Our Connected Neighbourhoods
A Dementia Enabling Communities Project

The following is a joint response from the Our Connected Neighbourhoods project partners and team to the Stirling and Clackmannanshire Health and Social Care Partnership:

Strategic Plan and Budget Consultation

Our Connected Neighbourhoods is a dementia enabling communities project. Funded by the Life Changes Trust with support from Stirling Council, this innovative 3-year project is looking to put people living with dementia at the heart of their community. Bringing together people living with dementia, practitioners and researchers, Our Connected Neighbourhoods is looking at how a dementia enabling community is created and how this process can best be supported.

Project Partners are:

Alzheimer Scotland - Stirling Council - Macrobert Arts Centre - NHS Forth Valley - Dementia Services Development Centre (DSDC) - Town Break - SSAFA Forth Valley - Memory Friendly Networks - SDS Forth Valley – Stirling Voluntary Enterprise (SVE) - CESREC - Nordorf Robbins - Ideas for Ears - Stirling Libraries - CTSI

Intermediate Care

Context

Intermediate care is a core delivery priority of the Partnership.

Intermediate care is a collection of services that focus on prevention, rehabilitation, reablement and recovery. They can provide an alternative to going into hospital and provide extra support after a hospital stay.

The Bellfield Centre is an innovative, integrated service which was a cornerstone of the 2016-19 Strategic Plan. It opened in winter 2018 and provides integrated intermediate health and social care services mainly for older people within a modern purpose built, homely facility with 116 short stay care rooms.

The Centre will continue to evolve over the next 3 years. It is important that this links to the core priorities and the Implementation Plan for Intermediate Care for the Partnership.

Care closer to home, via Community Nursing intends to provide assessment, treatment and care at home for a short period. It is key that this service becomes integrated with social care via Reablement and Technology Enabled Care thus maximising efficiency of resources, and ensuring the appropriate skills mix within the workforce.

Options/improvements

- Focus provision of bed based services within 2 'Centres of Excellence' at Stirling Health and Care Village and Clackmannanshire Community Healthcare Centre (CCHC). This will require substantial redesign of services provided at CCHC, in line with the new model of care recently implemented at Bellfield Centre.
- Redesign of respite care services.
- Explore opportunities to develop new care models including housing with care, as well as other opportunities that may exist or arise, to replace the residential care home in Menstrie.
- Develop closer links to Third Sector to deliver community based support and redesign of respite care services leading to the withdrawal of services from Ludgate House.
- Develop closer links to Third Sector to deliver community based support and redesign of respite care services leading to the withdrawal of services from Strathendrick care home.
- Work with all providers in the Third and Independent Sectors to commission Care at Home Services focussed on helping people achieve personal outcomes, such as regaining independence, and targeted to greatest need.
- Review of Housing Contribution Statement to determine level of appropriate housing to support people to remain well and independent in their own homes and communities.

1). What Impact will these proposals have on you and your community?

Our Connected Neighbourhoods has already begun to engage with the new Intermediate Care model based from the Bellfield Centre, as a natural hub for collaboration and partnership working, both in the Third Sector Hub and within the bed based services. The process so far has involved the third sector in the design of the building and environment, and the programme and delivery model for the third sector is now in development.

Building on neighbourhood models of care and utilising these hubs as spaces to test, learn and connect communities to our health, social care and third sectors will consolidate resources, offer points of access for preventative and recovery work that is joined up with care provision, supporting better referrals, continuity of care, self-directed support access and a much better access to the full range of available formal and informal interventions across a range of areas of need which include: environmental, digital, community and creative.

Tangible outcomes of this work we hope to develop are a jointly designed digital/library resource, an integrated hub programme of activity and increased capacity for collaboration, joint fundraising and social enterprise development that supports health and social care outcomes and priorities.

The Our Connected Neighbourhoods Project welcomes the opportunity to build on the work at the Bellfield with other developments, for instance in Clackmannanshire Community Healthcare Centre.

