
Inquiry into adult carers' experiences of social work and social care services

December 2022

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Foreword

It is estimated that there are around 800,000 adult carers in Scotland. The contribution of unpaid carers is critical to the sustainability of the health and social care system. The importance of carers is reflected in the Scottish Government commissioned Independent Review of Adult Social Care and the proposed legislation for a National Care Service.

We undertook this inquiry to help us understand adult carers' experiences of adult social work and social care services. We focused on the support carers received to maintain or improve their quality of life and to support their ability to continue to care. The inquiry was carried out while health and social care partnerships continued to be in a period of recovery and remobilisation post the acute phase of the Covid-19 pandemic.

This report draws together the views of carers, health and social care partnerships, local carers' organisations and service providers. The findings of the inquiry contribute to learning across social work and social care sectors and aims to inform how future support for carers can be developed and improved.

Jackie Irvine

Chief Executive

Care Inspectorate

1. Introduction

Part of the role of the Care Inspectorate is to scrutinise the social care and social work services delivered by health and social care partnerships. In turn, part of the role of health and social care partnerships is to support unpaid carers. We carried out our inquiry to better understand adult carers' experiences of adult social work and social care services. We focused on the support carers received to maintain or improve their quality of life, and their ability to continue to care. Our inquiry identified improvement areas for health and social care partnerships to consider for adding value and focus to strategic planning for carers' services. Learning from the lived experiences of carers should shape improvements across social work and social care. The improvement areas we identified will also inform our own areas of focus in future strategic inspection work.

We focused on carers' experiences of progress in implementing the Carers (Scotland) Act 2016. In particular, we focused on the duties and responsibilities conferred on local authorities. These were delegated to integration joint boards and NHS Highland and Highland council's single agency lead authority in line with the Public Bodies (Joint Working) (Scotland) Act 2014. (Highland delivers integration through a single lead agency model. In this report, we include Highland when we refer to health and social care partnerships.) Health and social care partnerships have responsibility for the implementation of the Carers (Scotland) Act 2016. Social work and social care services are part of health and social care partnerships.

Health and social care partnerships' key responsibilities include:

- offering and preparing adult carer support plans
- setting local eligibility criteria
- providing support and replacement care
- involving carers in service planning
- preparing a local carer strategy
- establishing and maintaining an information and advice service
- preparing and publishing a short-breaks service statement.

Our inquiry focused on seven key questions.

- How did carers experience approaches to providing adult carers with the opportunity to receive an adult carers support plan and their review(s)?
- Were carers supported to understand their options and rights? As a result, was their health and wellbeing maintained, helping them to continue to care?
- What were carers' experiences of accessing information and advice?
- Were carers able to access in good time a range of preventative and enabling social work and social care services?
- Did carers experience personalised and coordinated social work and social care support?

- To what extent did health and social care partnerships engage, involve and communicate with carers (including their respective representative organisations) in the planning and evaluation of services?
- How did health and social care partnership leaders know that their local carer strategy had supported positive health and wellbeing outcomes for carers and helped them to continue to care?

We carried out our inquiry between March and August 2022. This followed the most acute phase of the Covid-19 pandemic to date. Most legal restrictions in relation to social work and social care services had been eased. The impact of the pandemic on social work and social care services was ongoing. This impact was evident in areas such as staff recruitment and retention challenges, sickness absence levels and in the recovery and remobilisation of some services.

Our focus was carers' current experiences of adult social work and social care services.

Our inquiry processes

Phase 1 – Planning and information gathering

Our inquiry team collated and analysed publicly available data (for example from Scottish Government and Public Health Scotland), intelligence held by the Care Inspectorate and information provided by health and social care partnerships. Local and national carers' organisations contributed to our planning for the inquiry.

We developed a quality indicator framework specific to our inquiry. These indicators related to carers' outcomes and experiences, and carers' and other stakeholders' engagement in planning services, and leadership and direction.

As well as having a nationwide focus, we undertook additional work with five participating health and social care partnerships that had volunteered to work with us. In these partnerships, we worked with social work staff and leaders, local carers' organisations, service providers and carers. This gave us a deeper understanding of individual carer experiences at a more local level. We are grateful to the partnerships that volunteered to participate.

Phase 2 – Surveys, engagement and analysis

We had direct contact with carers, health and social care partnerships, local carers' organisations, national carers' organisations and care and support service providers across Scotland. This contact involved the following activities.

- 1,489 self-identified adult carers gave a written response to a set of key questions in an electronic survey.

- 26 health and social care partnerships gave a written response to a set of key questions in an electronic survey.
- 20 local carers' organisations gave a written response to a set of key questions in an electronic survey.
- We held online focus groups with 85 social work and social care staff, service provider representatives and senior leaders across the participating health and social care partnerships.
- We held online and in-person focus groups with 24 staff and leaders from local carers' organisations across the participating health and social care partnerships.
- We held focus groups and individual conversations using telephone, video conferencing, or a mix of both with 91 identified adult carers within the participating health and social care partnership areas.
- We held focus groups with national carers' organisations, Scottish Care and the Coalition of Care Providers Scotland.

Phase 3 – Reporting

Appendices 1, 2 and 3 to this report provide numerical analyses of our survey findings. Appendix 1 also contains a profile of the carers who participated in this inquiry. Click on the following links to access the appendices.

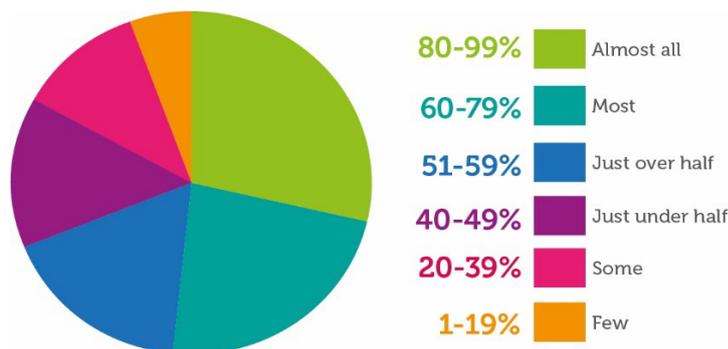
[Appendix 1](#) National carer survey findings

[Appendix 2](#) National health and social care partnership survey

[Appendix 3](#) National local carers' organisations survey findings

Note: throughout this report we refer to the proportion of carers, health and social care partnerships, local carers' organisations, or service providers who reported on a particular issue. For example "in almost all health and social care partnership areas there was a published carer strategy". How we describe these proportions is shown in the figure below.

Figure 1: Data descriptors for percentage scale



Source: Care Inspectorate

Terms used in this report - definitions

Adult carer support plan provides a framework for identification of personal outcomes and individual needs for support for adult carers. It links to the duty and power of the responsible health and social care partnership to provide support. The adult carer support plan is intended to help to increase the numbers of carers identified and have their personal outcomes carefully considered.

Carer means an unpaid adult carer of an adult person.

Eligibility criteria help health and social care partnerships to prioritise and to target resources as effectively and efficiently as possible. There requires to be consultation with carers and carers' organisations about the development of local eligibility criteria frameworks.

Good conversations are the conversations that take place between carers and staff. These conversations allow an understanding to develop of what is important to, and for, carers on their terms. This allows the identification of desired personal outcomes for the carer.

Health and social care partnership is an organisation formed between local authorities and health boards to deliver integrated health and social work and social care services across a geographical area. Duties and responsibilities include delegated responsibility for the implementation of the Carers (Scotland) Act 2016. The term 'health and social care partnership' is also used in the sections of the report that focus on integrated joint board strategic planning, policy, quality improvement, leadership and direction.

Local carer strategy sets out a health and social care partnership's plan to deliver on duties and responsibilities of the Carers (Scotland) Act 2016. This should be developed in collaboration with carers and carers' organisations.

Pandemic refers to the Covid-19 pandemic.

Personal outcomes are defined as what matters to a carer in terms of the impact or end result of activities. These can be used to determine and evaluate activity.

Prevention and early intervention approaches include signposting to community resources and information, providing advice, initiatives to reduce social isolation and reablement. These preventative approaches can support carers to live independently, help maintain or improve their wellbeing and support their participation within their communities.

Relationship-based practice involves social work staff developing and sustaining supportive professional relationships in unique, complex and challenging situations. It places particular emphasis on the 'use of self' (where the professional connects with a person and builds a relationship using their own personality and experiences) and the relationship as the means through which interventions (how the professional helps a person) are channelled.

