CHILTERN AND SOUTH BUCKS STRATEGIC PARTNERSHIP

MEETING – 19 October 2015 at South Bucks District Council

PRESENT

Cllr Ralph Bagge (Chairman)	Leader of South Bucks DC
Cllr Isobel Darby	Leader of Chiltern DC
Cllr Jonathan Rush	Chiltern DC
Cllr Martin Baker	Gerrards Cross Parish Council
Michael Saxby	Fulmer Parish Council
Marilyn Heath	Denham Parish Council
Cllr Vicky Thompson	Farnham Royal Parish Council
Sue Lynch	Stoke Poges Parish Council
Tim Stevenson	Great Missenden Parish Council
Bob Smith	Acting Chief Executive CDC/SBDC
Jim Burness	Director of Resources CDC/SBDC
Anita Cacchioli	Interim Director of Services CDC/SBDC
Martin Holt	Head of Healthy Communities CDC/SBDC
Katie Galvin	CDC/SBDC
Rachel Prance	Communications, Performance & Policy CDC/SBDC
Richard Corbett	Healthwatch Bucks
Marion Seneschall	CAB
Pam Warren	Bucks Vision
Nick Phillips	Community Impact Bucks
Dr Simon Daily	Burnham Health Centre
Ruth Ryan	Age Concern
Ann Whiteley	Carers Bucks
Robert Panting	Bucks Care
Jeremy Hutchings	London & Quadrant Housing Association
Annet Gamell	NHS Chiltern Clinical Commissioning Group
Gill Lyle	Age UK
Liz Sheppard	Age UK (Memory Advice Service)
Cathy Colsell	BCC Community Learning
Natalie Judson	Bucks County Council
Rebecca Carley	Bucks County Council
Nicola Lester	NHS Chiltern Clinical Commissioning Group
Korrine Leney	Bucks County Council
Madeline Howe	Bucks County Council
Tim Day	Bucks County Council
Gemma Workman	Bucks County Council
Lesley Perkin	Bucks County Council
Simon Webb	Bucks County Council
Jackie Wesley	Bucks County Council
Chris Holden	Bucks County Council
Viv Saunders	CDC/SBDC
Aaron Percival	CDC/SBDC
Dominic James	CDC/SBDC

Paul Nanji	CDC
Andy Garnett	Garnett Foundation
David Wright	Pinewood Studios
Chris Reid	Bucks County Council/CCG
Sarah Grahame	Thames Valley Police
Elaine Hassall	AVDC

APOLOGIES FOR ABSENCE

Cllr Mike Appleyard, Vee Bharakda, Cllr Mimi Harker, Cllr Nick Naylor, Cllr Adrian Busby, Ken Walker, Cllr Ray Sangster, Andrew Smith, Jennifer Allott, Conan Hassim, Trevor Boyd, David Gardner, Cllr Roger Reed, Jennifer Woolveridge, Cllr Patricia Birchley, Alistair Pike, Yvette Hitch, Steve Goldensmith, Ashley Green Parish Council

MINUTES FROM LAST MEETING

The minutes of the Chiltern and South Bucks Joint Strategic Partnership meeting held on 22 October April 2014 were received; copies of which had been previously circulated.

RESOLVED that:-
The minutes were approved and accepted by Councillor R Bagge as a correct record.

PRESENTATION by Korrine Leney (Bucks County Council) and Nicola Lester (NHS Chiltern Clinical Commissioning Group) -
"**What does the ageing population mean for us across Chiltern & South Bucks over the next 10 years?"**
The aim of this presentation was to open up the workshop section of the event covering the issues currently faced by older people in the south of the County.

NOTES FROM THE CASE STUDIES (the case studies have been sent out with the minutes).

Attendees at the meeting were split into five case study groups to consider five different scenarios. Each case study had a section on what the future looks like for the individual with public health data to support this. The aim was to discuss the issues and decide on three main actions to take forward.
The notes from each of the case studies are below (please note the facilitators/notetakers have used slightly different styles when recording the discussions and outcomes and these have been replicated here:

Case Study 1 – dementia/Alzheimers (Reg)

Attendees
TD=Tim Day – Bucks CC (facilitator)
GW=Gemma Workman (facilitator)

SL=Sue Lynch – Stoke Poges Parish Council
KG=Katie Galvin – CDC/SBDC
RR=Ruth Ryan – Age Concern
LS=Liz Shepperd – Age UK
CR=Chris Reid – Bucks CC
MB=Cllr Martin Baker – Gerrards Cross Parish Council
PK=Cllr Paul Kelly – SBDC
AG=Dr Annet Gamell – Chief Clinical Officer, Chiltern CCG
KL= Korinne Leney – Bucks CC (notetaker)

MB – key piece of unknown information is the individual's financial situation and the ability to pay for support; an individual's financial situation has major bearing on care provision: taxis, extra care, cleaning, etc. Additionally, what financial support can the family afford to provide from afar?