The impact of these changes will be increased demands on the third sector, and the relationship with the third sector will need to become far more collaborative and partnership orientated in the future, as a purely commissioning based model will not necessarily lead to improved outcomes. It is important that thirds sector partners, academic partners and volunteers have a stake in the development of these new community based support models from the outset, so that these organisations have the time and capacity to deliver new models rather than have them imposed on them.

There can often be a perceived and/or real expectation that the Third Sector is there to pick up on gaps and catch the people who fall down the gaps of 'integrated care' whilst at the same time unpaid carers and self-carers can be left with little and no support.
Often the third sector services are provided through raising funds. Provision is then limited to 1 – 3 years. After the project ends the need is still there and all the insight, networks, coordinated care and local knowledge base built up is lost. A longer strategic plan including third sector integrated into a sustainable care process could achieve great results.

2. Are there any other changes or other options we should consider?

Recognising that community based models should be led by people who needing care and support, rather than have limited options of care imposed on them, more time needs to be spent on building community and neighbourhood capacity, utilising national and local third sector provisions. Part of this capacity building should be ensuring communities (in all forms) are fully aware of and invested in utilising a community-based model so there is

more flexibility to the model to adapt quickly as needs change. People we engage with highlight that local resources, from neighbours, to libraries, to paths, to community spaces could all be challenged and supported to be more accessible, allowing people more independence and autonomy in their everyday lives, close to home, rather than needing to travel to central points to access services that highlight impairment and do nothing to reduce stigma relating to condition or disability. Central Hubs can bring capacity to do that work with neighbourhoods and users of services can be empowered to challenge and support their communities to reduce discrimination, support inclusive meaningful activities and promote wellbeing in their local environment and community.

Early on in the OCN project, through the involvement and inclusion focus of the work, there emerged a significant need to focus on connecting organisations across Stirling who were working in dementia and supporting carers with one another. Possibly due to years of austerity, funding, cultural, geographical or political reasons organisations were not perhaps working jointly as much as they could benefit from. The partnership meetings and joint working fostered through OCN have worked well to develop closer working connections between the different organisations. This has led to some really good joint working and sign posting between the partners.

Community-led action requires engagement, commitment and involvement from the NHS and Local Authority partners to influence change across the Health and Social Care partnership. Large community-led projects such as OCN need that engagement to affect systemic change and to ensure we are joined up. A lack of capacity for these projects from public sector staff has been a barrier and we need two-way interfacing between the public sector agenda and work that is independent.

The Bellfield Centre is in the process of developing as a shared space which could support learning opportunities for collaborative organisations to hear what people are looking for, try out new responsive and innovative ideas and then implement them. Residents receiving care could have care complimented by other types of capacity building regarding living well using technology, linking into clusters of community support, staying active in inclusive activities and supporting people's capacity of individual agency, identity and citizenship.

There is also a unique opportunity to follow the pathway of residents from when they arrive through to treatment, discharge and integration back home which could be responsive, flexible and innovative in its approach.

Often services with very little funding such as volunteer led handy person service who also do trip and fall prevention, can provide a service which helps maintain a person living independently and safely in their own home for longer.

Primary Care Transformation

Context

The move towards new ways of working in Primary Care is set against a background of ongoing sustainability issues.

We recognise that less doctors are choosing to become GPs and over 50% of our current GPs in Forth Valley are over 50, with 23-25% aiming to retire or significantly reduce their clinical commitment in the next 3-5 years. This poses a real risk to sustaining good access to GP services and we know that access to primary care support matters greatly to people and to the wider health and care system.

Options/improvements

- Multi disciplinary approach: patients offered the most appropriate health professional for example Pharmacists, Physio, Mental Health Nurses, Advanced Nurse Practitioners etc.
- Training more Advanced Nurse Practitioners.
- Joint Pain Advisor service (physio led).
- Practice administration teams upskilled to improve workflow for GPs – directing patients to appropriate professionals in the first instance for example physio, Mental Health Nurse.
- Pharmacy First – Highly skilled Pharmacists are often able to offer guidance without the need to attend a GP appointment, and can prescribe medications.
- Using new technologies for example home monitoring of blood pressure.
- Reducing variation and waste in prescribing – educating people to only request the amount of medicine they need, and not over order.