Self-directed support (SDS) is a way of providing support that means people are given choice and control over what kind of support they get. It starts with a good conversation with social work and social care staff about what personal outcomes an individual wants to achieve. There are four options available for arranging support.

1. Option one: a direct payment where the person purchases their own support.
2. Option two: person chooses the service and the provider, and the health and social care partnership organises the support for them.
3. Option three: health and social care partnership identifies and arranges the support.
4. Option four: a combination of the options.

Short break is a form of support that can enable a break from caring. A short break can be taken with or without the cared for person(s). It includes residential respite, day services and day opportunities, sitter services, overnight and evening support, involvement in a leisure pursuit and a holiday.

Short-breaks services statement should be prepared, published and reviewed by each health and social care partnership. This should set out information about short breaks available locally, including empowering carers' choices. The views of carers and carers' organisations should be considered during the development of short-breaks services statements.

Social care staff refers to practitioners who provide and deliver social care services such as care and support at home, day services, respite care and residential care.

Social work staff refers to practitioners who work in health and social care partnerships undertaking social work assessment, care planning and management functions.

2. Key national findings

1. Caring had a negative impact on most carers' physical and mental health and wellbeing, as a result of caring without all the support they needed.
2. Carers were not consistently experiencing responsive, proactive, co-ordinated and person-centred social work and social care services to support their caring role.
3. Having an ongoing, trusting relationship with a social work staff member helped carers feel understood, valued and supported. A few carers experienced this.
4. Local carers' organisations commissioned by health and social care partnerships offered carers positive experiences of access to advice and information, signposting, training and peer support.
5. Carers were not always aware of their right to an adult carer support plan. Those who had a plan benefitted from the support they received. However, plans were not always reviewed regularly and in good time.
6. Availability of short breaks to support carers to sustain their caring role and meet their needs was frequently lacking.
7. Financial hardship and balancing employment and caring were key challenges in sustaining caring.
8. Whilst a few carers were supported to continue to care through early intervention and preventative approaches, these were generally limited.
9. Carers experienced inconsistent approaches to engagement, involvement and communication.
10. Carers did not consistently have positive experiences of self-directed support. This limited their choice and control.
11. Meaningful involvement with carers in the development of key strategies was inconsistent. Carer inclusion on planning and governance bodies was not fully representative or consistently impactful.
12. Social work and social care service delivery was under considerable demand and resource pressure. Factors influencing this included staff recruitment and retention difficulties, increased staff workloads and a lack of service provision. These factors pre-existed but had been compounded by the pandemic.

3. Experience of carers who use services

3.1 Carers' experiences of person-centred social work and social care

Health, wellbeing and quality of life

Caring had a negative impact on most carers' physical and mental health and wellbeing (figure 2). Some carers had a good balance between caring and other things in their lives. They had been able to keep good health and wellbeing and when provided, the support they received had improved their quality of life.

Carers put aside their own health and wellbeing needs to continue caring due to having no or not enough support or services for the person(s) they cared for. Most carers were exhausted, unable to 'switch off' or had lost touch with their friends due to their caring role.

Coordinated and personalised support

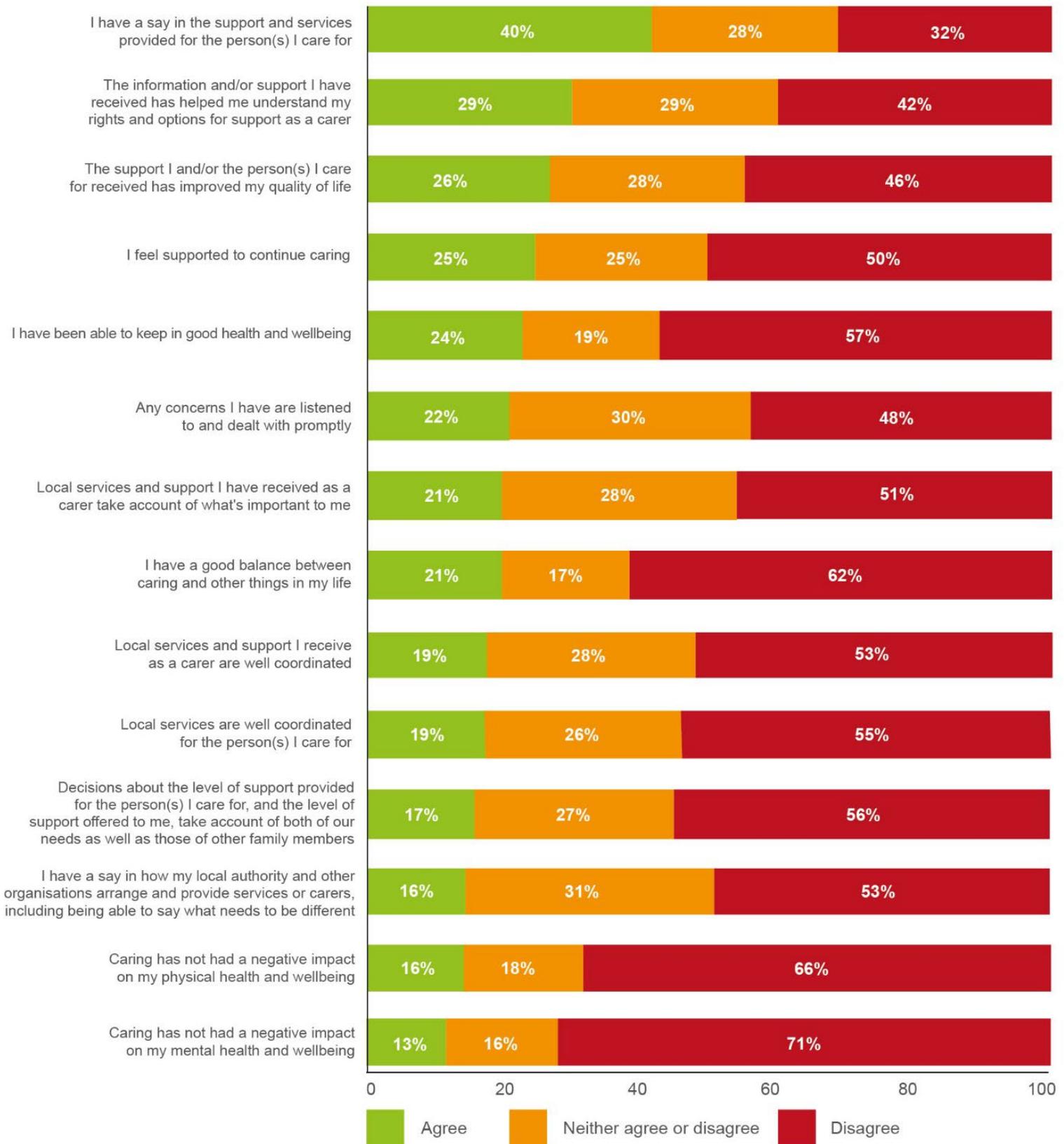
Coordinated and personalised support takes account of carers' preferences and needs and provides the right level of help at the right time and place. Some carers had not received help or support of any kind. When carers did receive support, a few agreed that local services and support were well co-ordinated. Carers often experienced difficulties and delays accessing social work and social care services. This made it difficult for carers to participate in their communities or other social networks.

Most carers felt they were coordinating care for the person(s) they cared for and that services did not communicate well with each other. They experienced challenges in being allocated a social worker or key worker and retaining a worker over time. The system was cumbersome and overwhelming for carers. Carers felt they needed a straightforward single point of contact in order to discuss and access support in good time.

Some carers received contradictory advice or information from different workers at initial contacts. Social work recording systems did not always contain information that had already been given to them. Carers were not always confident that social work staff were familiar with the Carers (Scotland) Act 2016. When carers had contact with social work staff, there was not always proactive input and subsequent follow up from staff. Trying to access social work services was described as "hard work", "tiring" and "an exhausting process".

Carers did not feel consistently listened to by social work staff. They did not always feel their needs and preferences were understood. Carers did not always feel they had been treated with dignity and respect.

Figure 2: Carers' experiences of their caring role



Source: Care Inspectorate Carer Survey (2022). NB Percentage figures are rounded.

A few carers experienced positive communication with social work staff. On these occasions, carers felt staff took time to listen and understand their needs, preferences and desired outcomes. They felt staff were responsive and helpful where there had been a consistent relationship over time. Having an ongoing, trusting relationship with a social work staff member helped carers feel valued and supported. Where staff had time to adopt relationship-based approaches, there were benefits for carers, but there were barriers to staff doing this. These included increasing caseloads, the need to work additional hours, and staff supply and turnover. These themes were prominent in our conversations with social work and social care staff.