KG - main concern is social isolation; will the individual cut themselves off from the community entirely? What sorts of problems will we see for him at this point?

RR – main concern is his driving against GP's recommendation, this is most alarming from the case study

AG – his sons should encourage him to take a look at his driving ability and send him to an assessment. Can assessments be more than voluntary? Can DVLA actually take away his license? Also concerns about Reg not remembering where he parked his car.

RR – stated that 70 is far too young to not be able to drive, this will cause him many problems with his independence.

LS – illustrated the process of driving test that the Memory Clinic refers individuals; following the assessment the individual returns in 6 months to be re-assessed. There are also issues with the stress of a test making memory problems worse in some situations.

AG – pointed out concern about Reg missing his appointments

RR – suggested Reg might look to local volunteers for transport, like a good neighbour scheme, to drive him to appointments. He would additionally benefit from having some social contact with the volunteer driver.

LS – highlighted his overall loss of independence from not being able to drive.

RR – pointed out his resistance to help, knowing that he may require a volunteer driving, but not having the attitude to ask for help.

LS – highlighted his bereavement issues; his wife likely did a lot of things for him, and this support is not available from her anymore.

AG – stated how many older couples have joint coping strategies and when one dies the support situation becomes troublesome. She may have been helping him to remember appointments, medication, etc.

SL – pointed out how individuals, even when referred to memory services, are often quite good at 'passing' the test by hiding their dementia.

AG – stated how it was worrisome that Reg, and likely many others, are falling between two services. As he is still independent enough and his memory issues aren't bad enough he isn't qualifying for social services. There is a gap in provision here.

LS – pointed out how community mental health teams are now able to intervene at an earlier stage and could provide better support to people like Reg going forward.

AG – summarised major issues with regards to dementia: because of the stigma attached to dementia, many people don't come forward early enough, however, identifying dementia early is the best way to put support in place for an individual.

LS – asked about Aricept (drug treatment for Alzheimer's)

AG – explained that Aricept is being offered at an earlier stage which is good progress.

MB – recommended that family/children in this case need to 'tell' on their father to his GP because of his resistance to support.

GW – asked the group about his lack of interest in Men in Sheds

LS – suggested that perhaps he was forgetting which days it was on and recommended his family buy him a large diary and input his appointments to then follow up with a phone call each day to ask what he is doing.

AG – other than Men in Sheds, individuals need to know about the support available.

CR – Reg potentially needs extra care which would be the next level up from living at home alone, as he wouldn't be eligible for home care because of his financial situation. He should be looking to extra care for help with gardening, cleaning and cooking to allow him to live at home well.

TD – with regards to finances, as older population grows and more people need support, finances will become tighter with regards for services; waiting for crisis moment which is concerning.

LS – referenced Age UK memory services and help from Alzheimer's Society that Reg could access.

AG – emphasised that until Reg decides he needs help it will be difficult to motivate him to access support.

LS – would Reg accept a befriender once a week at home?

CR – have assistive technologies been offered to Reg? A vibrator reminder of appointments could help, device for family to track where he is, alarm for prescriptions, etc.

AG – can family make referrals for assistive technology?

CR – CPW can do assessment and make referral for assistive technology.

LS – asked if wearing a pendant might be another assistive technology that could help with potential falls in the house.

AG – mentioned that his house should be assessed for safety, he might have obstacles or too many rugs, etc.

LS – pointed out Safe and Well services that could be helpful to Reg.

MB – identified the difficulty families have in identifying which organisations are offering support and which organisation offers what services; this is very convoluted.

KL – pointed out care advice Buckinghamshire website which should combine all the groups, activities, services available for families to access for their parents and older neighbours.

AG – suggested whoever is the first point of call should hold all this information.

