



# **Boleskine Community Care**

## **Community Engagement Report**

### **Findings and Recommendations**

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## 1 Background

Boleskine Community Care (BCC) was formed at the end of 2013 due to an increasing local concern about lack of care provision and social isolation within the community. Volunteers running the lunch club and coffee mornings recognised the needs of people attending the lunch club becoming greater and the lack of local service provision to meet their needs. Consultation with the Highland Council, NHS, Local Highland Councillors and local GPs took place and the decision made to constitute the group and seek charitable status. This was achieved in 2014 when BCC become an OSCR charity.

The purpose of the organisation is

- To improve the quality of life, health, well-being and independence and to reduce social isolation of people of all ages in need by reason of age, ill health, disability or social circumstances
- To provide recreational facilities and / or organise recreational activities with the object of improving the conditions of life for the persons for whom these facilities or activities are primarily intended

BCC are governed by a board of 8 trustees and have over 200 supporters and members (Friends) of BCC. BCC's successful implementation of Home Care within a rural community has been widely acknowledged as a model of good practice and has been used as an example of Rural Community Care throughout Highland and beyond. In 2015 BCC and their partners Highland Home Carers, received an award from Scottish Care in recognition of their progressive delivery of home care within a rural area.

BCC currently hosts a part time Care Manager responsible for 7 professional care staff, employed by Highland Home Carers. All professional care staff are part time. During holidays and sickness there is one relief staff and the manager steps up to cover care. It is to the credit of staff that they will work additional hours if needed in emergencies and during times of crisis.

BCC has experienced a gradual expansion over the past eighteen months. From small beginnings where professional care was provided for 3 people they now care for 14 people with an additional 7 waiting for assessment at the time of writing. The demand for this service is evident within the geographic area and most referrals are provided by self-referral, word of mouth from concerned individuals in the community with local knowledge of people requiring additional support. In addition, the strong links forged between GP practices and NHS Highland ensure a steady rate of referral.

## 2 The Project

BCC has identified the need to review the service they are currently providing based on emerging community need, and to identify the direction required for future developments based on community consultation. Athena Solutions were asked by BCC to produce a short term development plan outlining options for the further development of the services they provide.

The outcomes commissioned by the study focussed upon

- 1) The potential demand from the local community for these services and the likely future need
- 2) The regulatory requirements including the Care Inspectorate
- 3) A feasibility study to demonstrate how a mixture of funding and use charges might meet employment and other costs involved in delivery.

BCC identified the following potential needs to be explored by this project:

Community Support:

- People's awareness of community services provided by NHS Highland, in contrast to those provided by BCC;
- Community awareness of services provided by BCC and people's understanding of those services and in particular:
  - Professional home care
  - Social activities
  - BCC transport
  - BCC fundraising

Feasibility of service developments:

- The need for a Day Care Centre which could provide a range of services to reduce social isolation, increase mental and physical activity, provide personal care services, laundry facilities and be a centre for advice to carers and others
- Residential respite care; providing short term respite care beds and facilities for local residents.
- Sheltered or support housing for community residents.

## 3 Summary and conclusions

### 3.1 Current position of Boleskine Community Care

#### BCC is well-known in the community

Boleskine's current services are well-known by stakeholders and by the local community. The community survey showed that over one-third of respondents would contact BCC first if there was a requirement for care; and that this rose to over one-half for households over 65 (Section 8.2).

#### BCC's services are well used by the community

Although BCC is aimed at all adults requiring support, its social events in particular are open to all. Our observations were that most, but not all, of those attending were older adults. Participation at the social events was between 20 and 35, with over 50 at the ceilidh; a significant attendance in a population of 700.

In the survey, just under 50% of all respondents attended BCC social events, rising to 60% of people aged 60 or over. The survey also demonstrated the level of demand for current services, particularly the handyman, volunteer driver, and including the Care at Home service.

#### BCC should continue to promote awareness of its full range of services

Awareness of all services requires continuing communication to ensure that people who may be eligible are aware of it. 50% of survey respondents attended the social activities at least every now and then, with only 2 respondents indicating that they did not attend but would be interested in these. Looking at the answer "no, but I would be interested in these services" as an indicator of awareness, demonstrated that the transport, handyman, and Care at Home services could potentially double their levels of activity if people became more aware of these services (Section 8.3).

#### BCC's services are highly regarded by stakeholders, users, and the community

All key stakeholder interviews (NHS, GPs, Highland Home Carers) spoke highly of the BCC services and the positive impact on people's health and wellbeing (section 6.1 to 6.3). GPs were interested in demonstrating the reduction in use of primary and tertiary care as a result of BCC's provision. Service users were very happy with the services provided (Section 7.1), and 100% of comments received in the survey were very positive about the services and the impact on the community (Section 8.4).

#### BCC is successfully addressing loneliness

BCC delivers its service through the active involvement of around 60 volunteers, many of whom are in active retirement. People attending the events spoke of the importance of these in providing a place for social interaction and a real feeling of community.

The survey confirmed the importance of the social events, with just under 50% of respondents attending the events either "weekly", "more than once a month", or "every now and then". 60% of respondents aged over 60 attended these events.

We asked people about their perceptions of their feelings of loneliness, using a standard question format drawn from academic studies, where the lowest rating is 3 and the highest, most lonely, rating is 9. Boleskine's average "loneliness score" for people who live alone, is 4.24. This compares very favourably with the English Longitudinal Study of Aging's average score of 5.8 for people over 50. .

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#### 3.2 Future service development by Boleskine Community Care

BCC has a strong track record of delivering both volunteer and professional care services to the community, with a growing evidence base of a community-level impact in terms of maintaining people's ability to live independently and well, reducing loneliness, and reducing use of statutory health services.

When asked about future developments to meet current and future needs, there were key themes in the conversations with stakeholders and users, and resulting from the survey.

These key themes were:

##### NHS

- Home based respite
- Social isolation and the need for transport
- Outreach service

##### Highland Home Carers

- More flexible use of SDS to meet a range of outcomes;
- earlier intervention before the need for professional care at home is identified
- wider range of service provision to meet identified needs

##### GPs

- Demonstrable impact of BCC services in reducing hospital admissions
- Need to continue to improve data-sharing for future planning
- Provision of Respite and palliative care beds to enhance services

##### Volunteers

- Continue to value volunteers as essential links from individuals to services
- Provision of "day care"

##### Users / Community

- Improve SDS awareness
- Continue to focus on / develop Transport
- Expand / extend handyman and increase awareness – volunteer rota for "a little bit of help"
- Central provision of particular health and care services – podiatry; physiotherapy; bathing help
- Social activities: Men's shed; cinema; home visits / greater inclusion
- Respite – particularly day-care at home, and more support in a crisis.

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#### 3.3 Potential future expansion – the results from engagement

One of the key themes for engagement was the need to explicitly consider **family carers and their needs**. Respite care is a significant issue in Highland; was highlighted by GPs as a requirement; and a total of 51 out of 99 respondents said that they would use paid respite care “regularly” or “in a crisis”. BCC has not explicitly focussed on family carers, but they are ever-present as some members of the community rely increasingly on friends and family to enable them to stay in their own homes.

#### Respite Care in Highland

NHS Highland commissioned “A Review of Respite/ Short Break Provision for Adult Carers of Adults in the Highland Partnership Area”, completed in 2016. The following are some of the key findings and recommendations that emerged from this review.

