as the quantitative data suggest.

Some other findings are worth noting at this point as they were consistent across several sources of data. First, it appears that the importance of outreach and community development approaches cannot be overstated. Carers, trainers and course organisers all discussed how vital it was to have a bi-cultural worker who could reach out and help the carers enter into and navigate this new world of carer training. This is a slow and laborious process, but important to the success of engaging marginalised groups of people and building community capacity.

The focus groups and information from the trainers and outreach workers also support several benefits of the training beyond increased knowledge and skills. For example, carers received many referrals and access to needed resources and adaptations as a result of the training. Carers also described increased confidence in their caring roles and feeling less stress. The new knowledge and skills also were cascaded beyond the individuals who took the courses as they shared the information with family and friends.

The power of mutual aid and social support was also an important finding that was echoed across the various sources of data. Bringing these carers together helped to combat some of the isolation they experienced. They also were able to support and learn from one another. These benefits go beyond the content, knowledge and skills.

The Black and Minority Ethnic Carers Project had additional outcomes beyond the provision of training. These included objectives concerning the development of partnership with mainstream carers organisations. The partnerships were envisioned to build capacity in and support partner organisations in their efforts to support carers from BME communities.

By and large, establishing these partnerships was successful. For example, training local authority staff on how to work with an interpreter was well received. However, barriers to successful partnership working were encountered in all the projects. These included resource issues (e.g., the considerable time required for staff from the project and the partner agencies to establish the partnership working arrangements as well as carry out the partnership work), political issues (e.g., working across boundaries and being sensitive to the work of other existing organisations, working through differences of opinion, and confronting different priority levels for BME carers), and other organisational and environmental challenges (e.g., changing staff, differing relationships across partners, under resourced partners).

Given the short timeframe of this project, it is highly commendable that such complex issues were sufficiently dealt with to deliver outcomes in most partnerships. Except when partner organisations ceased to exist, sufficient progress was made in partnership development to warrant further development of the partnerships. Time and continued sensitivity are required.

KEY FINDINGS OF THE HIGHLANDS PROJECT

Like the BME project, the multiple sources of data collection generated a considerable amount of information and provided for many interesting results for the Highlands project. A full description of the results of the evaluation can be found in [Appendix 3](#). Here we will simply outline the key findings from the Highlands project. These key findings include

- 69 carers completed at least one of the carers questionnaires and 21 answered both the pre and the post-test. 20 carers participated in focus groups.
- Statistically significant improvements were found in feelings of support, finances, knowledge and skills, and isolation.
- Training courses were well received both in terms of content and delivery.
- Distance and lack of resources in rural and/or remote areas are barriers to participation. Participants felt the project successfully addressed these.
- Carers wanted more courses and valued a suite of courses.

- Organising carer training in remote and rural areas requires considerable labour intensive pre-training work and community development.
- Focus groups and interviews identified benefits to participation. These included:
 - Receiving support from other carers;
 - Accessing resources and financial and legal planning;
 - Improved finances;
 - Receiving needed information;
 - Taking better care of oneself;
 - Recognising and dealing with stress;
 - Being better able to deal with professionals;
 - Being reassured and more confident;
 - Courses were a form of respite; and
 - Feeling listened to.

DISCUSSION OF HIGHLAND RESULTS

Two of the objectives of this project were to support and improve carers' emotional, physical health and wellbeing and to support and develop carers' skills and knowledge. Based on the evidence it appears that these objectives have been met. Carers felt more knowledgeable in relation to their caring role, more supported, more positive about their financial situation, more skilful in relation to their caring role and less isolated. Because the numbers of participants completing both the pre and post-test was low, we do not have as much confidence in these results as we would like. However, when considered alongside the data from the focus groups with the carers and interviews with trainers/course organisers, one can have much more confidence in the results.

