



Queen Margaret University  
EDINBURGH



*Working together to promote resilience and enhance  
informal carers' well-being in Tweeddale*

FINAL REPORT

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## Project Summary

The Borders Carers project enabled teams from community nursing, Borders Carers and family carers to work together to find ways of promoting health and well-being in their role of caring for their loved ones. By adopting practice development principles, the group developed a shared *commitment to hear the voices of carers of people with dementia and respond in a way that could help promote a sense of well-being*. A co-productive approach was adopted, enabling the group to also pay attention to the current culture of practice. By working together, identifying and agreeing ways of working, built on explicit shared values, a more sustainable approach to collaborative working was established. By including carers in the project from the outset, the developed resources meet their expressed need.



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## Background

In the UK there is an estimated 850,000 people with dementia (Alzheimer's Society 2014) with 2401 people registered as having dementia in the Scottish Borders (Alzheimer's Scotland 2017). Scottish Borders Health and Social Care Partnership (SBHSCP) (2015) suggest that current figures may underestimate the scale of the problem due to the high number of persons presenting with symptoms but not being formally diagnosed with dementia. Scottish Borders Health and Social Care Partnership (2015) predicts that the prevalence of dementia will continue to rise across Scotland, and that in Scottish Borders the rate of increase will be faster than the national average, given the higher incidence of older people compared to the national average.

Keeping people with dementia at home, requires commitment by unpaid carers. According to the National Carers Organisations, carers contribute £10.8 billion unpaid care in Scotland each year. They suggest the number of adults in need of care is expected to rise by 30% by 2026 as the population ages. There are an estimated 12,502 adult carers living in the Scottish Borders; 19% aged 60 – 69 years, and 18% aged 70 years and over (Princess Royal Trust for Carers 2011). Within the Tweeddale locality, the proportion of people providing unpaid care range from 8.5% in Innerleithen and Walkerburn to 10.2% in Peebles South (Scottish Borders Community Planning Partnership 2016). People over 65 years account for a third of all carers providing more than 50 hours of care a week. However, Scotland's Census in 2011 highlighted only 59% of carers who care for more than 50 hours a week in very good or good health, compared to 83% of people who are not carers (Princess Royal Trust for Carers 2011). Newbronner et al (2016) state that 65% of older carers (aged 60–94) have long-term health problems or a disability and 68.8% of older carers report that being a carer has an adverse effect on their mental health (Newbronner et al 2016; Oliveria et al 2015). In 2013, the Carers Week Consortium revealed the caring role increased the risk of isolation and loneliness, 61% finding it difficult to maintain friendships after taking on the caring role.

There is a need to enhance resilience to prevent carers reaching crisis point and consequently, the cared for person with dementia being admitted to hospital (Alzheimer's Scotland 2014; Donnellan et al 2015, Scottish Government (SG) (2016). Scottish and UK strategy has set out priorities for carers, developing personalised psychosocial support through comprehensive assessments by inter-agency partners, with the emphasis on promoting health and wellbeing (National Institute of Clinical Excellence 2006 and SG 2016). However it has been identified in conversation with the Borders Carers Centre that there is less uptake and engagement with support services by carers in the region. The Scottish Borders Carers Planning group are currently working on how to improve links to services (Princess Royal Trust for Carers and Borders Carer Centre 2011). Community nursing teams can be a catalyst of change for carers. They have opportunities in their work to identify isolated carers, provide supportive relationships. Working in partnership with the Carers Trust, carers can be enabled to access the support they need, to ensure they feel a sense of well-being and are resilient in their caring role.

By participating in a Community Capacity building and networking day for the Tweeddale community (April 2017), close links were established between the community nursing team and 3<sup>rd</sup> sector colleagues. It was identified that while there is a plethora of assets in the community to support carers, these are not being accessed or utilised to their potential. It may be these do not meet their needs. Additionally, carer referrals are not being received from community nursing teams. Carers Trust Scotland (formerly the Princess Royal Trust for Carers) was established in Scotland in 1991. They are the largest provider of comprehensive carers support services in Scotland, reaching over 40,000 carers from all groups and communities through a unique network of independent

carer's centres throughout Scotland. The Borders Carers' Centre develops services in response to identified local needs including practical help, advocacy, education and training for carers and professionals and liaison with hospital and social care staff. The Scottish Borders Carers Planning Group brings together individual carers and staff from the local authority, the health service and local carers' organisations. Surprisingly, there has been little liaison with community nursing teams, despite teams being in an ideal position to identify and support carers.