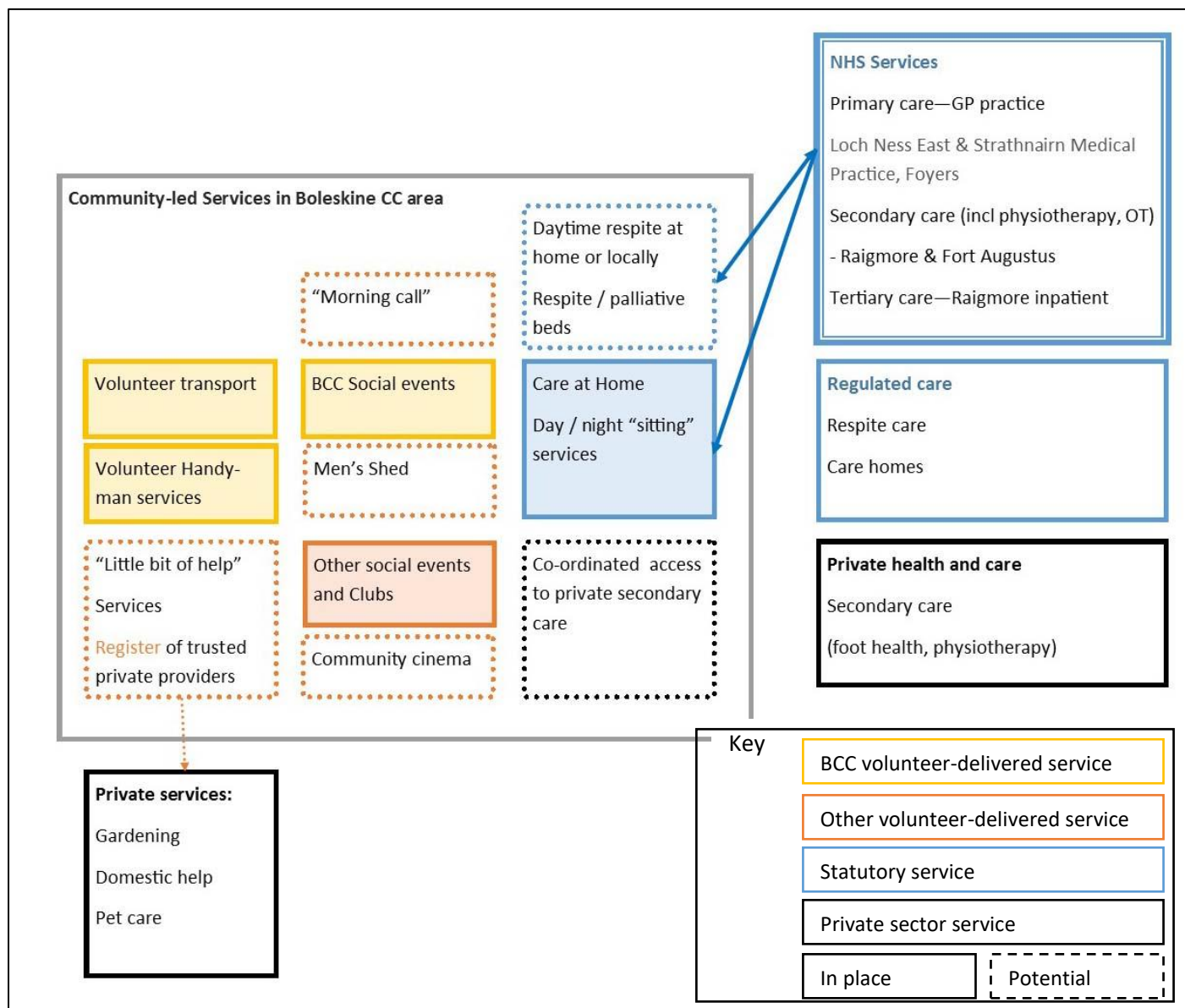
- Although respite is seen as a service for the carer, access to this service is through an assessment of the cared-for person.
- Carers can explore what supports they need by having a carer support plan; these are not widely used in Highland
- There is a lack of accessible, core residential respite services within Highland
- This lack is having a detrimental effect on the well-being of carers and a demoralising effect on those working closely with carers
- There are “gaping holes in the provision of residential respite services for carers of older people in Inverness, Nairn, the Black Isle and much of Easter Ross”
- There is a need to develop appropriate ‘core’ overnight respite services to meet need
- There is a need to introduce separate systems for planned respite and emergency care
- Self-Directed Support (SDS) needs to be more fully functioning across Highland
- Transport should be available to take the cared-for person to respite when needed
- Carers should not be charged for services

The themes from engagement can be usefully grouped and matched to existing services, to provide BCC and its community with a range of options for future service expansion. This is presented in the diagram, over.

Current services are shown with a solid outline and shaded.

Potential future services are shown with a dotted outline, in relation to the current services.

## 3.3.1 Diagram: the current BCC environment and potential expansion



**Enabling actions** to support any expansion are:

- **Regulatory** requirements for provision of respite / palliative care services
- **Data protection and confidentiality requirements** for referrals between voluntary services, HHC carers, GPs
- **Protection of Voluntary Group Certification / risk assessments** for home-based volunteer services
- **Location** for respite services, if not at home;
- **Volunteers and volunteer management** for expansion of any additional community services;
- **Financial viability** including access to SDS individual funding for demand-led services;

**Enabling factors** include:

- Support from stakeholders, in particular GPs and HHC
- Improved use of SDS to enable people's outcomes to be met
- Potential to work with Connecting Carers and the use of Carers Support Plans



## 4 Service development priorities: Respite and Foot care

At the final engagement event in September 2016, the community discussed the findings from this report and from their discussions (see Section 9, Feedback and Prioritisation Event) were asked to choose two key priorities for development. These were “respite” and “foot care”.

### 4.1 Foot care

BCC already works with a Foot Care Practitioner and encourages people in need of basic foot care to access these services. The service is already available, but is not perhaps widely advertised; people may be in need of this service and not think to ask BCC about it, or assume that as NHS Podiatry is not available for basic foot care, there is no other provision. The GP practice cannot refer on to selected private practitioners as a matter of policy.

Many of the findings from the engagement survey for additional services, (volunteer transport, the extent of handyman services, day- and night-sitting at home) were for services can already be provided by BCC. Part of the issue is communication. While BCC strive to advertise their services through the newsletter, through the website, and with leaflets at events, the most effective communication is word of mouth. People may not want to discuss their need to access care and support services, even those as neighbourly as the handyman and transport services; they may not want to “take advantage” of a volunteer service.

This may improve when there is a “hub” where the Care Manager is based, so that people can drop in and ask questions. Ongoing communication with the nurses at the GP practice, so that they understand the services on offer and know that BCC maintain a register of providers (including a Foot Care Practitioner) may assist. A monthly Foot Care clinic before or after one of the community social events may also raise awareness and uptake of this service.

### 4.2 Respite care – increasing awareness of current provision

As noted above, BCC already have the capability to provide both day time respite at home, and a night-sitting service. People may not be aware of this service. If the cared-for person is not currently receiving care at home support, then they will not have a Personal Outcome Plan; they will not be in contact with BCC’s Care and Home Service; and they will not know of the services offered. Further, they will have no state-funded resources for the family carer to access respite.

It is key that BCC support the community to better awareness of support for family carers. This support can be accessed through Carer Support Plans, which will then provide some access to state funding for respite resources.

**As a first step, BCC should work with Connecting Carers to increase awareness of the support that family carers are already entitled to, and to roll out Carer Support Plans to help ensure that people are able to access financial support for their caring role.**

### 4.3 Respite care - planned short breaks / residential respite care service

#### 4.3.1 The setting

Short breaks and respite care can be offered in a wide variety of settings including:

- breaks in respite-only units (specialist guest houses, community flats, purpose-built or adapted houses);
- breaks in care homes;
- breaks in the home of another individual or family who have been specially recruited;
- breaks in your own home through a care attendant or sitting service;
- holiday breaks;
- supported breaks for both the individual and carer together;
- befriending schemes where volunteers provide short breaks;

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- breaks in supported accommodation;
- flexible breaks through direct payment arrangements. Also some forms of day care should be seen as falling within the definition of short breaks and respite care. These were covered by the 1996 Guidance on Respite Care.

#### 4.3.2 The level of demand

Currently there is no information on what sort of breaks family carers are looking for in the BCC area, and further work would be required to establish the level of demand.

#### 4.3.3 Support from statutory agencies – NHS Highland - Area Manager

To undertake the development of a short break/residential respite service BCC will need to fully understand registration requirements. The following provides a brief outline of the next steps to be taken if this option is pursued.

#### 4.3.4 Short breaks and residential respite care

Care Services must by law register with the Care Inspectorate. You must meet the requirements of The Public Services Reform (Scotland) Act 2010.

Partnership arrangements can be considered to undertake registration if BCC can find a partner who will deliver the registered service (as HHC does for Care at Home). The significant difference between Respite Care outside the home, and Respite Care away from home, is that the facility as well as the service must meet Registration requirements.

#### The application process

The application process is straightforward although a great deal of work is required to pull together the various documentation that will be required. When the decision is made to apply for registration, the care inspectorate will assist you through the process. Help and advice is offered by them for each step. The main areas that require to be fulfilled include:

- The provider or registered manager must be fit to manage the service. The full criteria for fitness to manage is contained in the documentation provided by the legislation on the care inspectorate website. The service manager must be registered with the Scottish Social Services Council, (SSSC). Note that this person does not have to be on the premises 24/7 but there will be stated staffing ratios to meet National Standards.
- The premises must be fit for purpose. The Building / location must meet Care Inspectorate Registration requirements including room size, fire regulations, physical accessibility. The size of the facility is critical to generate the income required. There are small facilities which are single or two-bedded; others are larger but could require a larger number of service users to become financially viable.
- The service must make proper provision for the health, welfare, independence, choice and dignity of those using the service
- The provider will need to provide a financial statement /Business Plan detailing how the service will be funded and most importantly how viability will be sustained
- You will also need to provide details of constitution/charitable status

If you make the choice to apply for registration it would fall under the section “Services for people who need care and accommodation” and it would be classified as a care home service. That is, a service providing accommodation which includes; nursing care, personal care, or personal support to vulnerable adults. This encompasses short breaks and respite care services for adults.

The service will need to comply with National Occupational Standards and provide information to individuals and their carers on:

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- living arrangements and lifestyle;
- the physical layout and design of the accommodation;
- details of the accommodation, including the number and type of rooms;
- visiting arrangements;
- personal belongings (including pets);
- any restrictions on smoking and alcohol;
- policies and procedures about the possession of unauthorised alcohol or drugs during your stay;
- arrangements with local health and social work services.