MB – the first point of call is often GP and otherwise it is not always clear to families where they can find services.

AG – suggested the community should hold this information, communities should be built up to know what's going on and can signpost other community members to information. There is a need for a friendly community response.

RR – highlighted the need for more volunteers and good neighbours.

LS – pointed out how most volunteers are informal, offering support to neighbours frequently without any official position as such. Neighbours can be a crucial piece of support to older residents.

MB – highlighted the need for community drivers as they offer a solution to many individual's issues. In Reg's case this would enable him social contact, resolve safety issues of him driving himself, he would get to appointments the correct day at the right time.

The three key actions identified by Group 1:
Need for good transport – community drivers/Chiltern Dial-a-Ride

Use of assistive technology

Recognising gaps between service provision and knowing what's available

Case Study 2 – physically frail (Ron)

Attendees
Chris Holden (CH) facilitator from Trading Standards
Natalie Judson (NJ) facilitator/note taker BCC Prevention Matters
Marion Seneschall (MS) CAB
Ann Whiteley (AW) Carers Bucks
Andy Garnett (AG) Garnett Foundation
Sarah Grahame (SG) Thames Valley Police
Pam Warren (PW) Bucks Vision
Gill Lyle (GL) Age UK

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CH- What do you feel are the overriding problems with this particular case study?

AW- The lack of good neighbourhood schemes that link people together and keep a watch over the older people.

GL- Age Concern runs a good neighbourhood scheme in Amersham and Chesham

AW- is this reliant on volunteers as years ago the role of the coordinator was a paid position?

SG- I feel that we at TVP are seeing a lot of elderly people with large properties who leave it too late to sell and are a prime target for burglaries. If the garden is unmaintained these home owners stand out and become easy targets. RON could be a potential target.

CH- Trading Standards is promoting this idea of communities becoming more neighbourly as we can no longer rely on funding for these support groups moving forward.

PW- in my field some older people are reluctant to reach out or even to accept support when it is offered to them. I feel RON is very like this. We are told he is reluctant to use the befriending service that was offered as perhaps too proud. There is this stigma that our society has to growing old and older people feel that they have lost a place within society as a key individual.

CH- How do we build a positive outlook to growing old within our culture in the next ten years?
AW- biggest barrier is how we pay for care. Families drive change of the support structure so we need to look at the holistic family as a whole. With volunteering numbers dropping do we introduce more young people to support with this void?

CH- What makes people volunteer?
General consensus ALL:
Information and knowing where to find information on how to volunteer is key- more volunteer campaigns are required targeting a mix of ages.

AG- Sixth form does have volunteer time allocated into the timetable. The Duke of Edinburgh awards also advocate this. Ideally if we put the idea of supporting communities and young people volunteering on the curriculum this would be a great support- it's just getting the head teachers attention as they have many demands.

NJ- target stay at home mums who can't afford childcare or find working hours to fit in with raising a young family. Gets them work ready and increases their self-esteem. Plus if time credits offered by the organisation they can treat the family to a day out.

ALL- One idea brought forward was the idea that we have an affordable housing shortage amongst in particular; young professionals. If we matched Ron up with a likewise professional for return of a reduced rental fee they could support Ron with various household tasks. This would increase Ron's social activity and give him the support with household task as his mobility is a concern and trips and falls are prevalent amongst this age group.

GL/AG/PW- When you are at retirement age or even 5 years before DWP guidance should be sent out giving people an idea of what the reality is like when you get older and how planning now is just as important as saving for your pension. Advice on downsizing before it's too challenging and how to keep active was discussed. A community hub (library) should be the font of all knowledge so you know where the groups are and advice and support for other topics and even volunteering opportunities.

Job centres should have a section for older people who are still able to work with appropriate jobs on offer. If someone looked at Ron's strengths they would see that he has had a varied working background and could share his skills set with others in the right environment. This idea that older people can still contribute to society whether through employment, volunteering, spending or by taking on citizenship roles should be explored further.