1). What Impact will these proposals have on you and your community?

GP's can often be a referral point to third sector and other local support, it would be useful to consider the increased importance of pharmacies in the future. A GP is likely a person of trust for many people, so efforts should be made to engage with communities over how any shift of support to pharmacists could affect how willing individuals are to seek/use support.

2. Are there any other changes or other options we should consider?

We know there are initiatives looking at supporting dementia friendly pharmacies in the area, and would encourage all pharmacies to adopt memory-friendly practices. We also recognise pharmacies can be key places for keeping people connected and would welcome opportunities to support pharmacies to play a part in neighbourhood wellbeing, and to consider their role in supporting individuals to remain connected in their communities, not just in delivery of health information and services alone.

Providing there is a consistency in the support role pharmacies play, they could become a hub for the responsible signposting of pertinent information and services. With the correct design, this could be shaped to fit the needs of the individual, rather than just an empty 'support' gesture comprising piles of leaflets.

This however does not negate the need for GPs and it would seem a necessary priority support and encourage people to take on the profession including addressing some of the systemic problems that are acting as a deterrent.

Mental Health

Context

Scotland's Mental Health Strategy calls for equality with physical ill health. Services across the Partnership are working to ensure that people accessing services for support with mental health problems do not experience a lesser service than those accessing support for physical ill health.

Joined up services where people are seen efficiently, by the right professional at the right time.

Options/improvements

- Tackling the high suicide rate, particularly in the Clackmannanshire area.
- Joined up services where people are seen efficiently, by the right professional at the right time with minimal transitions of care
- Give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons by creating 20 new posts by 2021 in line with Action 15 of the Mental Health Strategy, via ring fenced funding from the Scottish Government.
- Work with partner organisations and communities to support people with mental health issues.

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1). What Impact will these proposals have on you and your community?

It is positive to see that there will be an increase of work to tackle acute mental health, however there needs to be far more investment in preventative models of support to reduce pressure on acute mental health provisions, prisons, police and emergency services.

Considering the dire state of mental health services (and this goes for other areas as well) the opportunity should be taken to have a frank debate about the potential negative impact of changes. Given the paucity of investment available, areas and services that will be hardest hit should be clearly identified in any future plan and not just subsumed into changes that are presented as "improvements"

The Option/improvement of tackling the suicide rate, particularly in Clackmannanshire would seem to be a desired outcome, not an action or improvement plan. More clarity should be offered on how the partnership is seeking to achieve this through the plan.

2. Are there any other changes or other options we should consider?

There is increased need to support carers with mental health and wellbeing, and indeed professionals working within health and social care and the third sector as there is a continuation to austerity, low salary rises, increased pressure on services and businesses, particularly social businesses. Employers and Third Sector agencies in particular should be supported to enable people experiencing poor mental health to stay in work and to support

carers to be able to balance their caring responsibilities against the needs of their work. Far more health promotion, training and support and investment in third sector and non-formal preventative mental health services could make a big difference to the pressure health and social care services are under.

Often unpaid carers of people living with dementia have expressed that they are advised to take care of themselves and their mental health, but need more practical support to do this when they are caring for someone else. Unpaid carers are under an enormous pressure which can have a big impact on mental health.

Dementia

Context

With an aging population, the prevalence of dementia is set to double within the Partnership area by 2041. In recognition of this, there is a need to prioritise funding of supports for people living with dementia and move towards an approach where dementia is everyone's business.

Options/improvements

- Develop a localised dementia strategy.
- Positive work via dementia friendly initiatives for example training staff in local shops and cafes to understand the needs of people with dementia, and improving access to local community facilities.
- Improve experience, access and outcomes for people with dementia.
- Improve post diagnostic support for people with dementia – timely access to appropriate support to help people in their journey with dementia.
- Develop the role of the Dementia Outreach Team (DOT).

1). What Impact will these proposals have on you and your community?