#### **4.3.5 Sources of income and costs**

Ongoing funding sources – the primary source will be through self-directed support for cared-for individuals and their carers or from private income sources. Respite is provided through the cared-for person's Personal Outcome Plan and the Carers Support Plan, so these must be in place prior to funding becoming available. Anyone receiving Care at Home should already have a POP, but their carers may not be aware that they are entitled to a Carers Support Plan and potentially additional resources for respite.

Project costs would be the set-up costs for the service including the building, staff recruitment, staff training and development, registration costs. As the service cannot be Registered until it is in place, there would be initial losses while the facility reaches capacity.

**A full Feasibility Study and Business Plan will be required to test the provision of Residential Respite Care services.**

## 5 Community and Stakeholder Engagement

There were two groups of people and organisations identified in our project proposal.

### Key institutional stakeholders:

This involved key stakeholders with whom BCC is already working or considering working, to gather the views of these stakeholders, why the stakeholders have that view, how this view fits into their strategies and plans, and what – if anything - they might contribute in terms of resource or funded activities, or even in providing referrals.

### Canvassing the Community:

We used two main ways to engage with the community:

- Structured discussions with key user groups prior to the survey to help assess current understanding of services, gain feedback on services, and to assess key needs, benefits, challenges and opportunities in expanding services. This was done by attending 6 existing community events and having discussions with attendees to gain their perspectives.
- Community survey, provided to all households in the community, used to get a broad understanding of the awareness of services and who delivers them; to gain feedback on services; and to identify any unmet needs;

This work of the first phase has been carried out and has involved semi structured interviews with a range of individuals from the Stratherrick and Foyers Community drawn from those attending BCC community events; coffee mornings, lunch club, “broth and blether”, a ceilidh, and afternoon tea. We had discussions and meetings with BCC board members, staff and volunteers. We also had face-to-face meetings with stakeholders including Highland Home Carers, NHS Highland representatives - the District Manager and local social work staff, local GPs, and Stratherrick and Foyers Community Trust board members.

The information from the engagement events was used to help shape a Community survey which was sent to all 377 households in the community, provided with BCC’s quarterly newsletter. This survey was also available in electronic format.

## 6 Stakeholder engagement

### 6.1 Highland Home Carers

BCC work in partnership with Highland Home Carers who have been instrumental in enabling the service to develop and grow. This has been possible through use of Option 2 of the Self- Directed Support Bill enabling people requiring support to choose a specific provider to hold a budget for their care. SDS funding provides funding for the care service on an individual case by case basis. HHC act as “service brokers”, handling the funding from SDS, the payments to service providers, employment of professional carers, and all issues relating to regulation and to e.g. employment law.

In addition to providing support and training, Highland Home Carers enable the project to be flexible and responsive particularly during times of crisis prior to funding being in place. Without this support it would be unlikely that BCC could respond as quickly to crisis as they do. SDS funding is key to the function of BCC and provides an opportunity to explore creative and flexible models of care.

HHC have been able to support the growth of the project by taking some of the financial risk of start-ups. One of the barriers of SDS funding is that it is given to individuals, making it more difficult to predict the overall level of need and demand for a service over time and therefore a financial risk to commit to training a providing a service in advance of referrals to that service. HHC have taken both

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a pragmatic and proactive approach, setting up services in partnership with BCC in the informed expectation of demand.

The Care Manager post has been essential in local coordination and management of professional home care; this post is (part) funded by the SFCT from windfarm funds; there is insufficient direct funding from SDS.

All referrals to the Care at Home service are in receipt of or in the process of applying for Self-Directed Support which funds the professional care provided. This provides flexibility with people choosing what type of service they want and most importantly, when they want it. BCC should be commended in their ability to provide a service that is flexible, responsive and relevant to those who use it. BCC have also provided local people with information and advice on Self-Directed Support. A major strength of the project is in the ability to respond to urgent cases and provide an immediate service until a more formal assessment can be undertaken. GPs have identified that as a result of the flexibility of the services BCC are able to provide there has been a reduction in hospital admissions and reduction in delayed discharge. Assessments centre around the needs of the individual and packages are delivered around the person. As the needs of individuals change BCC is able to respond. A major development was the employment of the Care Manager who has been instrumental in driving the project forward and in developing local and staff networks and resources.

The Care Manager's role involves

- Staff management/ supervision
- Preparing staff rotas to support a flexible and varied demand for services
- Preparing care plans/reviews /risk assessment
- Awareness-raising and engagement work within the community;
- Ensuring compliance with regulations;
- Liaison with NHS Highland/Highland Home Carers/GPs

Staff have received training from Highland Home Carers. This has included:

- Personal care
- Hoist training
- Health and safety
- Moving and handling
- Dementia awareness (online)
- Escort training
- Fire/home safety

The manager has identified further training needs in Palliative Care and the role of health care staff.

### Emerging themes

HHC are exploring the possibility of applying the successful "Boleskine model" elsewhere in the Highlands, and are working with other communities to do so.

- **The potential offered by SDS for support and care based on individual outcomes is not being fully realised; the majority of assessed needs relate to the provision of professional care at home, rather than other possible services to meet need and deliver individual outcomes;**
- **Care assessments appear to be offered only at the point that an individual requires support at home; this in itself is often triggered by an emergency resulting in that person becoming perceived at higher risk, rather than earlier intervention;**
- **HHC would support the expansion of services for identified need, and would support a wider range of services for individuals if there was evidence of demand.**

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#### 6.2 NHS Highland

NHS Highland work closely with the Care Manager and are supportive of the role played by BCC. They have indicated that they would be supportive of working in partnership to develop any new service that would be of benefit to people requiring support. There is close liaison with NHS Highland on referrals and regular meetings take place between social services and the Care Manager to ensure implementation of personal outcome plans. Regular review meetings also take place to monitor changing needs of those receiving the service.

NHS Highland have identified social isolation and the need for respite resources, in particular homebased respite, as major priority areas and would welcome the opportunity to explore this further with BCC. There was less demand for residential respite from within the area.

It is well documented that NHS Highland are experiencing financial restraints and NHS staff interviewed considered it highly unlikely that funding would be found for a new day care resource at this point in time. The only caveat to this appears to be in “spend to save” projects where proven long term financial savings can be made from innovations in care provision.

The “day care” model is not one that is currently viewed by NHS Highland as best meeting the needs of older people in a cost effective manner. Services provided by them follow a “resource centre” model which is more cost effective and far reaching. This involved identifying particular needs and then setting up services to meet individual needs, using a central location where it was practical and cost-effective to do so. It was suggested during interview that it is unlikely at this stage that NHS funding would be available for the development of a day care centre.

Areas of unmet need identified by NHS Highland appear to be more with younger adults with long term conditions such as for example Multiple Sclerosis. Services for younger people were lacking in spite of the availability of direct payments. NHS Highland acknowledged the difficulties associated with the rurality of the area recognising the need for more outreach services and transport schemes to counter the isolation often experienced. The development of an outreach service was mentioned as a possible development to combat social isolation experienced by people living within the area.

**Staff interviewed from NHS Highland identified three priority areas:**

- **Home based respite**
- **Social isolation and the need for transport**
- **Outreach service**

#### 6.3 GP Services

The GP practice is increasingly supportive of BCC. Regular updates have recently begun between the Care Manager and GP practice, and BCC report that GPS support to Home Care staff in queries over health and care of their clients. The service is highly valued by them; in particular by the ability of BCC to respond to emergency situations and crisis. The GP interviewed expressed the view that BCC’s ability to respond quickly to emergency situations could possibly contribute to the prevention of some hospital admissions assist in reducing delayed discharge. GPs also mentioned the value of the volunteer transport scheme in enabling people to access health services and appointments.

The GP interviewed did not see the need for local community beds within the area due to lack of demand and ease of access to Raigmore, however he did mention that respite and palliative care beds would enhance the services provided. The practice would be supportive of any developments that would support care within BCC area in particular a resource that would enable allied health professionals and community nurses to have closer contact at community level.

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#### Emerging themes:

- **Strong collaboration between GPs and BCC may result in reduced hospital admissions**
- **Increased partnership working between the GP practice and BCC will benefit those who require home care services**
- **GPs were interested in exploring the provision of respite and palliative care beds to enhance the service provided in the community.**

#### 6.4 Stratherrick and Foyers Community Trust

SFCT are the main conduit for windfarm funding, in particular, into the community. They are clear that their role is to enable community groups to achieve their ambitions by a transparent funding process. BCC have been very successful in accessing funding because of their strong track record in delivering community outcomes and also as they are one of the few organised groups in the community.

SFCT have recently employed a Project Officer to help engender community projects, including whether there is any potential for a community hub building at a site in Lower Foyers.

#### 6.5 BCC Volunteers

BCC is a volunteer-run organisation, with voluntary Trustees developing, promoting, and managing both the professional care at home services and the informal, volunteer-delivered services such as the social activities, handyman services, and transport. This includes strategic development, developing partnerships with other organisations, community engagement, ensuring governance and compliance, fundraising, financial management, volunteer management, oversight of the volunteer services, and responsibility for the Home Care services in partnership with Highland Home Carers.