Services were mostly delivered to the person(s) the carer cared for rather than to them in their caring role. Some carers felt that they were regarded as resources rather than individuals. As a result, they did not feel that they were supported to continue to care in ways that met their needs. Their caring role was not made easier and more sustainable. Carers' experiences of social work and social care provision were variable. They did not consistently experience personalised support at the right level and time. When services were well coordinated and personalised, carers correspondingly told us they felt listened to, respected and understood.

Some carers experienced difficulties when people they cared for were discharged from hospital. When social care support was required, carers were not always effectively involved. A few carers felt consideration had not been given to their ability and/or willingness to continue to care when the person(s) they cared for was coming home from hospital. Adult carer support plans were not routinely influencing these processes. There were instances where the level of assessed care and support to facilitate hospital discharge was not provided and discharges had proceeded despite this.

Not all key partner agencies, including health staff, were aware of resources available to support carers. Most carers who had been involved in discharge planning processes said they had been not effectively involved. Carers felt this lessened the possibility of a successful and sustained return home. Sometimes, opportunities for early carer identification and consequent sharing of information and signposting were missed. There were occasions when carers were included and experienced responsive and proactive services.

There were examples of health and social care partnerships that had recognised the need to involve carers more fully in hospital discharge processes. Various initiatives were being planned to raise awareness among staff about identifying carers and including them in discharge planning. These initiatives were mostly in the early stages of development.

Person-centred approaches

Health and social care partnerships and local carers' organisations were committed to a strengths-based, person-centred approach to supporting carers. However, just under half of carers agreed that they were listened to, able to ask questions and given enough time to talk. Similarly, just under half agreed that they were treated with compassion and understanding. Carers did not consistently feel listened to, valued or respected.

“There was a lack of understanding of the role of carers. Too many tick boxes and staff who lacked an understanding of the challenges.”
(A carer)

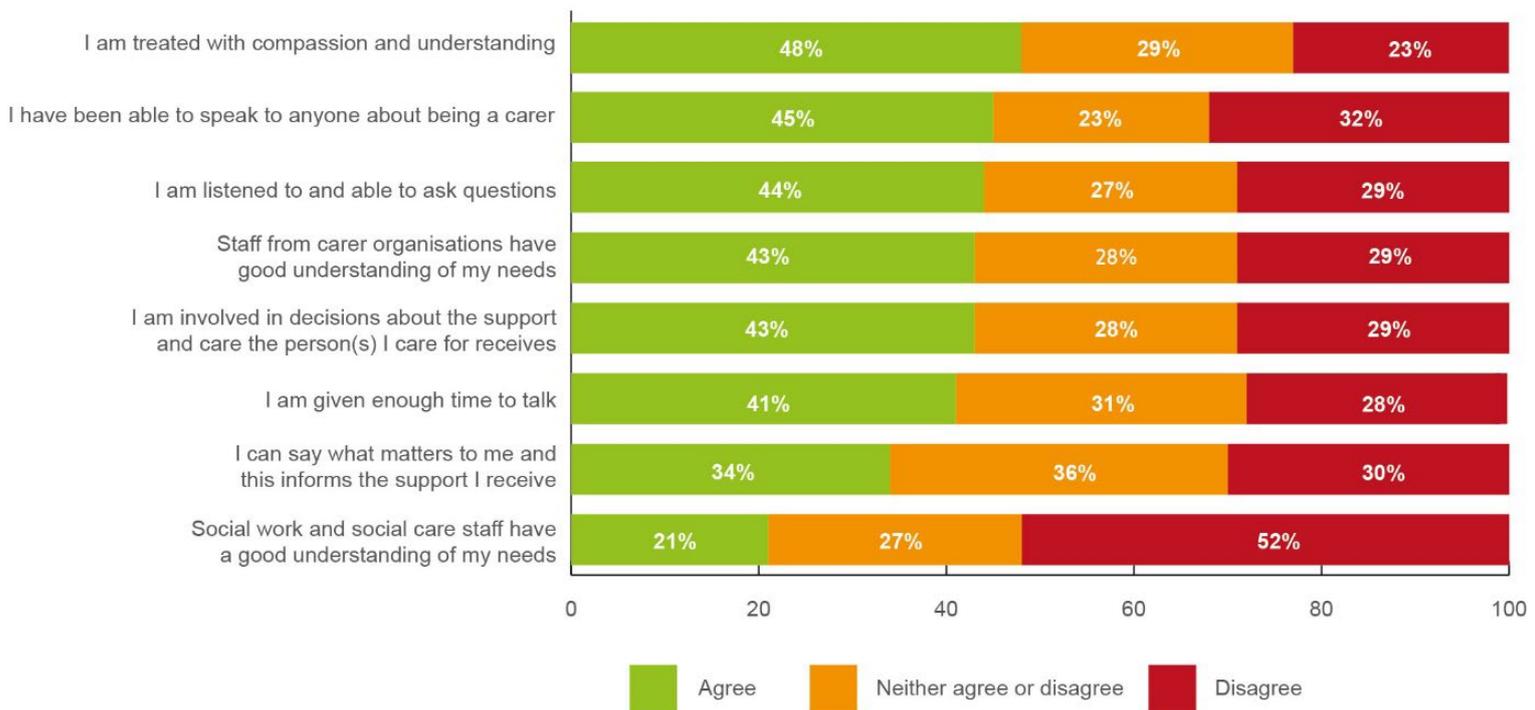
Just over half (52%) of carers disagreed that social care and social work staff had a good understanding of their needs (figure 3). This was a notably high proportion. Social work and social care staff were not able to consistently take a strengths-based approach in assessing, planning or delivering support for carers. Carers did not experience person-centred planning to help identify and build on their own strengths and enable their own capacity to help themselves. The primary focus for social work staff was mostly on the cared for person(s). There were sometimes differences of opinion between the carer and the cared for person(s). Social work staff were not consistently using 'good conversations' approaches to address this.

Outcomes-focused approaches for most carers were at an early stage of implementation. Health and social care partnerships' structures and frameworks had not yet fully embedded a strengths-based approach and organisational cultures had been slow to change.

Local carers' organisations were commissioned by health and social care partnerships to provide a range of services for carers in their area. Carers more commonly experienced local carers' organisation staff as having a good understanding of their needs than was their experience with social work staff. Almost all local carers' organisations provided information and advice to help carers understand their options and rights. They completed adult carer support plans, enabled peer support, and supported carers to engage with the health and social care partnership. Local carers' organisations frequently gave carers consistent and reliable support. They were often the initial place where carers were made aware of their rights and options. When carers were linked in with their local carers' organisation, they were able to access advice and support.

“After joining my local carers' organisation group I realised I could get help and support. I am so glad I was introduced to them as they are now showing me other paths to life.”
(A carer)

Figure 3: Carers' experiences of person-centred approaches



Source: Care Inspectorate Carer Survey (2022). NB Percentage figures are rounded.

Adult carer support plans

Across Scotland, just over half of health and social care partnerships had adopted a combined approach with their local carers' organisation(s) to preparing adult carer support plans. In around one-fifth of health and social care partnership areas, the local authority was solely responsible, with local carers' organisation(s) responsible in the remaining areas.

Of the carers who responded to our survey, some (38%) had been offered an adult carer support plan and just under half (48%) had not. The remainder did not know or could not remember. The proportion of carers offered an adult carer support plan was notably low. Of those who had been offered a plan, almost all had taken up the offer. Most carers agreed that their plan helped everyone know what level of care they wanted to offer. Just over half agreed that their plan helped make sure they got the right support so they could keep caring (figure 4).

This indicated positive outcomes for some carers who were offered and completed adult carer support plans. Given all carers have the right to be offered an adult carer support plan, the proportion being offered a plan was significantly low. There had been limited work undertaken by health and social care partnerships in conjunction with local carers' organisations to promote the benefits of adult carer support plans.

Demand from carers had increased during the pandemic. People who had not previously been referred to services had identified themselves as carers and sought support. Carers who were already receiving support needed more support. Carers

who had in the past been known to services returned to ask for assistance again. While it was positive that more adult carer support plans were in place, it was an indication of the immense pressure that carers had been under during the pandemic. The impact on health and social care partnerships in trying to resource the preparation of adult carer support plans and the delivery of support had been significant.