The three key actions identified by Group 2:

Good neighbourhood schemes- more befrienders

Inter-generational activities breaking down the stigmas associated to getting older

'Life after work'- more statutory guidance about health and wellbeing and opportunities to explore not just the financial planning side

Case study 3 – loneliness and social isolation (Marion)

Attendees
Jackie Wesley – Bucks CC (facilitator)
Simon Webb – Bucks CC (facilitator)
Aaron Percival – CDC/SBDC (notetaker)
Cathy Colsell – Bucks CC
David Wright – Pinewood Group
Marilyn Heath – Denham Parish Council
Tim Stevenson – Great Missenden Parish Council
Rob Panting – Bucks Care

Transport

- Organising group activities at home to save costs
- Car sharing schemes – community groups and clubs organising a scheme for their members (part of club ethos / policy to sign up to)
- Voluntary bus/car scheme (similar to drive to work scheme)
- Dial-A-Ride /Community Free Bus

Tackling self esteem, isolation and loneliness

- Address self esteem issues before it's too late
- Low self esteem will make the person become more vulnerable – may be taken advantage of e.g. rogue traders and door to door scams
- How to capture people with low self-esteem? - Other people have a key part to play e.g.
  - GP's – Do they have the time to speak to patients? – Community Practice Workers
  - Neighbours – Are they part of a Neighbour Care Scheme?
  - Community – hairdresser may notice they are starting to neglect their appearance
  - Family – is there anyone who visits regularly?
- Befriending services – Age UK (ways of finding new volunteers)
- Life Mentors – volunteering time and support to encourage someone

- Accommodation scheme – elderly renting out spare rooms to students / tenants who can offer help around the house at a cheaper rent

Digital Media

- Silver Surfers Group
- Services available to maintain social networking
- Social media – interact with others, community group pages
- Skype / Face Time – keeping in touch with families and friends
- Online shopping services
- Keeping up to date with local news

Other comments

- Movers and Shakers
- Promoting services available to the elderly
  - Information sent out with council tax bill
  - Publicity in local paper, parish council newsletters
  - Lunch clubs – a place to meet people and get advice on nutritional meals

The three key actions identified by Group 3:

Community Transport
- Good Neighbour Scheme
- Car sharing to group/social activities

Digital Media
- Social Media e.g. Facebook
- Skype / Face time
- Online shopping

Access to services earlier
- Detection
- Signposting

Case study 4 – carers (Martha)

Attendees
Nicola Lester – CCG (facilitator)
Rebecca Carley – Bucks CC (facilitator)
Viv Saunders – CDC/SBDC (notetaker)
Jeremy Hutchings – London & Quadrant Housing Association
Nick Phillips – Community Impact Bucks
Anita Cacchioli – CDC/SBDC
Michael Saxby – Fulmer Parish Council
Cllr Jonathan Rush – CDC

Discussion about personal experiences/what helps

Keeping mentally active
Getting involved in the community
Taking gentle exercise – provides discipline, facilities and social contact
Church providing care, social interaction and meals at reasonable prices
Being aware of the support available
Need for respite for carers
Difficulty of breaking through the 'pride' barrier
Importance of encouraging people to engage in the community before situation becomes critical
Who cares for the carer – conversation needs to take place when care/intervention is put in place for partner
Volunteer befriending scheme
Role of the GP following bereavement
Early engagement – Carers Bucks, building relationships, learning about the system, raise awareness to what the future may hold
Ever changing environment of where services are available
Raise neighbourhood/community awareness/Neighbourhood Watch – via Council Tax bills

The three key actions identified by Group 4:
Need for a trusted network with early engagement and sensitive referral to Carers Bucks by people looking after the person being cared for/need for a holistic approach to the couple

Need for an informal environment for carers to meet and learn about the system – essential to build trust and knowledge

Need for social networks and volunteering

Case Study 5 - Finance (Sheila)

Attendees

Madeline Howe [Facilitator]
Jim Burness
Martin Holt
Paul Nanji
Lesley Perkins
Elaine Hassall
Dominic James [note taker]
Simon Daily