Volunteers run a year-round programme of informal activities for people within the community. The social activities pre-date the formation of BCC, and have been operating for five years. There are around 50 volunteers actively involved in organising and delivering these services. The paid caring services and the volunteering services operate separately, and volunteers are very aware of the need for confidentiality amongst those using the service; particularly given that this is a small community.

BCC volunteers organise a minimum of 1 event per week. They volunteer for a range of activities from running lunch, coffee mornings, soup club and outings. They also provide the volunteer driver scheme and the volunteer handyman scheme. Volunteers have received training in food hygiene and also car training for the car pool. Further work would be necessary to determine the amount of volunteer time needed to run these events but it is substantial. For example, they have 30 volunteers who make soup for the soup and blether event. This roughly equates to 2 pots of soup per year. This may seem insignificant however it does prevent volunteer burnout and demonstrates the commitment of local volunteers. 5 Volunteers make bread and they have 3 cooks.

Some of the work undertaken by them involves

- Preparation work
- Sourcing recipes and cooking
- Transport
- Preparation for events
- Socialising
- Driving

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### Themes emerging

- **Volunteers provide an invaluable service to the community**
- **Volunteers help identify when people attending events are requiring more support**
- **Volunteers appreciate having BCC to refer people on to when they are concerned about health or other welfare issues**
- **Volunteers provide a substantial amount of time and energy that is of benefit to the local community**
- **The volunteers are keen to see a day centre facility develop within the local area**

## 7 Community engagement: BCC Service users

BCC attendees at social events were wider than the “core” service user of people over 55, with a range of people attending including people with young families. This was more so at the ceilidh event than others. Although BCC is aimed at all adults requiring support, its social events in particular are open to all. Our observations were that most, but not all, of those attending were older adults. Participation at the social events was between 20 and 35, with over 50 at the ceilidh; a significant attendance in a population of 700. People attending the events spoke of the importance of these in providing a place for social interaction and a real feeling of community. BCC also have been successful in encouraging older men to attend and to volunteer in service delivery, counter to trends elsewhere. Some of the volunteers said they were older than some of the attendees, demonstrating strong age-group self-support in this community.

### 7.1 Feedback on current services offered by BCC

Without exception there was a really good awareness of the work being undertaken by BCC. This included both formal and informal services, people using the services and those within the local community such as shop and coffee shops, local churches etc. Feedback from those interviewed strongly indicates the value placed on BCC by local community members.

Most attendees used the lunch club and coffee mornings as a form of social interaction. This was greatly appreciated. Social isolation was mentioned by at least seven respondents with the lunch club being their only opportunity to socialise. Attendance at the various events on offer was not uniform. Most people attended the lunch club and coffee morning. Others attend lunch club and afternoon tea. One respondent suggested that people didn’t always want to leave home but this was the only local opportunity to meet people. It is worthwhile noting that the lunch club provided a very welcoming and inclusive environment. People chatted and engaged easily. All commented on the high quality of the food provided.

All respondents that we spoke to were aware of the volunteer transport scheme and the handyman scheme. It was not possible to determine if everyone was aware of the professional home care provision but of those we spoke to everyone knew what could be provided by BCC.

### 7.2 Transport

Some people drove themselves to the lunch club. Others used the volunteer driver service and professional carers from BCC transported more frail people to the club and also provided assistance. An interesting point is that there seems to be a cut-off point when people are unable to drive. This leads to social isolation which many described as the worst aspect of living within a rural community. The volunteer driver scheme was generally known about due mostly to the publication of information by BCC. People mentioned that transport to hospital was not possible as drivers are not insured to take people to hospital appointments. This has now changed, but despite BCC’s efforts the change is not yet widely known. Most people who can no longer drive relied on relatives for hospital transport, and to e.g. visit Inverness and go shopping, attend other appointments etc..



### Community Engagement Report

The public bus service was discussed with people complaining that it was inadequate particularly when travelling to Inverness for hospital appointments. The rural nature of the area was problematic for some who found it difficult to walk to the bus stop.

#### 7.3 Awareness of SDS

Very few people had heard of self-directed support. One person mistook this for helping themselves and another respondent added that this was not applicable to them. From the conversations held it would seem that knowledge of self-directed support is very limited and this may be one area where an information programme might support individuals to learn more about SDS and how to apply for it.

#### 7.4 Awareness of NHS Highland services in local area

At least four people that we spoke to also attended day care at the Telford Centre. Two people travelled to Inverness for physiotherapy. People made use of GP services in Foyers and Riverside. Transport to GPs was indicated as problematic for those with mobility problems. Family neighbours and the volunteer transport services were mentioned as ways to get to the surgeries. Raigmore presented greater problems for people as bus timetables often do not coincide with appointment times. District nurses were known to people however social services and how to contact a social worker was less well known.

#### 7.5 Other needs within area that are not being met

Chiropody and podiatry were highlighted by most people as being the one service most needed. One woman explained that this service meant the difference between her being able to get out and about and being “stuck indoors with sore feet”. Those attending the Telford day centre expressed an interest in local day care. Services most used there were bathing and podiatry. Although the centre was spoken of very highly winter travel proved a barrier to attendance on some occasions with the road conditions being poor. Having a centrally located resource where people could access chiropody, physiotherapy and other health resources was mentioned more than once.

There was a high number of male attendees at events, which compares well with the difficulties similar organisations have in attracting older men in particular to social events. On discussion they suggested they would be interested in having a men’s shed, and possibly a community cinema. They indicated that there was nothing within the area for older men other than the lunch club. One of the volunteers had tried to make contact to visit the men’s shed in Inverness and this might be an area worth pursuing.

All of the people we spoke to indicated that they would be very supportive of the idea of having a local day care centre. On further discussion this was to access services (bathing, podiatry); for social interaction and enjoyment (film club, outings), to go somewhere different and get “out and about”. Reasons centred around combatting social isolation and helping maintain independence.

One issue that was emerging was the need for a local befriending service. Although attendees were more than happy with the services offered by BCC some stated that they didn’t always want to go out to an event and would have preferred someone to visit them at home. On further discussion, some attendees noted that they knew of people who used to attend but no longer came, or who did not attend, as they found it difficult to participate due to physical conditions or mental health issues such as increasing dementia; there was concern expressed about how they might remain socially active. BCC have investigated this as a potential service, and have met barriers around the need for formalising the service; for example, PVG checks; “matching” befrienders to service recipients. BCC try to encourage social visits between volunteers and service users, and between service users, on a voluntary an informal basis.

Respite care is a recurring issue in national and local policy. The number of family carers is increasing across Scotland both due to a growing aging population, and also because people are now being

### **Community Engagement Report**

encouraged to live independently at home (and often with a family carer) for longer. Various forms of respite care are identified frequently as being essential to help family carers continue in their caring role. We did not identify people specifically as “carers” and no-one we spoke to mentioned “respite” directly. There are many cultural and social reasons, for this, which are explored in the 2016 Report on Highland Respite Provision<sup>1</sup>; these are that people don’t self-identify as “carers”, that a need for respite can be felt by some to be an admission of failure to care; and that respite services continue to be assessed based on the cared-for person’s condition, not on the carer’s needs.

#### **Themes emerging**

- **BCC services very well known within this group**
- **BCC services and resources well used and highly thought of within this group**
- **Podiatry was mentioned by nearly everyone we spoke to as a service that is difficult to access**
- **People travel to Inverness for Physiotherapy and this is not easy with bus timetables**
- **Little knowledge of SDS**
- **Men’s shed**
- **Support within this group for a local day care centre and for befriending services**
- **What more would help people who find attending the social events, too difficult?**
- **Social isolation was a recurring theme**

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<sup>1</sup> “A Review of Respite/ Short Break Provision for Adult Carers of Adults in the Highland Partnership Area - Key Findings and Main Recommendations”, A McDonald, D Macleod, January 2016

## 8 Community Engagement: Survey findings

The survey was sent to all households in the Stratherrick and Foyers Community Council area, a total of 377 households, and additional copies were made available at the Foyers Post Office and Shop, and at Cameron Tea Rooms.

There were 99 responses; a response rate (by 337 households) of 30%.

### 8.1 About the respondents

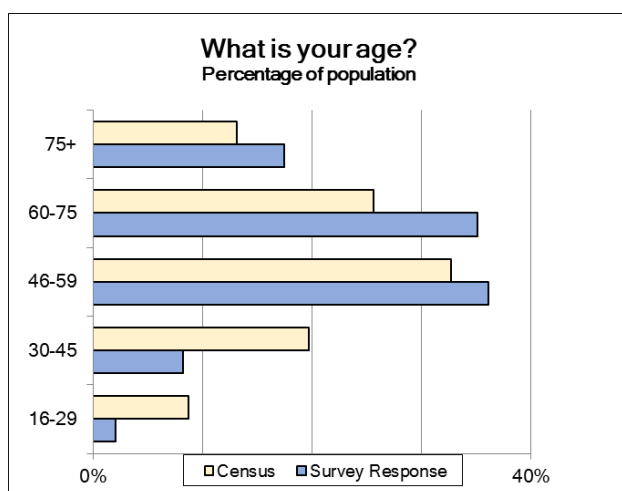
#### Occupation

50% of respondents described themselves as retired, with the next biggest group (35%) working locally or commuting. 13 respondees described a mix of working, volunteering, and caring roles.