Our Connected Neighbourhoods has been supporting the Dementia Friendly Stirling initiative for the past few years and is designed to address the challenge of making dementia everyone's business. Our evidence base says that people diagnosed with dementia face a 'shrinking world' and that in reconstructing the way in which neighbourhoods support and enable people to lead full and more autonomous lives, we can improve outcomes and quality of life for people living with dementia. A focus on neighbourhoods makes sense in a number of ways:

- Tying dementia/memory friendly development to place concentrates efforts and brings together residents, public sector, community support and business in a localised (and or across digital or other connected neighbourhoods) to make a more quantifiable difference, partnering and led by the people who will benefit the most.
- Neighbourhood based models enable communities to take a whole community approach, addressing community assets, capacity, safety, transport and health and

social care rather than simply looking at the issue from a health and social care perspective. As communities control more of their own assets they can bring their own solutions and resources to the table and reduce pressure on central resources.

- Tying dementia friendly training to meaningful community action will deliver better outcomes than simply awareness raising and time limited impact on a small number of business and groups. Examples include Meet your Maker project with Craft Scotland, Artlink Central, Historic Environment Scotland and Forth Valley College and the outcomes can be varied and relevant to the organisations taking up the training perhaps with a focus on creating strong community resource of practical support (eg: tech help, friendship groups, help with shopping etc)

A focus on a work place or area becoming dementia friendly is a positive step. But when staff leave and an area's population change this work can be lost (as in the case of dementia friendly Motherwell). We need to focus on cultural change as well as practical change. We need to enable people living with dementia to feel more included in our communities through integration and not segregate people living with dementia in closed groups. It important to burst the bubble of dementia, raise awareness and connect people.

The proposed 'options' under dementia are very broad and woolly and we suggest that these are linked to specific indicators of progress and a plan to monitor development with some clear lines of accountability.

It's good to see that there is a commitment to focus some training and attention on non-HSC workers and it would be good if the proposed local strategy carried a plan for supporting those workers in other sectors who are having increasing contact with people with dementia but also beyond this offered a vision for a more co-ordinated community action plan that fosters better relations between the sectors and includes some cross-sector policy objectives. In other words they really need to be involving transport, town planning, local redevelopment etc. from the outset. This could foreground place based approaches to working and should engage community planning partners, local community councils and local area development planning to embed dementia-friendly planning and equalities across all areas of work.

We must also reiterate the importance of working directly with people with dementia to ensure the places that are important to them in their neighbourhood remain accessible.

2. Are there any other changes or other options we should consider?

Recognising that community based models should be led by people who need care and support, rather than have limited options of care imposed on them, more time needs to be spent on building community and neighbourhood capacity, utilising national and local third sector provisions. People we engage with highlight that local resources, from neighbours, to libraries, to paths, to community spaces could all be challenged and supported to be more accessible, allowing people more independence and autonomy in their everyday lives, close to home, rather than needing to travel to central points to access services that highlight impairment and do nothing to reduce stigma relating to condition or disability.

Central Hubs can bring capacity to do that work with neighbourhoods and users of services can be empowered to challenge and support their communities to reduce discrimination, support inclusive meaningful activities and promote wellbeing in their local environment and community. There can be a tendency for a scattergun approach or a medical model approach to dementia-friendly support and this needs to be addressed by ensuring people living with dementia and their carers are driving and informing community change. Place based models of working with a focus on including people with dementia can improve wellbeing, connectedness and a sense of civic pride, contributing to better health outcomes and sharing the benefits with everyone in the community/neighbourhood.

To improve the experience, access and outcomes for people with dementia it is imperative to look at areas where a difference can be most effective and recent research from the 'Neighbourhoods: Our People, Our Places' research project at the University of Stirling (Forthcoming) points to recognising key emotional and cognitive areas dimensions that can impact on a person's ability to feel connected within a neighbourhood, community or within a health or social care setting. Greater effort needs to be made in enabling people to feedback on what does / does not work for them so this becomes part of an ongoing means to strengthen the community model. Mentoring from those with lived experience should be looked at as a way of connecting communities across Scotland.

We would also highlight the potential benefits of a Dementia Local Area Co-ordinator that draws on the model currently used in disability and learning disability. We believe this is essentially the direction that Our Connected Neighbourhoods is taking with our Community and Integration Coordinator role, but it needs to be a permanent post not something tied to time-limited project work and we look to strengthen the case for this approach through our project evaluation.