Carers sometimes experienced a long wait before an adult carer support plan was undertaken, particularly from social work services. This delayed the potential for appropriate and timely support being identified and provided. This negatively impacted carers' ability to maintain their own health and wellbeing or feel supported to continue caring.

Outcomes-focused practice was yet to be fully embedded. Where carers had an adult carer support plan, almost all agreed that it had been developed jointly with them. Most carers felt they had been given enough time to talk about everything they had wanted to. However, just under half agreed that realisation of the plan helped them to do things that were important to them.

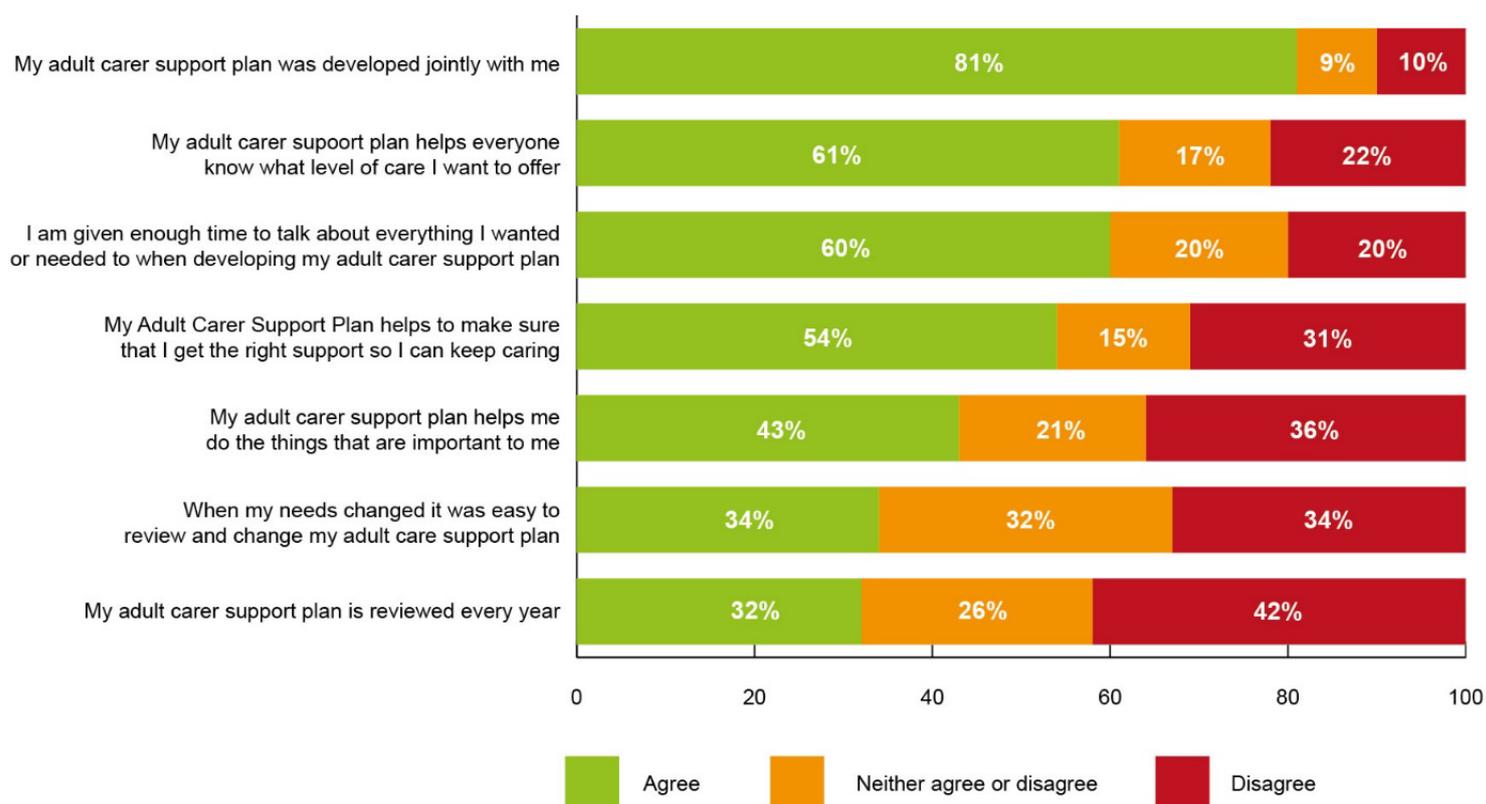
An adult carer support plan should include information about whether the carer has plans in place for the future care of the person(s) they care for. Just over half of carers did not have a future plan in place for either themselves or the person(s) they cared for. A few carers did have a future plan in place. Carers expressed concerns about the future, particularly if they were unable to care. They were not always confident that there would be suitable services available to support the person(s) they cared for in such circumstances.

There was also limited evidence of emergency planning if the carer had been unable to continue caring, for example, due to illness. The absence of future and emergency planning added an additional layer of anxiety and worry for carers. This was linked to lack of accessibility to services and whether services were available to step in should an emergency occur. Planning for predictable life events, such as the carer becoming older and potentially not being able to continue to care, was uncommon.

There were some examples of long-term planning from local carers' organisations. This was included in their adult carer support plan discussions. However, there was limited evidence of this taking place consistently, which was a significant concern for carers.

Preparing an adult carer support plan was not always easy for carers. In some carers' experiences it could be an invasive process. To prepare a plan well required time and a positive relationship with the respective staff member. Having a conversation rather than focusing on completing paperwork was important to carers.

Figure 4: Carers' experiences of adult carer support planning



Source: Care Inspectorate Carer Survey (2022). NB Percentage figures are rounded.

Some carers felt the adult carer support plan represented ‘another hoop to jump through’. Others felt it was a helpful process to identify the outcomes they wanted to achieve. It facilitated participation in care planning for the person(s) they cared for as well as providing additional support to themselves.

Carers did not have consistently positive experiences of review processes. Adult carer support plans should set out the circumstances in which the plan would be reviewed. This should be at least annually. This was most likely to be when there was a change to their circumstances such as a carer’s illness or the person(s) they cared for being in hospital. For some carers, when their needs changed, it was easy to review and change their plan. Their plan was reviewed every year. However, this was not the experience of most carers.

Social work staff and leaders were aware that improvements to systems were needed for the completion of timely reviews. They understood that reviews should be an ongoing process and not a one-off annual event. Carers stated a preference for more regular and smaller check-ups. This could be with an allocated worker or someone who was at least familiar with their ongoing circumstances. However, this was not always the experience of carers.

When reviews took place, some carers believed that the process was at least in part about potentially reducing service provision. Consequently, formal reviews carried out by social work services led to feelings of anxiety and stress for some carers.

Some health and social care partnerships identified that their social work IT systems did not allow adult carer support plans and carers' outcomes to be recorded accurately. This had an adverse impact on identifying early intervention measures to support carers. Carers had to tell their story repeatedly because of poor information recording and sharing.

Sustainability of caring

Most carers struggled in their caring role to the extent that their own health and wellbeing had suffered. Some carers agreed that they felt supported to continue caring. Some had had a carer's break away from the person(s) they cared for. A few had experienced a supported break with the person(s) they cared for.

The most prevalent issue in sustaining care was short breaks. Just over half (55%) of carers could not access flexible short breaks when they needed them. This was a notably high proportion. Of the few that could access breaks when needed, some said these breaks did not help prevent things getting worse or a crisis from happening. There were inadequate opportunities for breaks from caring. Overnight care, evening and weekend support was usually not available.

To have a social life outside of caring, carers needed flexible short breaks to be available outside office hours. Short breaks had been difficult to access before the pandemic. They then became more limited as some services had only partially reopened or had remained closed after the acute phase of the pandemic.

“It feels like the pandemic had become a good vehicle for some local authorities to alter and/or remove services.”
(A carer)

Access to short breaks, respite and day services were identified by most carers as key to early intervention and preventative support. Where short breaks or respite were available, some carers agreed that they helped prevent things getting worse or a crisis from happening.

There were long waiting lists in social work services for assessments for short breaks. These lists were longer compared to pre-pandemic levels. There was a lack of short breaks service capacity. Where carers required replacement care so they could take up on breaks for themselves, this was often unavailable. This resulted in the carer being unable to take up the offer of a short break.