#### Age

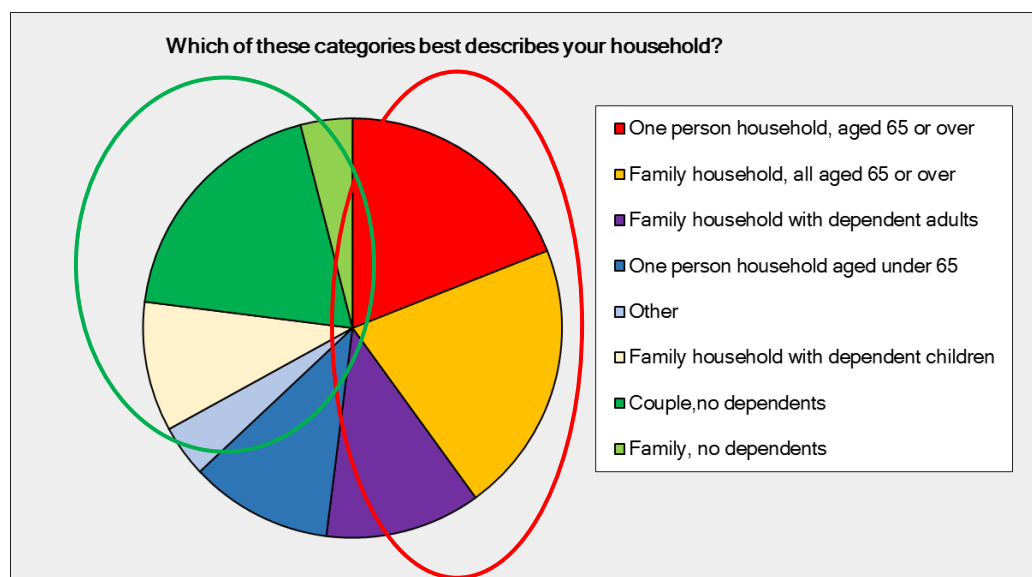
In terms of age, respondents were overwhelmingly in BCC's target age range, either as potential volunteers, as service users or as people likely to have an older person in their family. Relatively few people were below 45; this is typical of survey responses, and the effect is possibly increased by the subject of the survey.

Compared to the community's age composition in the Census data, a higher proportion of people who were 46 and over responded; and less than half of those 45 and under responded.



#### Household composition

The survey asked about household composition, to enable responses to be compared by type of household. It did not use the full 15 point categorisation used by the Census, and attempted to focus on main categories. 31 people described themselves as "other". Analysis of these responses allowed "other" to be re-categorised into two other categories – "Couple, no dependents" (the highest number) and "Family, no dependents", to be re-assigned to an existing category, or to be left as "other".

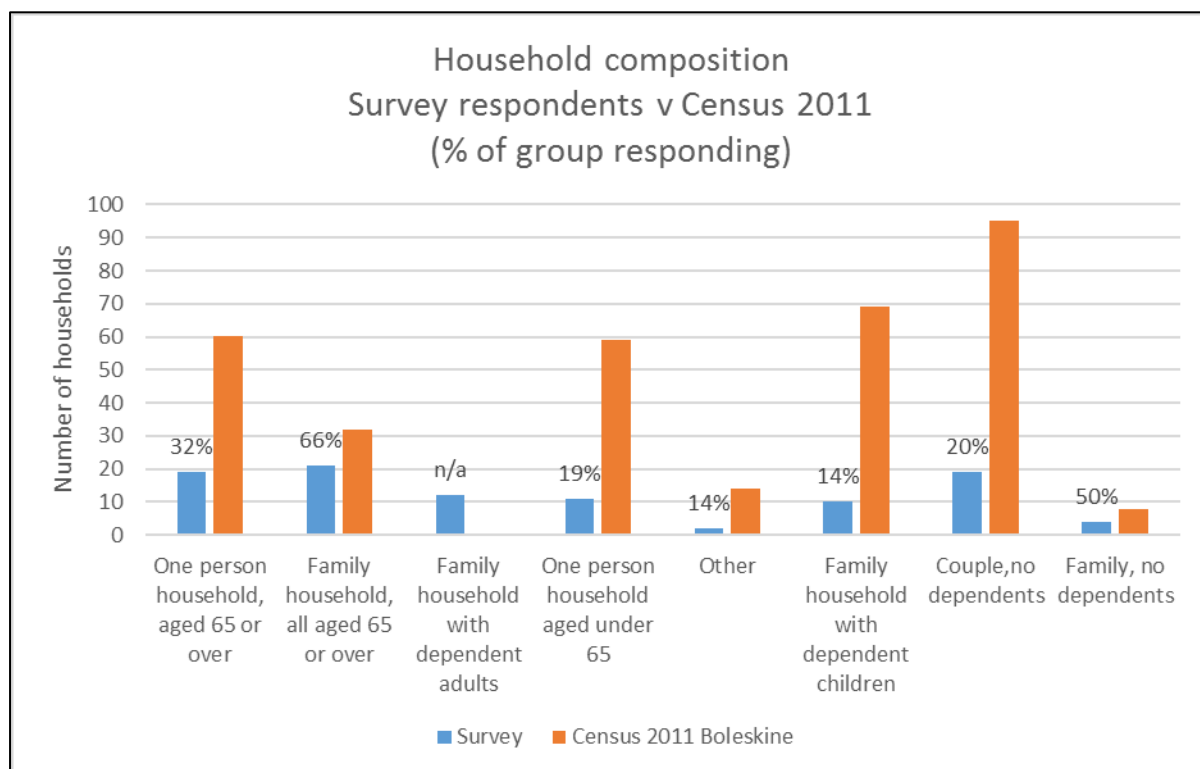


## Community Engagement Report

Just over half (52%) of respondents were from the BCC's "target" population that is, people whose household were all over 65 or who described themselves as having "dependent adults". These are circled in red in the chart above.

33% were from households less likely to use BCC services – families with dependent children, couples and families with no dependents at home. 11% were from single-person households aged under 65. These are circled in green in the chart above.

Compared to Census data, there was the highest percentage of respondents from family households where everyone was 65 or over (66%) and from single person households over 65 (32%).



*NOTE: "dependents" in Census definition is reserved for people under 18. It does not include "dependent adults" that is, people over 18 who require to live with a family carer. "Family household with dependent adults" does not exist in census household categories.*

The high response rate from the "target" population in particular is a good indication of the respect for BCC within the community and their interest in shaping services in the future.

This may be partly because 59% of respondents, are Friends of BCC.

## Boleskine Community Care

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#### 8.2 How well known are BCC services?

BCC are clearly both known and respected in the community.

Over one-third of respondents would contact BCC first with a requirement for care, second only to GPs:

If you or your family or friends needed help with care, who would you contact first?		
Answer Options	Response Percent	Response Count
GPs	47.4%	46
NHS Highland	2.1%	2
Social services	5.2%	5
Boleskine Community Care	37.1%	36
Other - please tell us who?	8.2%	8
answered question		97

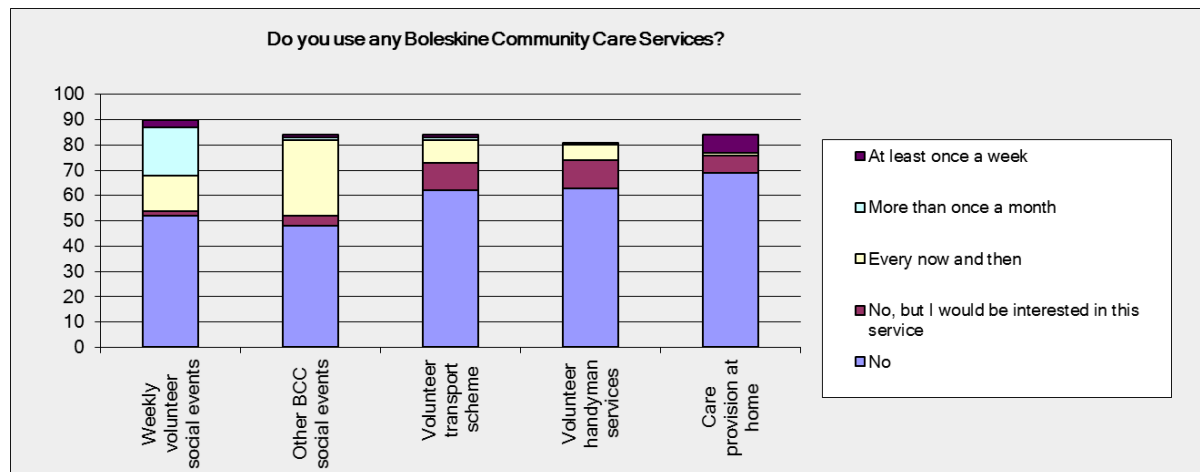
This finding was reversed in looking at people living in households where all occupants were 65 or over ("Older households"), where 54% would contact BCC first, and 32% contact GPs. There is a clear illustration of BCC's success in awareness raising of its services, and also in reducing the burden on GP services.