- Assumption that population is healthy and wealthy which is not the case

- Identify gaps in provision of services

- Scenario – maybe professional network help – ex-journalist

- Any scheme needs to start small, form cluster groups and then grow
- Early intervention important to target issues – importance of prevention matters
- Help for vulnerable does not always have to be high cost.
- Importance of trigger events to bring people together and understand local issues i.e Macmillan cake event and then provide examples of help available
- Technology can help reduce isolation but needs to be supported by training
- Help needs to be provided almost at a street by street level
- Good examples of community groups working to help vulnerable people in Winslow, Burnham [Opportunity box] and Great Missenden, providing friendship networks and events. Winslow group does not require high funding as providing low cost activities, board games / card games sessions.
- Example town hall cinema – showing black and white files, at matinees to help grow community hubs
- Community help is linked with faith groups in the community [mosque Chesham]
- Important to understand the community needs as all very different
- Large schemes do not work and require grants which are difficult to get
- Working with the community has to developed over a longer time frame to build up trust – concern with group over how to measure success.
- Public / Private links – use an existing provider of service Tesco and work with them to provide affordable tablets to buy services [food shopping]. Working together a big order could be placed to 5 – 10 people rather than individual orders
- Pull together information on what is happening in local areas
- Transport to events can be difficult if do not have transport.
- Difficult to get a loan when not working – importance of revolving loans / credit union
- Importance of volunteering to get additional capacity from community. Spending 1 hour with an elderly person to chat and help with shopping.
- U3A important for learning and socialising

- Intergeneration events between elderly and young people

- Technology – Skype, websites to communicate messages and let people know what's going on.

- Home help – assistance to change light bulbs, cleaning slippery paths, fire alarms

The three key actions identified by Group 5:
Trigger event for communities to get together e.g. Big Coffee Morning

Corporate Social Responsibility (big and small)

Promote initiatives such as Credit Unions, revolving loan fund to buy the kit they need e.g. laptops

ADDITIONAL ISSUES AND SUGGESTIONS MADE AT THE MEETING

Housing
- Small repairs scheme
- Aids and adaptations
- Check houses with overgrown gardens as may need assistance
- Develop housing for older people and allow them to move on

Transport
- Greater access to volunteer transport groups
- A self service digitalised community transport scheme

Social networks/support
- Provide greater knowledge of the Car Act and what's available to carers too
- Community navigators – to know what is going on locally and who might be at risk - link with statutory providers
- Support charity and other befriending services
- Personal mentors to encourage and signpost elderly people to use existing services
- Support local community networks (single issues and reduce red tape)
- Community gardening / shopping/decoration/eating/play/fitness
- Enable early access when not at risk (they can be facilitating and then will receive the benefits)
- Volunteering networks – share DBS clearances
- Increasing demand for volunteers – how we make it easier for more people to volunteer with a streamlined process
- More investment in good neighbour/befriending schemes
- Isolated people don't always have networks to identify them – hairdressers/shopkeepers/neighbours may be potential gateways/facilitators
- What can we learn from culture who have extended families – elders play a key role

Finance

- Look at funding from professional organisations that people have worked for
- Dementia helpline – key information for family or carers as to what services and funding for people with dementia is available from local authorities
- More investment in dementia awareness for families/citizens (to spot early signs)
- Fuel poverty

Safety

- Outreach work by Fire Service – link to their prevention work
- All older people covered in the case studies are likely to be at risk from doorstep crime, repeat victimisation and grooming for financial exploitation
- Neighbourhood Watch

Health Services

- Consider planning in urgent care/care needs when things go wrong
- Closer links between health, social care and community care
- Need to invest in Telecare (sic) provision
- More proactive partnership to be built between private sector and local authorities opening up more services

Others

- On a local basis e.g. for residents in a specific parish or town, utilise parish and town council web sites to signpost what resources are out there and how to connect with them. This gets over the problem of an individual or their supporting family not having a clue about numerous organisations and resources which might be able to help.
- Advise people early (60+) on the facilities available.
- Older peoples families – ideas how social media can be useful; increasingly older people have iPads
- Finding out the best way of making all the potential opportunities out there known to people who could benefit from them.
- A centralised website provided by councils to list all the services and facilities, volunteers etc.; councils will act as facilitators in the future.
- Tap into the potential of people approaching retirement looking around for opportunities t sue their time and expertise locally.
- How to help small local groups set up something they see a need or in their community.
- Could parish networks support communication on initiatives?
- Publicity to encourage referral with consent of elderly needing services targeted to general public, hairdressers, GPs, shops etc.
- As a street to put a message in a bottle and put on their doorstep on what help they need

NEXT STEPS

The three actions from each group will now be taken away by a Task and Finish Group (which is meeting late November) to work towards a vision and outcomes plan which will be presented to the next Joint Strategic Partnership meeting in April 2016.

DATE FOR NEXT MEETING

April 2016 and will be held at the Chiltern District Council offices in Amersham