When carers got enough support, they were able to connect with friends and take part in activities they enjoyed. In turn, this helped carers to keep well. Where health and social care partnerships had made access to funding for short breaks easier during the pandemic, this had had a positive impact on the wellbeing of those recipients.

Carers seeking a short break for the first time experienced the process as complicated and protracted. Planned breaks often had to be booked many months beforehand and it was particularly hard to find emergency respite. Positively, when a short break was provided, carers valued the service. Some had used self-directed support to access short breaks as part of their care package.

There were examples of creative and flexible use of short-break budgets to fund more individualised support. These included breaks accessed through the Scottish Government's sponsored [ScotSpirit holiday voucher scheme](#) and [Time to Live grants scheme](#). These allowed carers to 'recharge their batteries'. Take up of these was not always based on carer's own preferred choices but was dependent on what was available.

Outreach community support developed during the pandemic when buildings-based support closed. This had helped a few carers continue to care. Some preferred it to the original support.

A key challenge to sustainability of the caring role was financial hardship and balancing work and employment. This led to increases in demand for advice from local carers' organisations on fuel poverty, accessing food banks and the loss of employment. Carers were sometimes unable to work due to the demands of caring. Carers felt more financial support would have reduced their stress.

Most carers struggled to cover the true cost of caring, which included having to pay for essential items. Financial pressures and not being able to work where they would prefer to, contributed to carers not feeling respected for the role they had in social work and social care systems. Access to income maximisation, debt and money advice services was not routine.

A lack of available information in the carers' policies of employers had meant that in some instances, carers had given up their job in order to care. Carers felt the significance of this was not routinely acknowledged. Lack of support had also resulted in some carers retiring in order to care. Those who continued to work were not always able to take up the support offered by local carers' organisations. Carers experienced few or no opportunities offered at the weekends or in the evenings.

A few carers felt this was not helped by employers who did not offer flexible working arrangements or patterns to allow them to continue caring. Information for working carers was often not readily available. It was encouraging that some health and social care partnerships had successfully achieved [Carer Positive award](#) status. The full benefits of these employers having increased awareness of carer issues had yet to be realised in the day-to-day experience of staff who were also carers.

3.2 Carers' experience of prevention and early intervention

Early intervention and prevention

Early intervention and preventative support includes advice, information, support to understand rights and options, peer support, financial advice, activity groups, training and practical support.

Most carers did not consistently experience a strong focus from services on prevention and early intervention approaches and support. Social work services most frequently became involved when a situation had become a crisis. This was due to situations worsening for some carers while they were on waiting lists. Some carers tended not to raise issues until they were unable to cope. This meant they had continued to care irrespective of the demands on them. The impact on these carers was a reduction in their opportunities to live independently and participate in their local communities and other social networks. This was exacerbated during the pandemic when some carers felt abandoned.

It was not typical that carers were supported to improve their quality of life by identifying how care and support could be combined with their assets and strengths. There was a few of carers who accessed early intervention services, initiatives and activities that resulted in them experiencing good wellbeing outcomes.

“(Social work) were short-sighted and waited until there was an emergency before providing me with the support I needed.”
(A carer)

Social work staff highlighted that there was an expectation of them to provide preventative services. They wanted to offer early intervention support but did not have the resources or sometimes, the knowledge and training to do so.

Almost all health and social care partnerships indicated that they had a formal preventative and early intervention approach to supporting carers. Almost all local carers' organisations agreed that a range of options was available to enable effective early intervention and preventative support for carers. Just over half of carers' organisations agreed that their local partnership collaborated with them to ensure a range of options was available to enable effective early intervention and preventative support.

Almost all health and social care partnership areas had agreements in place with local carers' organisations to provide low-level early intervention and preventative support. Local carers' organisations in most partnership areas were commissioned to support carers at the early stages of their caring journey. This included advice, information, support to understand rights and options, peer support, financial advice, activity groups, training and practical support.

Carers most commonly accessed information and advice. Just under half of carers accessed information, and some accessed advice. Most carers who had a carer support worker were satisfied with them. The carer support worker advocated on their behalf to social work and social care services if needed. Carers were supported by the carer support worker to manage their own needs where appropriate.

“Support, understanding and experiences I have had from the carers’ centre has improved; I feel not only supported by them but that the support is more proactive.”
(A carer)

A few new and developing initiatives were supporting early intervention, prevention and anticipatory care planning across Scotland. These included the development of ‘micro-breaks’. These were tailored individual options for a carer following a ‘good conversation’ with support staff to identify and outline possible empowering choices. However, progress had been limited.

In most carers’ experiences, it was only when a crisis was reached that they were able to get the support they required. Their experiences were that demand for crisis and emergency support from social work and social care services was almost exclusively being addressed as the main priority. This meant services were unable to align resources towards a more preventative approach. Challenges for health and social care partnership leaders were an increased demand in the number of carers with higher-level needs and the requirement to review adult carer support plans. This was adversely impacting on the ability to respond early to lower-level need.

It was unusual for carers to experience timely support from social work services in anticipating their future wellbeing support needs that could therefore prevent crisis arising. Some carers were advised by social work services that they were unable to offer help until the carer was in crisis. This was a particular feature for some carers living in rural areas, where there was sometimes a lack of access to services. Carers had to adopt a ‘make do’ approach.

During the pandemic, the volume of day services, particularly building-based services, was significantly reduced. Subsequently, some had been remodelled, some had not restarted, and some had changed their availability. Recovery of services had been slow for some. These changes to delivery levels were a major source of stress for carers and adversely affected their own wellbeing.

The use of IT by services, including telecare to support carers and those they cared for, increased substantially during the pandemic. A few health and social care partnership areas used telecare positively to deliver co-ordinated and preventative options. Further exploration of using telecare approaches would be worthwhile.

Eligibility criteria

In almost all health and social care partnership areas, the established model set out that social work services assessed carers who had critical or substantial needs. Local carers' organisations worked with carers with moderate or low-level needs. Social work staff were not always familiar with their own organisation's eligibility criteria and therefore did not always provide consistent information to carers.

Almost all health and social care partnerships stated that they had eligibility criteria for carers' services and that this was published and easily available to carers. Carers were usually involved in developing the frameworks by way of surveys, through representation from carers' organisations and focus groups. A few partnership areas had little or no consultation and engagement on the criteria. Just over half of local carers' organisations reported that there were locally effective arrangements in place for their organisation and carers to participate. They contributed to developing, implementing and reviewing the eligibility criteria.

Most carers were not clear about their local eligibility criteria and what it meant for them to access services such as day services or short breaks. Where carers met local eligibility criteria, there could be long waits before support was put in place, even in a crisis. Social work staff attributed this to a shortage of resources, sickness leave or staff turnover.

In some health and social care partnership areas, the parameters of local eligibility criteria thresholds had recently changed, sometimes without formal notification. This had resulted in a movement towards more carers being assessed as having moderate rather than substantial or critical needs. This had created increased demand on local carers' organisations without the commensurate increased resources in most instances.

Eligibility criteria frameworks sometimes negatively steered social work practice towards a deficit-based approach, which was not compatible with self-directed support. Social work staff were at times having to manage the tension of having two different approaches: one an outcome-focused and strength-based approach with carers and the other deficit-based with an emphasis on managing budgets.

It was a mixed picture in relation to whether health and social care partnerships' eligibility criteria were effective in ensuring that the right level of support was offered to carers at the right time. It was common for carers' wider needs to be overlooked when they did not meet the criteria for social work and social care support in their own right. Information was not always shared or co-ordinated across the relevant organisations to ensure the needs of both carer and cared for person(s) were considered and the necessary early supports put in place.

3.3 Carers' experience of information and decision-making in social work and social care services

Information and advice

Health and social care partnerships were committed to, and had invested significantly in, the provision of information, advice and signposting. This had been done alongside local carers' organisations, third sector partners and other commissioned services. Social work services aimed to work collaboratively with their partners to ensure there was a coherent approach to providing information and advice for carers. Almost all partnerships were confident that quality, comprehensive and consistent information and advice services were available to carers. However, less than half of carers agreed that they could find information and advice to help them in their caring role when they needed it. Where they had accessed information and advice, most carers agreed that they could understand it. Some stated that this had helped to prevent problems getting worse or a crisis from happening.

Most carers had not received the right information or understood their options and rights in relation to social work and social care. Carers were not always supported to make meaningful decisions, to experience choice and control in managing their wellbeing. Most carers did not feel they had consistent access to good-quality advice and information to inform their choices about their own social care.