From people who recorded themselves as "friends" of BCC, the GP / BCC split at around 40% each.

## Community Engagement Report

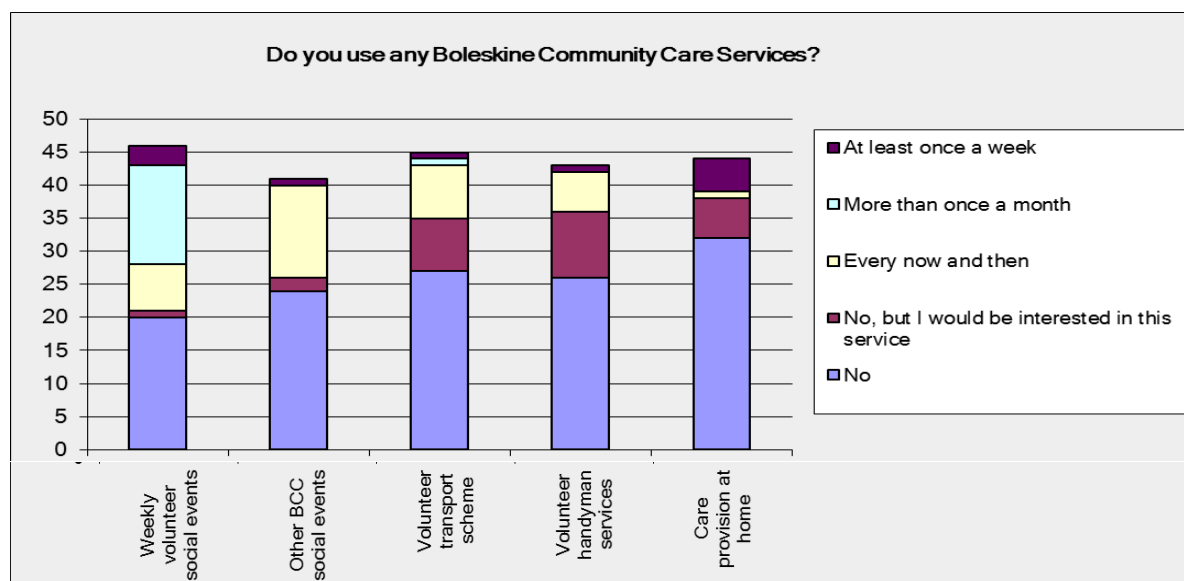
### 8.3 How well are BCC services used?

The most used services of the respondents were the social activities, with around 50% of respondents accessing these at some point. While only a small number – 3- came every week to the social events, 33 % were regular attendees.



There was a small uptake of the volunteer transport scheme, with only 11 respondents using this; and 7 for the volunteer handyman services. Only 8 respondents used the professional care at home scheme, out of 14 who BCC deliver the scheme to.

If respondents aged over 60 are examined, there is a far greater proportional uptake of BCC services from respondents. 31 of 51 respondents use BCC services:



The answer “no, but I would be interested” demonstrated that 11 additional people would be interested in the handyman and volunteer transport services, 10 of whom are aged over 60 7 additional people would be interested in the professional care at home services, 6 of whom are aged 60-74 but only one of whom is aged 75+.

Delivering services to these respondents would be a significant uptake in these services. The numbers of these responses demonstrate that despite BCC’s activities, continual communication practices, and engagement with the GP practices and social workers, it is still not easy to reach people who are in need.

BCC services are received with gratitude by their community. This was a “free” answer to the question, “please tell use what you think about BCC’s services”, and the response was 100% positive.

“Very good if they had been set up a few years back my mother could have stayed local.”

“Well run, effective, appreciated. The big achievement has been Care at Home but the other events and services help to reduce isolation. I may need care at home when I am older.”

"I would not be able to remain in my home if it wasn't for BCC."

The “wordle” diagram below represents the comments made. The larger the word, the more often it has been mentioned by people in their responses.



## Community Engagement Report

### 8.5 Potential additional services

The survey sought to identify unmet need in three questions about additional help at home, local healthcare, respite services, and social activities.

#### 8.5.1 Help at home

82 people of the 99 survey respondents answered this question. In general, 30+ people would only use these services “in an emergency” but there were some who would use these services “regularly”, particularly help in the garden:

What help at home (paid or voluntary) might assist you or your family / friends to live safely and well?				
Answer Options	Regularly	Only in an emergency	Never	Response Count
More domestic help (e.g. cleaning, cooking, laundry)	13	32	23	68
Help looking after pets	7	36	21	64
Help looking after the garden	18	31	26	75
Other help at home (please tell us what)				12
<i>answered question</i>				<b>82</b>
<i>skipped question</i>				<b>17</b>

It should be noted that only 60% of the “regularly” or “only in an emergency” respondents were over 60, with the others mainly between 46 and 59. This could relate to a busy household, or to increasing infirmity, of people younger than 60.

One respondent’s comment demonstrates that people remain firmly independent and are willing to use options if they are available:

“I employ a company to cut grass and strim and I look after flower beds myself. Occasionally there is heavy work to be done e.g. moving boulders and I would probably ask the Handyman scheme if they could help. As I get older I may need more help and would prefer to employ a local person but would expect to pay for this.”

Some of the additional services mentioned may fit into the existing handyman or transport schemes:

“Shopping if family unavailable and I am housebound. Help with paperwork/bank accounts if no family available!
Home visits for dentistry/hearing aids/chiroprapist
Hairdresser
Log cutting and stacking. Maintenance of private water supply.
Help taking things to dump
I am finding getting the coal in an effort now and would be grateful for someone to once a week bring in some coal hods for me.”

BCC may wish to consider a “helping hand” type scheme, where people could volunteer to be on a list and contacted if a neighbour needs help in an emergency. Volunteer schemes such as reading to people whose sight is failing, helping deal with paperwork, keeping or encouraging people to remain connected through IT, have all been identified in national work on “that little bit of help” (Joseph Rowntree Foundation) that means people whose physical or mental health is deteriorating, remain in control and able to cope at home.



## Community Engagement Report

## 8.5.2 Other healthcare services (non-NHS)

There was a strong demand for allied health professional services in the respondents; and it was made clear in the question that such services would have to be paid for.

What other local, non-NHS health care services might assist you or your family / friends to live well?				
Answer Options	Regularly	Only in an emergency	Never	Response Count
Podiatrist or chiropodist	42	14	18	74
Occupational therapist or physiotherapist	19	25	18	62
Massage therapy or chiropractor	21	23	18	62
Other healthcare (please tell us what)				9
<i>answered question</i>				<b>79</b>
<i>skipped question</i>				<b>20</b>

42 people would use a podiatrist “regularly”, 19 would use a physiotherapist, and 21 a massage therapist or chiropractor. There were another 25 people who would use such a service “in an emergency”. Podiatry was a recurring theme in the engagement events, and is reflected as strongly, here.

Not all of respondents wishing to access these services were over 60. Of the 42 people who recorded that they would use a podiatrist or chiropodist “regularly”, 14 were under 60:

Age						No age given	Grand Total
Response	16-29	30-45	46-59	60-75	75		
Regularly		4	10	13	13	2	<b>42</b>
Total respondents in this age category, in the survey	2	8	35	34	17	3	<b>99</b>
Percentage of respondents responding “regularly”, by age		<b>50%</b>	<b>30%</b>	<b>38%</b>	<b>77%</b>		

38% of 60-75 year olds would use the service “regularly”, and 77% of the 75+ age group.

Using the same basis for the analysis for the other allied health professional services:

Age						No age given	Grand Total
Number of respondents who would “regularly” use:	16-29	30-45	46-59	60-75	75		
Podiatrist or chiropractor		4	10	13	13	2	<b>42</b>
OT or physiotherapist		2	6	6	5		<b>19</b>
Massage therapy / chiropractor		3	8	5	4		<b>20</b>
Total respondents in these age groups	2	8	35	34	17	3	<b>99</b>

BCC might consider setting up access to these services on a regular basis – perhaps monthly, with people paying directly to use the service. People who are receiving SDS should be able to use part of those funds to pay for these services, if they so wish; this could be managed through Highland Home Carers.

## Community Engagement Report

### 8.5.3 Respite services

The questions on “respite” were carefully worded to try to ensure that various different types of respite were included. The questions did not include “residential” respite, where the cared-for person stays elsewhere for some period of time to allow the family carer to have a break. BCC are not currently in a position to consider offering that service, as it requires a Registered Care Facility to do so. Residential respite is what is considered by most family carers, health and social care workers, and providers as “respite”, but it is important to realise that this is not the only possibility.

Respite was focussed on in the 2016 Report on Highland Respite Provision, and that report described the current position on core residential respite services (their emphases):

**“There is a lack of accessible, core residential respite services (however provided) within Highland** and this lack is having a detrimental effect on the well-being of carers and a demoralising effect on those working closely with carers and those for whom they care in health and social work services. **There are gaping holes in the provision of residential respite services for carers of older people in Inverness, Nairn, the Black Isle and much of Easter Ross.** We have seen the very reverse of what is often the case in other settings in that people from Inverness and surround are travelling long distances to access services”.