Take for instance the finding about improved finances, the statistical analysis suggested that carers felt less negative about the financial impact caring was having on their lives. In the focus groups with carers, most of them indicated finding out about benefits and supports that they were entitled to as part of the courses. They also indicated that they acted on the new information almost immediately after the course. The Project Lead and course trainers also reported witnessing "light bulb" moments when carers realised that they were entitled to receive assistance and were making plans to access the assistance. Taken together, these data strongly suggest that the courses did have a beneficial financial impact on the lives of many of the carers in the training.

The statistical analysis also suggested that carers may feel more supported in their caring role and less isolated as a result of the courses. Again, the focus groups with carers support these findings. The focus group participants spoke at great length about the support and mutual aid they received from other carers. They also spoke about feeling that the Carers Can project was on their side. In addition, they described the referrals to other support services, the provision of information, and other instrumental supports provided through the course. These supportive activities were echoed by the interviews with the professional staff. Taken as a whole, these data do suggest that carers felt more supported as a result of these courses, and we are provided with some explanations as to why that is the case.

The increase in knowledge is strongly supported in the qualitative data. The provision of information was a common theme across all the qualitative data and of vital importance to carers. We know that carers have a very difficult time accessing information they need, and as these courses were information rich, it is not surprising that this is such a consistent finding. Increased skills were also identified in the qualitative data. These skills included better moving and handling skills, but also an increase in communication skills for dealing with professionals, as well as self-care skills. Again, the triangulation of data strongly supports that the courses had a positive impact on carers' skills and knowledge.

A third objective was to provide opportunities to enable carers to have "an ordinary life" including the opportunity to take part in education and lifelong learning and learn skills to enter or return to employment. This project has given carers the opportunity to take part in education and lifelong learning. However, the objective for learning skills to enter or return to employment is probably an unrealistic objective for most carers within this short pilot project. For many carers this was the first training they had participated in. The Project Lead spoke about the incredible efforts she had to go to in order to encourage and support people to attend. This was an exercise in capacity building, and for many of the carers their caring roles have placed them at a great disadvantage for learning and personal development. A long term approach of capacity building and community development will be required to reach many of these carers. On the other hand, there will likely be a much smaller number of carers who are at a very different place. For example, two of the carers in the focus groups discussed all the skills they have acquired as a result of their caring roles and are thinking about pursuing a career in caring. They have started to look for vocational qualifications they can take while continuing their current caring role. They report that these courses have supported them in this process.

Some other important findings emerged from the qualitative data, rather than the statistical data. Focus group participants and course trainers identified benefits of the training that are related to but outwith the discussion above. For example, the carers in the focus groups described how they were taking better care of themselves as a result of the training. The trainers echoed this. Part of taking better care of oneself is recognising and dealing with stress; the carers in the focus group discussed this at length, and this was again echoed by the trainers. The carers also described feeling more confident and reassured in their caring, and trainers echoed this in their observations that carers felt listened to and understood for the first time in a long time.

Some process findings also emerged from the qualitative data. The first relates to the importance of outreach to carers. Many of the carers described how the Project Lead really worked to reassure and support them to try one of the courses. The Project Lead and trainers also described the importance of this. For example, the Project Lead described how important, yet time consuming, it was to contact, connect with, support, problem solve, and encourage the carers to try something new like the Caring with Confidence course. Simply turning up in a community to put on a course would not work in the Highlands. A lot of pre-training work is required.

The second important process finding is the importance of understanding and overcoming barriers faced by carers in the Highlands. The Project appears to have really understood the barriers and put in place many things to overcome them. These include trying to cut down on distance by moving the training around, assisting with travel expenses, being able to provide replacement care so carers could actually get away from their caring, designing the first course as a capacity building training experience, attempting to incorporate cultural aspects into the training, and doing an in-depth and participatory scoping exercise to ensure that they were delivering what carers wanted and needed.