Most carers said they would know where to go if they needed general information about services. Some carers had experienced difficulties obtaining information about sources of help such as day services and respite support. Getting information about accessing services was highly dependent on the awareness of individual social work staff members.

Of the carers who responded to our survey, some lived in a different health and social care partnership area to those that they cared for. This was more common in urban rather than rural areas. These carers reported difficulties in accessing information, advice and support in the partnership areas where they lived. Carers' advice, information and support was connected to the area that the cared for person(s) lived in. This cross-boundary demarcation of carers' ability to access information and advice was unhelpful.

There was a high degree of divergence across health and social care partnerships in the range of information provided. It varied in the type of information actively promoted, readily accessible and in a range of formats that could be easily understood by carers. There were uneven experiences of carers with language or literacy barriers accessing suitable information.

**"The information and support I got in my own language was lifesaving."
(A carer)**

This adversely impacted on their understanding of the options available to them and support available to meet their outcomes and needs. Effective, local arrangements for carers who had specific cultural or language-based requirements were intermittent. There was variation on whether carers had information about how to access social work and social care supports and services in their local community in a readily accessible format. Carers experienced positive impacts when information was available in their own language.

Help carers received (see [Appendix 1](#))

Carers reported that most of the support they received for their caring role was information and advice. In addition, the type of support received included support from a carers' centre, care/support at home for the person(s) they cared for, help with housing adaptations and equipment. It is significant that one-quarter of the carers had received no help or support. Access to day support and supported breaks was low.

Choice, options and rights

All local carers' organisations provided information and advice on support available to carers. They also provided direct support to help them understand the rights and options available to them.

Local carer organisations also delivered a range of practical supports in addition to a wide range of training. Just under half provided carer advocacy. Almost all stated that there was clear information and timely advice available locally for carers to understand their rights and choices in receiving support. Carers were positive about the role that advocacy support, where available, had played in supporting them. Fewer than one in ten carers said they had received advocacy support. The demand for advocacy services was not matched by service capacity.

Carers had mixed experiences of social work services providing them with information about their options and rights as carers. Carers were not routinely supported to make meaningful decisions about their own social care. They did not feel they had choice and control over the care services they received.

It was not typical for carers to have a clear understanding about how decisions were made about their own social care needs, or for those for whom they cared. This included any financial implications.

Just under half of carers were involved in decisions about the support and care that the person(s) that they cared for received. A similar proportion had been listened to and were able to ask questions and were given enough time to talk. Some were able to say what mattered to them and this had informed the support they received.

Few carers were meaningfully involved in decisions about the level of support provided for the person(s) that they cared for, and the level of support offered to

them. This seldom took account of both of their needs as well as those of other family or household members. Some were given a degree of choice and control over how support for themselves and the person(s) they cared for was arranged and delivered.

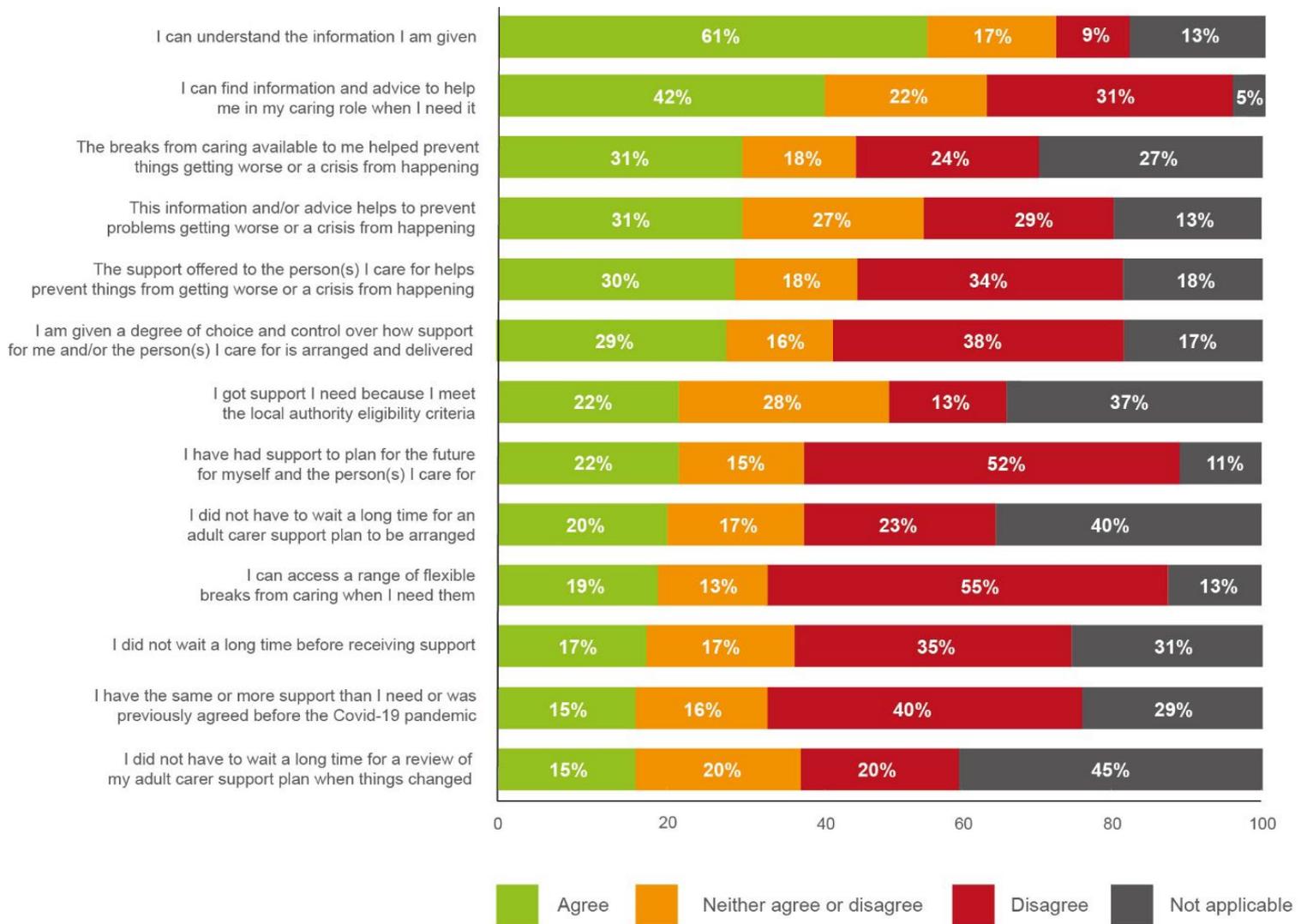
Identifying hidden carers was a particular challenge in providing early intervention and preventative approaches. Hidden carers were at a significant disadvantage in that they do not identify as carers and so did not seek information or advice. Reaching out to hidden carers was a difficulty acknowledged by all who participated in this inquiry. There was a significant number of carers who had been caring for many years but were not aware they could be regarded as carers. This gap in awareness meant there were missed opportunities for statutory and third sector organisations to provide advice and information and make carers aware of their rights and options.

Self-directed support

Carers had differing experiences of how information about self-directed support was shared with them or what could be available to them. There was not a significant use of self-directed support by carers for their own support. Some carers had limited information and felt frustrated at the delay in getting the right information. Not all social work staff appeared to be familiar with self-directed support guidance. Some carers had experienced receiving contradictory information from different staff.

While some carers had been able to secure individual budgets for the person(s) they cared for, not all were able to use their budget due to lack of local service provider capacity. The expansion of self-directed support was limited by the lack of care service provider choice and capacity in some areas. This meant the ability to select an option was constrained.

Figure 5: Carers' experiences of information and support



Source: Care Inspectorate Carer Survey (2022). NB Percentage figures are rounded.

Some carers waited, sometimes for lengthy periods, for a self-directed support assessment from social work services. There was a wide variation across Scotland of how carers could use their allocated self-directed support budgets. This caused confusion to carers, sometimes even within the same health and social care partnership area, when different uses of an individual budget were approved or refused.

Some carers experienced a lack of transparency in decision making. They sometimes felt they had to fit into the system rather than the system working flexibly for them. Jargon-heavy resource allocation meetings left carers uninformed and feeling disempowered. Carers were keen for more accessible guidance about the flexible use of self-directed support budgets. A few carers felt under pressure to move from option three to option one. This sometimes unintendedly shifted the responsibility for arranging care onto the carer.