This set of questions asked about locally based respite:

- Day-time respite at home
- Day-time respite locally
- Night-sitting or night-time services
- More support when my cared-for person has a crisis or is particularly unwell
- Local family carer support group and information

When the set of questions is analysed by the age of respondents, those responding “regularly” came from a variety of age groups, not only the older age groups.

Number of respondents who would “regularly” use:	Age					No age given	Grand Total
	16-29	30-45	46-59	60-75	75		
Day time respite at home		1	4	1	1	1	8
Day time respite locally		1	3	2	1	1	8
Night-time respite or night-time services		1	2	0	1	1	5
More support in a crisis		1	2	2	1	1	7
Local carer group and information		1	2	3	2	2	8
<b>Total respondents in these age groups</b>	<b>2</b>	<b>8</b>	<b>35</b>	<b>34</b>	<b>17</b>	<b>3</b>	<b>99</b>

The question was if there were around 8 households who would benefit in total; that is, were they the same “8”, or if there were more households in need of some form of respite.

## Boleskine Community Care

### Community Engagement Report

“Regular” responses: there were 13 respondents who wanted some form of “regular” respite.

“Emergency” respite: there were 38 respondents who did not need any form of “regular” respite but did want “emergency” respite.

These are split by household type as below:

Household type	“Regularly”	“Only in an emergency”	Total households in this survey
One person household, aged 65 or over	1	6	19
Family household, all aged 65 or over	5	12	21
Family household with dependent adults	1	7	12
One person household aged under 65	2	2	11
Couple, no dependents	3	4	19
Family household with dependent children	1	6	10
Other		1	2
<b>Total responses</b>	<b>13</b>	<b>38</b>	<b>98</b>

The most chosen forms of respite were “day time respite at home” and “more support in a crisis”:

I would like this support:	Day-time respite at home	Day-time respite locally	Night-sitting or night-time services	More support when my cared-for person has a crisis or is particularly unwell	Local family carer support group and information
“Regularly”	8	8	5	7	8
“Only in an emergency”	26	18	22	26	14

There is clearly a wish expressed for respite care.

In all, 51 of 99 responses to this survey would use some form of respite “in an emergency” or “regularly”.

BCC could consider how this need might be met in its local community, and the structures and resources required to provide it.

BCC may also consider that there is a clear need in the wider area for respite, and that it could ensure viability of its services by allowing access to others from outside the Community Council area.

#### 8.5.4 Discussion: who are “carers” and why must their needs be considered?

##### Carers and caring

As the population ages, there are an increasing number of people who look after family members’ health and care needs. Those family members may themselves have increasing age-related health and care requirements.

There is often confusion with the term “carer” and this definition taken from Scottish Government will help clarify specifically what is meant by the use of this title.

**“A carer is a person of any age who provides physical care or emotional support to another person due to frailty, physical or mental illness, addiction, disorder or disability and is not paid for providing that care or support.”**

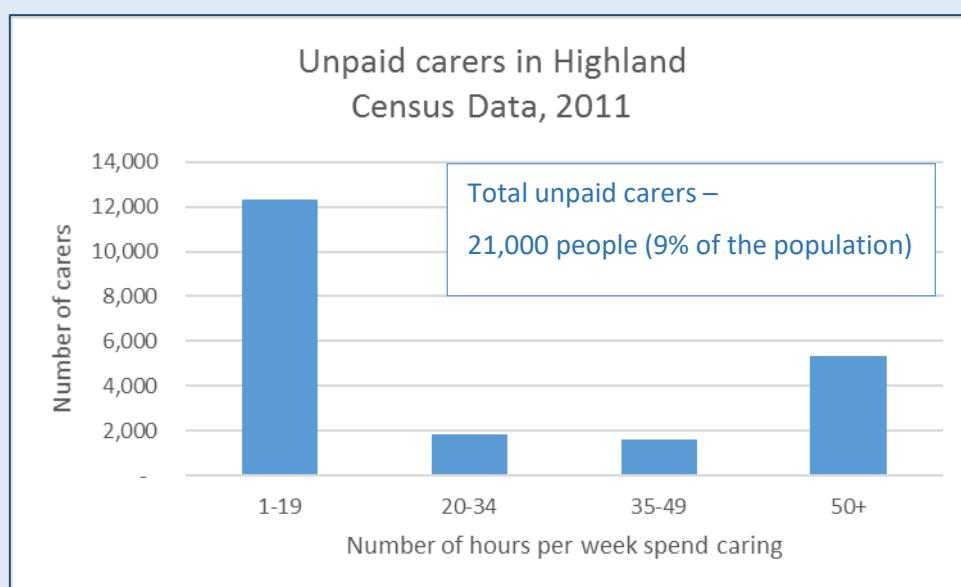
The term carer should not be confused with a care worker, or care assistant, who is trained and receives payment for looking after someone.

The Carers (Scotland) Act 2015 sets out a range of measures intended to improve the support given to carers. It includes the introduction of new duties on local authorities:

- to support carers who are assessed as needing support and who meet local eligibility criteria;
- to provide support to carers and young carers to ensure that they will be at the centre of decision making on how services are designed, delivered and evaluated; and
- to create an information and advice service.

In Highland, Highland Council and NHS Highland have commissioned Connecting Carers as the main carer organisation to undertake this function. Connecting Carers also support the roll-out of carer support plans on behalf of NHS Highland.

The statistics below provide an indication of the extent of unpaid caring occurring within Highland. It is widely believed that this is an underestimate of the number of people providing a substantial degree of unpaid care, predominantly because people often do not recognise themselves as carers



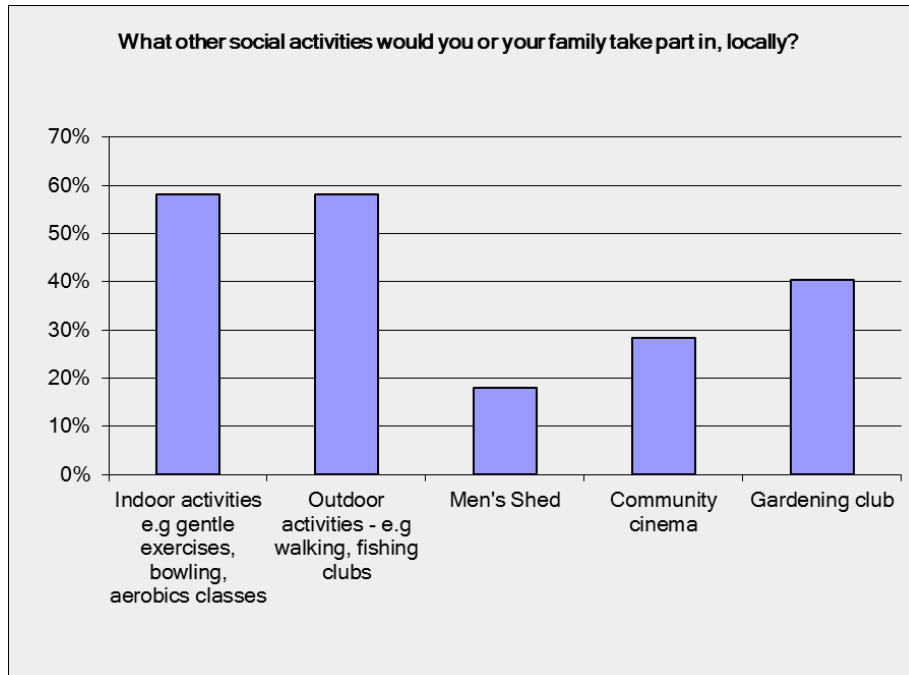
### Community Engagement Report

#### 8.5.5 Additional Activities

We asked whether people would like additional or different social activities, combatting social isolation and perhaps also finding activities that may be more accessible for people with health or mobility issues.

Only 67 of the 99 responses completed this question.