With an increasing number of informal carers in the Tweeddale area, identified caring for people with dementia, conversations have begun to take place between Community Nurses, informal carers and the Borders Carers Centre. The focus of these conversations has been to think about ways of promoting feelings of health and wellbeing for those at the centre of care. A funded project by QNIS would address inequalities in health of people within our community. At the same time, the approach adopted will enhance interagency working and carer involvement in their own care.

## Project Aim

To enable teams from community nursing, Borders Carers and family carers to work together to find ways of promoting health and well-being in their role of caring for their loved ones.

To encourage participants to engage with the theory and practice of facilitation and practice development as enablers in the delivery of person-centred practice

## Objectives

1. To adopt person-centred approaches to enable family carers to experience enhanced health and well-being
2. Develop resources to promote resilience of carers in Tweeddale.
3. Use practice development principles to enhance collaborative working between carers, community nursing and staff at Borders Carers Centre
4. Develop facilitation skills of the lead facilitator who is a newly qualified Specialist Practitioner District Nurse through critical companionship
5. Develop communication and engagement strategy to share learning and best practices
6. To evaluate the process and outcome of the project

## Proposed outcomes

1. Family carers feel included in development work
2. Family carers feel empowered to enhance their own health and well-being and feel more resilient.
3. Appropriate resources are developed that meet the needs of carers in Tweeddale
4. Improved collaborative working between community nursing team and Borders Carers, based on values clarification and developing a shared vision
5. Teams have the opportunity to engage in practice development and person-centred practices
6. The newly qualified SPDN will develop facilitation skills that will be used to continue developing a person-centred culture

## Theoretical Frameworks

The Person Centred Practice Framework (McCormack and McCance 2010) which provided a way of thinking about the environment of caring as a person-centred culture and a place that embraces meaningful engagement with people as colleagues and as families.

Transformational Practice Development (PD) which is an approach to practice development holds the continuous development of person-centred evidence-informed workplaces as its key focus. This is achieved through critical and creative engagement in facilitated learning. The focus of the learning is the individual practitioner's/individual teams' work. Through creative and critical reflective activities, members of the group are enabled to bring about change in themselves and the cultures and contexts in which they practice. The learning is set within a strategic context to ensure it is embedded in organisational cultures.

Critical companionship is a form of a helping relationship in which critical companions accompany less experienced practitioners on their personal, experiential learning journeys (Titchen 2001: 81). The fundamental principle underpinning the relationship is that of 'articulating professional craft knowledge' and so enabling staff to recognise their expertise and what is 'good' about existing practice. The critical companionship relationship was between the lead facilitator LW and CD, the Senior Lecturer from Queen Margaret University who has expertise in PD facilitation. It was 'framed' through processes of 'active learning' (Dewing 2008), which will improve chances of sustainability.

## Method

### Planning stage

Ethical approval was sought through Queen Margaret University. A steering group was established with the intention of guiding the project. Key stakeholders including the internal and external facilitator, Borders Carer Centre Manager, informal carers and a representative from the QNIS were invited. During this meeting, the group addressed the questions in Box 1.

#### Box 1

What is our shared purpose?

How do we hear the carers' voice?

What do we need to do to enable PD group to develop 'resources'?

What would success look like?

The group engaged in a visioning exercise where individually they wrote a piece for a local newsletter to report on the successes of the project. By sharing their thoughts, they were able to establish agreement on the project intended outcomes, process, key stakeholders and key questions to ask carers.

### Process

The project group consisted of Informal carers of persons with Dementia (People's Voice), members of the Community Nursing team, Borders Carers Centre and Community Capacity Building representatives, Social worker, facilitator (LW) and external facilitator (CD)

The group established their ways of working, by identifying what was important to them in the way they worked together (Fig 1). These ways of working included principles of Collaboration, inclusion and participation to ensure the voice of all participants were heard and a model of co-production implemented

Fig 1: Established ways of working



Values Clarification and shared visioning was undertaken to guide the project (Figs 2 & 3). By undertaking this process the intended outcomes of the project were being addressed at the outset.