A VIEW ACROSS BOTH PROJECTS

Across both projects **103** carers participated in the questionnaire component of the evaluation and **75** were involved in focus groups. An additional 32 carers completed a training evaluation for some of the BME courses. When the data for both projects are pooled, all 16 questions concerning carer outcomes indicate a significant positive change from pre-test to post-test. The strong changes in the BME carers' data exert influence over the pooled data. Though with increasing numbers statistics usually become more reliable or generalisable, in this situation it is probably safest to view the statistics separately due to reasons described earlier - namely uncertainty of the effects of social desirability and statistical regression in the BME data. It appears that changes did occur on key project outcomes in both projects, especially when viewed alongside the qualitative data, however we must be conservative with how much change we ascribe to the courses in the BME project.

When considering the qualitative data we can be more confident in the findings. Interestingly, despite very different cultural and geographical areas, there are some surprisingly similar findings across both projects. These will be described below.

ISOLATED CARERS HUNGRY FOR MORE TRAINING AND SUPPORT

First and foremost, the courses were overall well received by carers in the Highlands and from BME communities and the carers were hungry for more training and support. The reasons for this hunger are similar in both groups. Both groups are isolated and underserved. The reasons for this will be different as BME carers face language and cultural barriers, and carers from the Highlands face distance and rural barriers. However, the end result for both groups has been the same - caring in isolation.

IMPORTANCE OF OUTREACH, CAPACITY BUILDING AND COMMUNITY DEVELOPMENT

Interestingly, many of the strategies for overcoming barriers appear to be the same. Both projects attempted to use community development and capacity building approaches. This included a great deal of time and effort spent on outreach to individual carers, but also to key people and organisations within communities. For example, in the Highlands the Project Co-ordinator had to telephone individual carers and encourage and support their efforts to attend training. Community outreach workers had to do the same in the BME communities. In the Highlands it was important to find key partners and try to reach out to carers through them. This was the same for the BME project. Carers in both groups were not used to training and had to be prepared to undertake training. These efforts cannot be overstated.

WORKING WITH ESTABLISHED NETWORK RELATIONSHIPS

Working with established relationships was very important and facilitated the development and implementation of courses. Where these existed it was possible to reach carers and deliver training. Difficulties occurred where relationships did not already exist as these relationships take time to nurture and develop. For example, efforts in two areas in Highlands did not pan out. Yet in one of the areas a relationship with a network has now been formed and development work is possible in the future. In the BME project, relationship building with key partners in a semi-rural location was fraught with difficulties.

However, work with several of the key partners has led to a newly formed productive relationship. Given the time constraints of the project, work was not able to proceed further at this time. However, there is hope for future developments if resources to support this work are available.

TIME CONSTRAINTS

Time, on various levels, was an issue for both projects. Due to the need for a lot of preparatory work, developing and delivering training for Highland and BME carers is a time and labour intensive endeavour. This was an ambitious project for an 18 month time period, and given more time more of the development work could occur. MECOPP lost its Project Lead midway through and this added to the time pressures for them.

The outreach work was also labour and time intensive for both projects. Future developments will need to find ways to resource the time required for outreach if we are to reach these isolated carers. It appears that carers from BME communities are even more dependent on outreach workers to access training.

In addition, there are time constraints for individual courses as well. Due to the difficulties faced by carers in getting to training, a tension exists between giving as much information and support as possible in limited time and giving things proper time and attention. Carers in both projects indicated that they wished the courses could be longer. At the same time they realised the difficulties this would cause - both for them as carers, but also for organisations providing the training. Course planners did agonise over this dilemma, and without significant resources for travel, respite provision, translation, and trainers' time, this will always be a difficult choice.

BENEFITS

The benefits of carer training were similar across both groups. A key area seems to be an increase in information. In some ways this should not be surprising as lack of information is a universally difficult area for carers in general. Carers from rural areas and especially from BME communities appear to have an even greater dearth of access to information. Regardless of what course or courses were taken, carers received information on aids, adaptations, resources and supports that could be of benefit to them. Each course also provided some information that could be translated into skills. Carers valued this new information so much that they have begun to cascade that information to other family and friends.

Mutual aid was another benefit that cuts across both groups. Given that these were isolated carers it should not be a surprise that they all indicated the importance of social support, mutual aid and finding out that they were not alone.