Better post-diagnostic support for people should include clear pathways into options for self-directed support, including option 2 and self-directed support should be easier and timelier to set up and deliver. Consolidated and more joined up services will offer better self-directed support marketplaces for individuals. Self-directed support could be offered as a preventative service early after diagnosis and then shift into a personal care model of support later on. This would enable more continuity and better outcomes, with focus of early intervention being on meaningful activity.

There is an opportunity for care homes and other third sector interventions to be more inclusive. There is a strong potential and interest from care homes in building stronger links to the wider communities in which they're based and the role that arts organisations can play in facilitating this. We are developing the concept of neighbourhood festivals where communities and care homes become sites for connectivity, dementia-led activity, intergenerational activity and which reposition care homes as outward facing neighbourhood anchors for supporting people to remain connected in their own neighbourhood, rather than closed off facilities.

As part of our response to this consultation OCN ran a dementia / hearing loss specific Health and Social Care 3 year plan consultation with partners at Alzheimer's Scotland, Ideas For Ears and CTSI / SVE. There is a high correlation of hearing loss and

dementia and the two conditions dovetail very well for the purposes of a consultation like this and how each experience services and treatment. We
include this feedback along with our OCN response.

Drugs and Alcohol

No response from OCN

Informal Supports

Context

Social isolation and loneliness can affect anyone – at all ages and stages of life. We know there is also a link between loneliness and poor physical and mental health and that this can impact on everyday life.

Supporting people to access activities and groups within their local communities can be an important way for people to socialise and access advice and support.

Local action within communities can make a significant difference to everyone, and greater opportunities to work with those communities need to be explored to support the most vulnerable. This should include supporting unpaid carers in their valuable role.

Options/improvements

- Continue to work with our colleagues in Carers Centres in line with the objectives set out within the Carers Act.
- Development of our identified localities to ensure that people have local access to the services which are most meaningful to them.
- Development of a local service directory, which will allow people to search for community groups and services in their area, as well as access to self management information.
- Alignment with Local Outcome Improvement Plans developed by Clackmannanshire and Stirling Councils.

1). What Impact will these proposals have on you and your community?

Reduced capacity of Carer's Centres have impacted on their ability to support collaborative work with the third sector and therefore reduced the ability of carers to meaningfully engage in work that is significant to and in the interests of carers. The OCN partnership had originally included OCN had originally included a representative Carer's organisation who had to pull out due to lack of capacity. Although they have promoted our work they expressed that but due to additional responsibilities with the roll out of the Carers Act they were at overcapacity and just could not commit the time. When carers are feeling a lack of capacity to cope for the organisations that provide support to carers to feel the same way is a concern that should be taken seriously.

Work within identified localities needs the balance of a central hub where practical collaboration, partnership and resources can come together with a strong local neighbourhood led grassroots support programme, which involves carers as drivers and allies along with people they support.

The architecture of public service information provision is generally awful. A one-eyed approach to developing a 'directory' would quickly see outdated information and ultimately an abandoned platform. A truly inclusive and accessible approach is also needed so that information is available where and whenever required. A community development

approach to this is fundamental in ensuring both its ongoing relevance and the potential for it to adapt and evolve. Design and data need to be kept separate, the option for users to propose updates / changes should be baked in. Any changes should be transparently recorded and each iteration retained on the system as a version of record.

In order to benefit from public services we also need build the capacity of people to get access to the internet, effectively know how to use on line searchers to find appropriate services, explore on line peer support and find out about other technology that could support them and the people they care for to live well.

2. Are there any other changes or other options we should consider?

Self-Management is a terms that perhaps could be reframed to be more supportive to people who see it as a problematic way to describe arms-length interventions. In practice it has too often been used to signify an absence of services due to public sector cuts, rather than a reflection on the individual's capacities and capabilities. Self-management requires support in order to be sustainable, and an absence of support is not self-management. Perhaps a more appropriate discussion is about self-care or being a Self-Carer?