“There were too many forms to fill in. I’ve so little time and energy to progress this because of my caring role.”
(A carer)

Being unable to recruit personal assistants significantly impacted their choice and control with some carers therefore assuming full responsibility for supporting the person(s) they cared for. When they had been unable to recruit personal assistants, some carers were asked to return their allocated budgets to social work. This had impacted negatively on trusting relationships. It had left some carers feeling they had been offered support then asked to return it. They were in the same position of having to continue to care without sufficient support. This negatively impacted on having a life outside of caring.

There were concerns from social work staff about a lack of recent training on self-directed support. The impact of this was some carers were not being enabled or supported to make informed decisions about care for them or care for the person(s) that they cared for. Social work staff acknowledged that there was not a significant uptake of self-directed support for carers. Some carers had an awareness of self-directed support, however most said it was too complicated. They wanted more information to guide them, processes to be more straightforward, and decision-making to be more transparent. In many areas this support was not available. Health and social care partnership staff and leaders acknowledged that the uptake from carers had been limited and that supporting processes could be improved.

4. Strategic planning, policy, quality and improvement

Strategic planning and policy

In almost all health and social care partnership areas there was a shared vision for services for carers articulated through their published carer strategy. This formally involved relevant partners including carer representatives, third sector bodies, elected members and integration joint board members. Local carer strategies differed in how they were developed, implemented and reviewed.

Across Scotland, not all key carer-related strategic documents were up to date and published. Strategies did not always clearly articulate priorities on how carers' experiences and wellbeing outcomes would be improved. Some partnerships had gone beyond the date they had set to review their carer strategy. This was primarily because their focus was on responding to the pandemic.

Health and social care partnerships' carer strategies were intended to ensure a shared accountability and responsibility for leading the future direction of services. They helped prioritise activities that would be successful in delivering and sustaining measurable outcomes. In some partnership areas, the carer strategy lacked clarity and focus, and did not fully represent all relevant interests.

Carers and local carers' organisations were not consistently meaningfully involved in developing and implementing key strategic planning processes in all partnership areas. Nor were they always involved in developing documents such as the local carer strategy, local eligibility criteria and the short-breaks services statement. Some partnerships found it difficult to progress how services were planned in ways that fully and successfully engaged with carers.

Almost all partnerships had published short-breaks services statements. These statements should consider the views of carers, their representative organisations and service providers. They should ensure that they are fit for purpose and meet the needs of carers. Health and social care partnership leaders aimed to involve carers and carer representatives in developing these statements. Few carers had heard of or seen their health and social care partnership's short-breaks services statement.

Short-break services statements were out of date. Partnerships' responses to the pandemic were the necessary priority. These were currently being revised. It was evident from carers' experiences that the intended purpose of short-breaks services statements had not, overall, been fully delivered.

Consultation, involvement and engagement

Health and social care partnerships had engaged to varying degrees with partners such as the third and independent sectors, local communities, users of services and carers. Well-established methods of consultation, involvement and engagement such as surveys, focus groups and large-scale events were used by some partnerships.

These were sometimes successful in learning about the views of carers. Some carers told us that these approaches did not always suit them. This was due to their lack of available time and energy due to their caring responsibilities, working commitments and a lack of alternative provision of care for their cared for person(s). Engagement with carers around strategic planning and policy development tended to be conducted with those carers who could afford to commit their time and energy.

Maintaining carer involvement beyond the development of the local carer strategy and into implementation phase was important. Most carers felt consultation was done 'to' them and not 'with' them and they had not felt listened to when they gave their views and opinions.

“I don't feel they listen to what carers want on issues such as day care and respite. We don't get any feedback on the surveys we complete.”
(A carer)

Not all health and social care partnerships had reviewed the effectiveness of their engagement and participation approaches. There was limited evidence of innovative approaches to gathering carers' views from 'difficult to reach' groups.

Some local carers' organisations had used online platforms to promote better engagement including feedback. There were carers who were digitally excluded due to a range of reasons. This included affordability of IT equipment, poor internet accessibility in rural locations or a lack of IT skills. This meant they were not fully engaged or able to feedback and contribute to service developments. While some carers were confident in using IT, others were not.

“Modern life involves so much to be done online; most older people just can't do that. IT advice and support is key to helping them keep up with modern living.”
(A carer)

Health and social care partnerships made efforts to communicate their vision for carers by engaging and involving staff. In some partnership areas, staff were uncertain about key issues. As a result, there was not always a wide ownership and buy-in to the vision.

Some staff, including those from partnerships' third sector providers, had not always been involved in consultation and engagement exercises for a variety of initiatives regarding carers' services. Therefore, they did not feel their views were always taken into consideration or that their queries had been fully clarified.

Some health and social care partnerships were not clear about how resources could be used differently to deliver improved services and outcomes for carers. Most partnership areas reported that budgets for carers' services were agreed in consultation with carers' representatives and organisations.

Most partnership areas stated that national and local outcomes for carers were reflected clearly at a strategic level. These outcomes were reflected less in local resource decision making and allocation.

It was not always evident that carers and carers' organisations had been meaningfully engaged in budget setting processes. Just under half of local carers' organisations stated that there was a variety of methods for their organisation and the carers they supported to contribute to arrangements for resource allocation processes and decisions.

Quality and improvement

Almost all health and social care partnerships indicated that they reviewed and reported on their local carer strategy using measures of success with monitoring and scrutiny arrangements in place. Subsequent prioritising of activities, which were successful in delivering and sustaining measurable outcomes, was not always evident.

Health and social care partnerships indicated that social work service quality was assessed, and feedback was received through a range of means. Partnerships relied on processes, such as caseload management, professional supervision and service reviews to contribute to assurance of the quality of service. Additionally, reactive measures were used including reviewing complaints and compliments from carers. These provided vital sources of learning and a basis for improvement actions. These helped to provide feedback and articulate sound evidence to help have these views and experiences inform improvements being made to services.

Clear measures of successful impact were not always identified, reported or used to monitor progress at a local level. Some self-evaluation exercises involving carers had taken place and had influenced service redesigns. There was limited evidence of the effective use of data relating to carers at a local level. Where data was being gathered it was not always clear what purpose it would serve. Data collection tended to be quantitative, driven by national requirements. Experiences of carers in their own words to understand their outcomes was not routinely gathered and reflected in improvement planning.

There were some examples of service developments and improvements being progressed with meaningful input from with carers. This included development of a 'carer breather' short break initiative. This service supported carers to have regular and locally provided 'time out' from their carer role.

Involving a wide enough range of stakeholders to provide feedback on the quality of carers' services is helpful. The views of internally and externally commissioned service providers were not routinely considered. Not all health and social care partnerships regularly collected or analysed feedback from carers who received

services from third and independent sector service providers. This was a missed opportunity to inform service review and future service delivery.

5. Leadership and direction

Achieving the strategic vision

All health and social care partnership leaders were committed to implementing the statutory requirements of the Carers (Scotland) Act 2016. Across Scotland, efforts had been made by leaders to improve services for carers, engage and consult with carers and communicate their strategic vision for carers. At the heart of health and social care partnerships' carer strategies was an ambition to collaborate with carers as equal partners. They intended to provide the right support at the right time through an enabling and human rights-based approach.

Health and social care partnerships' strategies set out aims to provide better and consistent services and support. They aimed to help carers continue to care, have a life outside caring and maintain their physical and mental health. There were difficulties in translating the aims and ambitions of these strategies into everyday positive impacts and outcomes for carers.

Social work staff were not always supported to have ownership of the strategic vision for carers. Social work staff did not consistently make connections between the vision set out in carer strategies and delivering outcomes-focused practice through more effective systems. There was a disconnect between the vision and ambition of local carer strategies and the experiences of most carers. Carers faced major challenges accessing, understanding and navigating social work and social care systems. This had worsened during the pandemic.

This was not helped by some social work recording systems that were not fit for purpose for recording and sharing, where appropriate, carers' information. Some health and social care partnerships were in the process of commissioning new recording systems that aimed to help staff better record carers' information.

Leaders understood the importance of prevention and early intervention approaches. They acknowledged that embedding these approaches in social work practice had been adversely affected by the pandemic. Operational pressures had contributed to a focus on crisis intervention. Partnership leaders were committed to the principles of self-directed support and acknowledged there was much to do. This was a key area to refocus on as part of their recovery and remobilisation plans.

Challenges in supply and capacity of local care including preventative services for carers was significant. A recurring high priority for carers was access to short breaks including day services and residential respite. Ensuring that there was a sufficient supply of available services with high-quality standards in these care sectors was an ongoing task.