Taking better care of oneself is another benefit that was described by carers from both projects. This could be anything from taking time out from caring, recognising and dealing with stress, safer moving and handling techniques, better nutrition, gentle exercise to incontinence training exercises.

Though there are other examples of benefits to carers, they all relate to increased knowledge and skill in relation to the caring role as well as improved health and well being. It appears, then, that the projects did demonstrate the ability to impact on these key areas from the objectives of the overall project.

PARTICIPATION IN EDUCATION AND LIFELONG LEARNING

Another goal of the project was to provide opportunities for carers to have "an ordinary life" including the opportunity to take part in education and lifelong learning and learn skills to enter or return to employment. Given their caring situations, any programme would have difficulty in providing an ordinary life, whatever that may be. However, as will be apparent in the separate reports written by the individual projects, both projects delivered in the area of providing education. In addition, two carers from the focus groups in the Highlands indicated they were moving towards more training in caring for an eventual return to work in paid care work. In the Chinese group two participants may receive additional training to be volunteer outreach workers. Though anecdotal, these examples suggest that carers' training can have implications for lifelong learning and potentially for return to paid employment.

In order to deliver on this goal of lifelong learning and potential return to paid employment, a strategic, systematic and long term plan must be developed. A blue print exists in one of the projects.

The BME project developed training to meet the immediate needs of carers based on some initial scoping. Discrete training courses were developed to meet the needs of discrete groups of carers from BME communities. For example, a group of SE Asian carers was suffering from arthritis and this was making their caring more difficult. Developing a course to teach them to take better care of their own condition as well as supporting them in their caring role was important. Such courses could be developed for other carers as well, so the pilot served a useful purpose in developing a new type of carer training. The Chinese carers in Dundee needed a moving and handling course to help them be better carers. Not only did this course provide great benefits to the participants, but in the process of developing and running this course a host of invaluable and

transferable lessons were learned. However beneficial this approach was to the immediate needs of those carers, this approach is not as strategic as required to deliver on higher level objectives.

The Highland project, on the other hand, does supply a potential blueprint for delivering on this objective. Their initial scoping exercises started with a dual purpose. The first was to assess need and the second was to begin the capacity building process. Carers in the Highlands were not used to training of any kind, let alone education for lifelong learning or return to work. As such, they had to get used to the idea of training and learning how to learn. The two-tiered approach they developed built on the initial capacity building in the scoping focus groups. The tier-1 level provided a lot of information and support for caring, but it was also designed to get carers used to learning and training in an organised setting. The tier-2 courses then built on this and were developed as a suite of learning that people could dip in or out of based on their own needs. Rather than developing a series of one-off courses, the Highland project developed a learning pathway for carers that was responsive to local needs. Such an approach has the potential to improve the lives of carers by providing them with the knowledge and skills and supports they need in their caring role, but it also has the potential to provide the skills and some opportunities for lifelong learning.

INFORMATION TO FORM A COMPREHENSIVE STRATEGY FOR CARERS' LEARNING AND DEVELOPMENT

The final objective in the grant was to provide a sound knowledge and information base to form a comprehensive strategy for carers' learning and development. Certainly both projects within NCO Carer Training Initiative have identified important lessons that can inform future developments in carer training, especially for carers from rural and BME communities. In addition, the lessons can help to form a comprehensive strategy as well. Based on this project, key points for this strategy should include:

- Local scoping of carer needs for and barriers to training
- Dual emphasis on capacity building for lifelong learning and training to meet carers' needs in caring
- Development of a suite of courses or a learning pathway
- Appropriate investment in outreach workers and other required supports, such as trainers and interpreters
- Developing strategies for overcoming barriers identified in scoping exercise
- Developing a long term view of the process
- Investing time and energy into building networks with carers and carers' organisations as well as health and social care professionals