The results were:



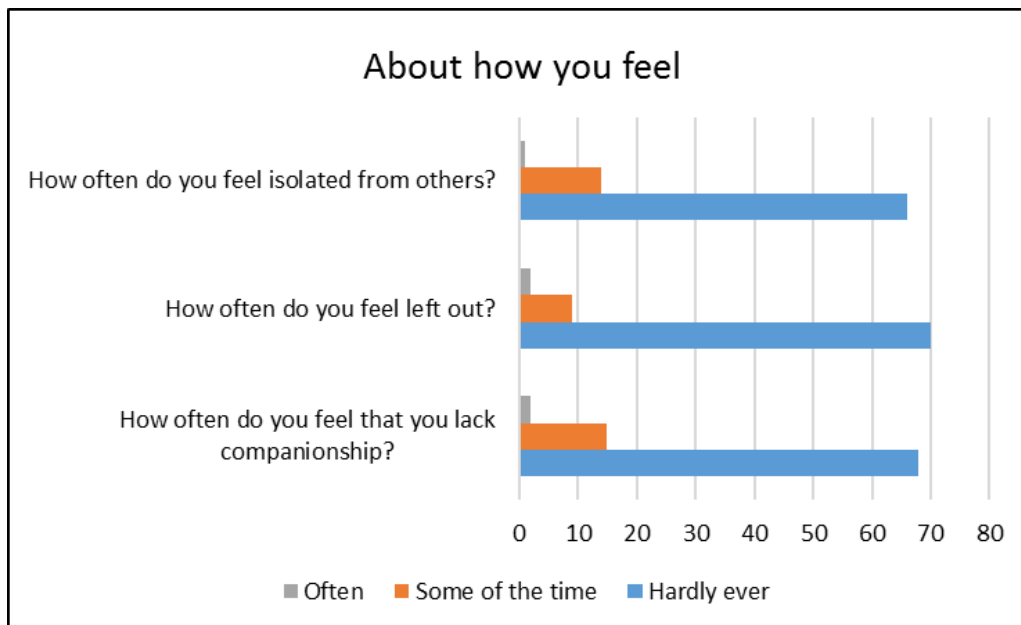
While BCC already coordinates many social activities with a considerable volunteering input, it may be that some others in the community could be enabled to lead on some of these additional activities, or other activities.

Community Engagement Report

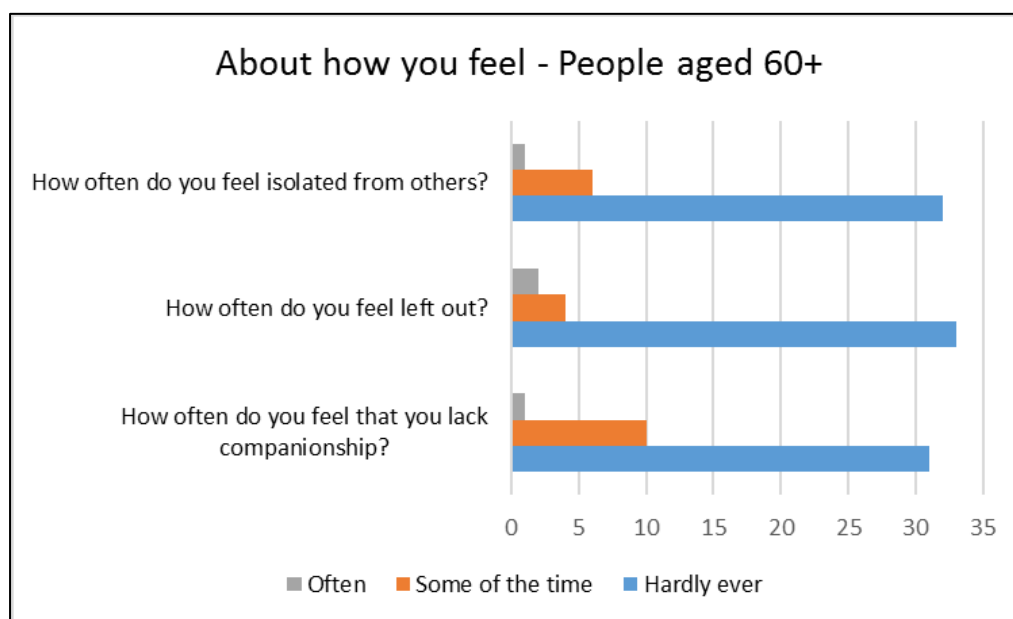
8.5.6 Social Isolation

The survey used the standard UCLA loneliness scale to assess loneliness.

BCC is already very successfully addressing social isolation, with an overall positive finding from the “loneliness” scale:



This is particularly impressive when older people (60+) are considered:



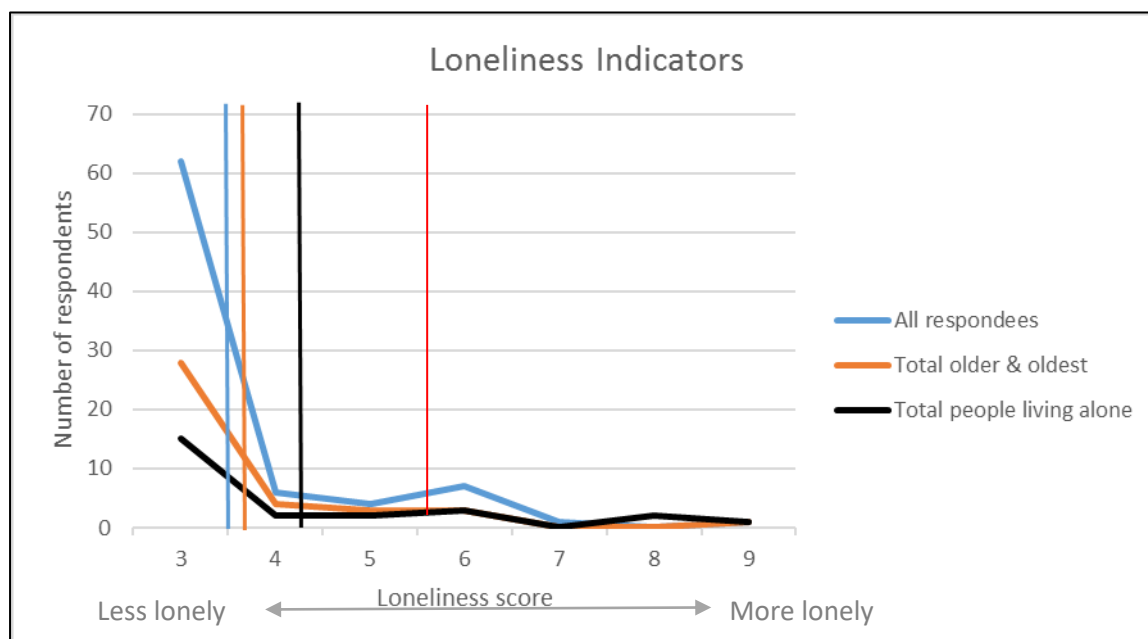
There were only 3 people out of 99 who “often” felt any one of these three; a strong indicator of the support that people have from the community, and the extent to which they continue to be part of their community at whatever age.

### Community Engagement Report

Looking at comparatives to the English Longitudinal Study of Aging, Boleskine compares well in terms of loneliness.

The chart below shows the weighted loneliness scores for all respondents, respondents aged over 60 (“older and oldest”) and for respondents living alone; against the number of respondents. The lowest possible score is 3 – which is “hardly ever” in response to all three questions. The highest possible score is 9 – “often” to all three questions.

The vertical bars show the mean score for these three groups.



Most respondents of all groups reported themselves as “hardly ever” feeling isolated, left out, or lacking companionship. 17 of all respondents scored between 4 and 6, indicating that they felt that way at least “some of the time”; and 7 of these lived alone. Only 3 people in total indicated they felt that way “often”.

In all, the mean (average weighted) score for these groups was around 3.5, with the people living alone having the highest mean score at 4.2.

The mean score for people aged 50 and over in the English Longitudinal Study of Aging was 5.8; a significantly higher score.

#### 8.5.7 Volunteering

We asked people if they already volunteered, and if they would be willing to help in a BCC project.

One-third of people who responded to this question, already volunteered – about the Highland average for any community.

When asked if they would help in a BCC project, of the 32 responses to this question, 19% said “yes”, 34% “possibly, and 47% said “no”.

There is clearly some untapped volunteer resource in the community, and further work should seek to establish the extent of that commitment.

## 9 Feedback and Prioritisation Event

The results of the community engagement and surveys were presented to the community at a feedback event on 10<sup>th</sup> September, to request feedback and to explore potential priorities for BCC to develop. 38 people attended, and there were a wide range of potential activities identified, many of which echoed those in the earlier engagement findings (please see below).

One key point was that older people want to be useful, just as they always have been; they have skills and abilities that they want to use for others' benefit. This continues even when they become less physically capable, or have early difficulties with memory and mental health.

When asked, the group highlighted two key priorities: **Foot Care** and **Respite Care**.

### **Heath care**

SDS – more information and who qualifies

Foot care clinic in Hall or at Surgery – happy feet, happy face

Respite – sitting in service; BCC is trusted, known – need alternative premises

Respite / time off for carers – volunteer respite and paid

More support for carers and raising awareness about carers

District Nurse service: lighten the load of home visits by GPs, based in local surgery. Would provide holistic and palliative care.

### **Infrastructure**

Transport – community bus, Minibus service for shopping etc

Communication – mobile, broadband

Designated community building

**Hall not appropriate as poor sound – can't hear**

### **Addressing isolation / socialising**

Good neighbour scheme – “informal” befriending, Identifying those who would like a visit

Gardening Club – all ages, different skills, market / sale / show

Men's Shed - allotment, mending, crafting

Board games etc.

Reminiscing get-together

Involvement of younger people – students, work experience, volunteering, befriending – phone or penpals?

Communicate with other care groups – what works for them?

### **Living independently and well**

Fuel supplies for 65+ (wood)

Meals on Wheels

Shopping service – help with on-line shopping

Hairdresser and foot care in the Hub at Foyers

Handyman – what jobs do they do specifically?

Home help e.g. cleaning overs