Collaborative and inclusive leadership

Leaders were committed to promoting collaboration between social work services and other partners. There were varying levels of productive interaction between health and social care partnership leaders, local carers' organisations and carers. There were examples of leaders working collaboratively to find solutions and mitigate risks across different sectors and functions. Supporting a culture of improvement through audit and evaluation and encouraging all stakeholders to continuously improve carers' outcomes should be part of this.

Almost all health and social care partnerships indicated that there were opportunities for carers to engage with elected members, members of integrated joint boards, community planning partners and senior leaders to contribute to service redesign and planning. It was positive that there were carers participating in formal planning and partnership governance arrangements. Leaders were not always clear or could not always provide evidence about the impact of their involvement. Sometimes, carers' representatives had demonstrated a range of useful experience and expertise that had contributed to promoting carers' views across service planning and governance bodies. Carers from a range of diverse communities were not always fully represented.

Analysis of the training, support or learning needs of carers' representatives on decision-making bodies was not common. Health and social care partnership leaders recognised that they needed to further enable the skills, understanding and expertise of carers and their representatives to participate in planning, decision making and governance bodies. For example, tailored briefings, development sessions and individual support for carers were not routine.

Most health and social care partnerships used information about protected characteristics to inform carer strategy and planning, quality improvement and service development and equalities monitoring. Some form of carers' protected characteristics information was collected in all partnerships. Most collected information on age and sex. Information on disability, religion or belief, and marriage and civil partnership was less commonly collected.

Health and social care partnership leaders acknowledged that more attention needed to be focused on their statutory duties in relation to the Equality Act (2010) and inclusion of carers with protected characteristics. There was variation in how equalities groups and/or protected characteristics information on carers was collected across Scotland. It would be beneficial if this information were collected as standard more commonly.

Supporting social work and social care staff

The most common way to support staff to be confident and competent in working with carers was through team meetings. Other approaches were through personal

professional development plans, supervision, and input from professional leads. A few areas planned to start using a member of social work staff or a team manager with a leadership or 'champion' role to promote carers' issues.

Social work staff's learning and training opportunities in relation to the Carers (Scotland) Act had often been reduced or stopped during the pandemic. Opportunities for new staff to learn from more experienced peers had been impacted. In some areas, this had led to inconsistencies of equity of service access and quality. Leaders recognised the need to reinvigorate ongoing learning opportunities for staff including during induction programmes.

Leaders were aware that more focus was needed on supporting staff to understand and consistently apply eligibility criteria. Social work staff often struggled with the contradiction between perceived deficit-based eligibility criteria frameworks and the impetus towards strength-based social work practice.

Recently recruited and existing staff had not always received induction, training or opportunities for peer learning in relation to eligibility criteria. This contributed to a lack of understanding and ability to explain eligibility criteria to carers. This meant carers were not consistently fully aware of their entitlements and rights. Involving carers and their representatives in contributing to developing, implementing and reviewing eligibility criteria would support a greater understanding among carers and staff.

6. Considerations to support continuous improvement

Health and social care partnerships across Scotland should:	
1.	<p>Develop and improve the accessibility and availability of short breaks available to support carers to continue to care.</p> <ul style="list-style-type: none"> • Assess carers' needs as part of strategic and local needs assessments. • Work in partnership with locally commissioned services, third sector service providers and local communities to identify solutions to meet the gaps identified by carers in short-break provision. For example, revisiting market facilitation strategies and approaches to commissioning. • Update short-breaks services statements in consultation with carers and carers' organisations. • Increase the supply of locally available, tailored short breaks that meet the identified needs of carers. • Introduce easily accessible routes for carers to access short breaks.
2.	<p>Promote awareness of the rights that carers, including 'hidden carers', have to an adult care support plan and the benefits of having one in place.</p> <ul style="list-style-type: none"> • Improve approaches to carer identification through public awareness raising, staff induction and training on carers issues. • Engage with carers to share their stories of the benefits of having an adult carer support plan, for example on social media. • Improve waiting times for adult carer support plans and, where relevant, subsequent service delivery.
3.	<p>Improve carers' experiences of systems and processes including initial access, resource allocation and reviews.</p> <ul style="list-style-type: none"> • Improve carers' experiences of systems and processes, with particular reference to the initial access and ongoing case management, for carers and those that they care for. • Introduce system improvements to better record and share, where appropriate, carers' information within IT systems. • Put in place sufficient arrangements to meet the demand for adult carer support plans. • Better record adult carer support plans including carers' outcomes. • Improve the transparency of resource allocation systems such as funding panels. • Improve the regularity of reviews of adult carer support plans.

4.	<p>Ensure there is refocus on prevention and early intervention, self-directed support and outcomes-focused practice for carers.</p> <ul style="list-style-type: none"> • Support practitioners to embed a focus on early intervention and prevention activities including signposting to community resources and reablement approaches. • Adopt a more balanced approach between crisis intervention and early intervention and prevention. • Embed self-directed support as the default approach to working with carers. • Support practitioners to move away from deficit-based practice to strengths-based practice within the context of eligible need.
5.	<p>Further support social work and social care staff to be more knowledgeable about the Carers (Scotland) Act 2016.</p> <ul style="list-style-type: none"> • Further provide supervision, support, training and continued professional development to staff on the Carers Act, self-directed support and outcomes-focused practice, relationship-based practice, prevention and early intervention and eligibility frameworks. This should be a core part of organisational development plans. • Undertake where relevant, training jointly with social work staff and local carers' organisation staff.
6.	<p>Further develop with carers engagement and consultation approaches including evaluation of these approaches and how best to feedback carers' views.</p> <ul style="list-style-type: none"> • Improve consultation and involvement approaches that creatively enable more carers from wider communities of carers to participate. • Identify how to evaluate and improve engagement and consultation approaches. • Identify ways to let carers know what difference they made.
7.	<p>Ensure that local carer strategies, short-break services statements and eligibility criteria are up to date and are coproduced with carers and carers' organisations.</p> <ul style="list-style-type: none"> • Update key strategic documents with carers, setting implementation and monitoring arrangements in place, and set review dates that are met.

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| 8. | <p>Ensure there is meaningful and representative inclusion of carers in planning and governance groups that impacts positively on service improvement.</p> <ul style="list-style-type: none">• Help carers contribute meaningfully to planning and governance groups such as the integration joint board by providing them with any necessary support and training.• Embed further arrangements for carers with protected characteristics in plans, policies and procedures to promote equality and inclusion.• Measure the impact of carers' inclusion in planning and governance groups. |
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7. Conclusions

The pandemic exacerbated the significant challenges that already existed in the delivery of support and services for carers. The social work and social care sectors experienced extreme demand and system pressures. This was partly due to the extraordinary response that was delivered by social work and social care staff during the most acute phase of the pandemic. Social work and social care services were in a period of recovery and remobilisation. There were significant challenges in areas such as staff recruitment, retention and remuneration. In turn, these challenges had negatively impacted on the services and support available for carers and the people they cared for.

Carers make a vital contribution to social work and social care systems. Carers' critical role had been relied on by the people they cared for and by health and social care partnerships before and during the pandemic. Most carers' physical and mental health and wellbeing were adversely affected by their caring role. Carers struggled to have a life outside of caring, maintain friendships and participate in social activities in their communities. They did not feel like 'equal partners in care'. Carers were concerned about the sustainability of their own caring role unless they became more valued, visible and had the right support and services at the right time.

Where carers received sufficient support, it helped them sustain their caring role. The availability of support such as regular and flexible short breaks from caring was not available to the degree required. Social work and social care staff needed further support to be more confident and competent in their work with carers. If these issues were addressed, they could contribute to improved carers' experiences of adult carer support planning as well as access to, and choice and control in, services. There is a need to develop resilience in the system to meet the further challenges ahead.

Next steps

We recognise that health and social care partnerships are at different stages in addressing the issues our inquiry has highlighted. These are key areas for consideration by all partners as we continue to recover from the pandemic and plan for the future. Nationally and locally, partners should ensure our findings from this inquiry are linked to feedback from carers and the people they care for. Listening to carers is essential. Our findings will inform our strategic joint inspections of adult services. We hope it will also inform deliberations on the reform of adult social care.

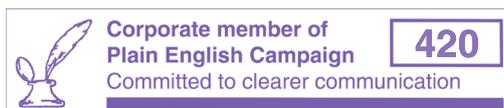
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