CONCLUSIONS AND RECOMMENDATIONS

This evaluation has demonstrated that carers from rural and BME communities are able to participate in and benefit from carers training programmes. However, in order to participate in such programmes a good deal of outreach work is required - both to individual carers but also to existing networks and organisations. These groups of carers also face significant barriers that must be overcome to allow their participation. The preparatory and supportive work takes resources and time. Both of the pilot projects within the NCO Carers Training Initiative have demonstrated ways that this preparatory and supportive work can occur. In addition, a model of good practice has been identified. Based on these findings we make the following recommendations:

1. Carers training programmes should be developed and delivered for BME and rural communities;
2. The training programmes should be part of a long-term and strategic plan to build learning and development pathways that support knowledge and skills for caring as well as for lifelong learning;
3. The training programmes should be adequately resourced so that appropriate levels of community development and outreach can occur. Because of the small percentage of people from BME communities in most areas across Scotland, local governments may have difficulty allocating sufficient funding for such work when balanced against the larger areas of need they face. As such, creative ways for financing such work should be found. Examples include, cross council funding or joint funding with health, education and social work;
4. Budget levels should be set to ensure that appropriate supports are available to overcome barriers to participation. Depending on the population this would include funding for transportation, replacement care costs, translation, and experienced trainers.

Conclusion NCO Group

It can be seen from the preceding pages of this report that many powerful messages have emerged from an unpaid carer training project which ran with limited resources over a defined timescale. The individual elements and the evaluation draw several conclusions and lessons learnt. Overall, key conclusions can be summarised as:-

The project has confirmed the ongoing priority of training for unpaid carers to enable them to continue in their caring role. Both pilots have demonstrated the value of investing in training which produces positive outcomes for carers and the cared for. It has also further strengthened the validity of the views on training expressed within the “Care 21” Report, and in the Guidelines on Carer Information Strategies.

The results from this project highlight the need to develop strategic training infrastructures which support carers both in themselves and in continuing to care - particularly vital in the light of current demographic changes, a shift in the balance of care from institutional to community settings with the attendant increase in pressure on unpaid carers, and the ever-increasing constraints on public sector budgets.

Training has relevance for all carers in that, properly designed and delivered; it can provide positive outcomes for carers on an individual basis which addresses their own particular needs and circumstances. This project has supported that contention, both through the successes and the challenges arising within the pilots.

The importance of partnership working has also been clearly demonstrated; both through the successes and challenges of the pilots. Given that, at some stage in their life, ninety percent of the population are likely to take on some level of caring responsibilities and that increasingly these responsibilities will become heavier, organisations supporting carers will find the challenges of providing consistent, high-quality training and services ever more difficult. It is essential, therefore, that a strategic approach to training highlights the need to maximise the opportunities for partnership working.

The adoption of a person-centred approach to the design of training has been one of the key successes of the project. Working with carers to define and respond to their own expressed needs has ensured a high level of commitment on their part, and highly positive outcomes from the training. The approach should not, however be confined to subjects to be covered; but needs to take account of carers' circumstances which may affect their ability to take up other training opportunities.

Training of any workforce is vital in sustaining good productivity and carers are the largest albeit unpaid workforce in the UK today. It makes absolute sense therefore, given the results of this project and the good outcomes for carers and the cared for that, investment in carer training should be a priority. During times of financial strictures, investment in training is an easy and early target for reductions, the impact of this targeting being felt later. Given the present and future challenges facing Health and Social Care services, investment in that huge resource namely, unpaid carers is essential. However much the expenditure is *now*, it should be viewed in the light of the potential costs to services and supports in the *future*, should that community and network of unpaid caring breakdown.

Finally, the thanks of the National Carers Organisations and the Project Steering Group go to all who have played a part in this stimulating challenge:

To the Scottish Government who invited the National Carer Organisations to develop the project, and provided the funding;

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Most importantly, thanks go to all the carers who gave their valuable time and commitment to participate in each of the pilot areas training programme.



National Carers Organisations consists of:

- Carers Scotland
- Coalition of Carers in Scotland
- Crossroads Caring Scotland
- The Princess Royal Trust for Carers
- Scottish Young Carers Services Alliance
- Shared Care Scotland



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