Fig 2: Values Clarification

- We believe the purpose of the Tweeddale Carers Project (TCP) is to: *Bring the right people together to improve multi-agency working, that better uses resources to help and support carers to improve their health and well-being. Recognition of informal carers contribution.*
- Factors that enable the TCP are: *Partnership working using collective experiences will enable accessible support opportunities which will aim to improve/ease the experience of caring*
- Factors that hinder the process at present: *Lack of communication means that people can't take advantage of the great opportunities, resources already available locally.*
- We believe that the TCP will be achieved by: *Working together with informal carers, actively listening to their voice to work towards a shared vision. Making use of local resources to improve health and wellbeing.*

Fig 3: Shared Vision

Our vision is of *effective multi-agency working, where people work collaboratively, utilise resources efficiently and hear service-users voices to support and enable carers to improve their health and well-being.*

To realise the vision the group identified what they brought to the process, what they wanted from it and what they needed to reach the shared vision. These were themed (Fig 4). This work in the early stages gave a clear action plan. The group agreed to meet monthly and committed to the shared ways of working.

Fig 4

What we bring	What we want	What we need
A willingness to learn and be challenged Integrity Passion Motivation Experience Ideas Supportiveness Openness Creativity Being a team player Compassion	Feel like an expert again Feel innovative A supportive team A healthful culture Have a clear vision To make a difference	Be supported Sharing Be understood Learn from others Trust Have fun Effective relationships

### Hearing the voice of carers

In addition to involving carers in the project group, fitting with the shared vision, and the initial conversations with the Advisory Group, it was decided to hold an informal tea party to hear about carers experiences of maintaining their well-being. Although in the initial proposal, there was an intention to bring family carers to a venue within NHS premises, with facility to have their loved ones cared for, the carers on the group suggested this may feel threatening to some carers and require effort and organisation. Initial advertisement of the tea party did not yield much interest, but following an advertisement in the local press, interest was generated (Fig 5). It was decided community nurses would also approach informal carers in their own homes and ask the same questions i.e. an extended focus group.



Fig 5: Afternoon tea invitation

# Afternoon Tea

Do you support a family member  
who has Dementia?

You are invited to come along for afternoon tea and an informal chat.

We would like to hear your stories about what caring is like for you.

Have your say about what is needed in the Tweeddale area.

Do you know what activities and services are available?

What would you like to know about?

What would be of benefit to you?



Tuesday, 27th March at the Eastgate Theatre, Peebles  
1:30—3:00 pm

**TRANSPORT CAN BE ARRANGED IF REQUIRED**

Members of staff will be present from NHS Borders,  
Borders Carers Centre and Scottish Borders Council  
Numbers are limited. To book a place call 01896 752431



From the data generated from the conversation, the group identified:

- There is a lot of information - what do we do with it? (we need to write a summary and give feedback)
- A lot of data relates to persons with dementia being cared for - this seems to be a measure of how the carers are feeling
- There is an expressed need for a drop-in facility
- People feel unclear about where to go for help
- People don't seem to know how to get respite - perhaps identified contacts would help?
- There are solutions within the data e.g. a 'step-wise approach of support' A diary might also be useful
- There is some mis-communication between agencies
- Weekends can be a difficult time for carers - perhaps informal networks would help
- People have the same concerns irrespective of their age
- Written information is important
- The Tree Top cafe (a dementia friendly initiative) worked well but is now closed - could work be done to raise awareness of other cafe owners?

- Raising awareness of people within the community helps/
- People feel lost post-diagnosis

From this data, there were actions for different agencies. The group decided to prioritise. They felt that the major issues emerging were:

- that at the time of diagnosis, people felt lost
- people felt well if their loved ones were well
- it is challenging to identify where to get support

The way forward was to develop a leaflet with important information, conveyed in an easy to understand, attractive manner Appendix 1 .

### Involving other stakeholders

It was important to gain approval for the leaflet from Health and Social Care if the leaflet was to be distributed to patients in the area. This was a complex process which was difficult to navigate; to find the appropriate contacts; including personnel from Health, Social care and Health and Social care combined, who would sanction publicity for the project and the finalise leaflet. The Consultant Nurse Specialist for Dementia (NHS Borders) provided useful links and advice in this area.

### Evaluation

This section of the report addresses objectives 1, 2 & 3 through collation of feedback from carers (Fig 7). Objectives 4, 5 are captured in the Claims, Concerns and Issues (Guba and Lincoln 1989) in Fig 8 and Objective 6 in the critical reflection by LW as novice facilitator (Fig 9).

Fig 7: Carers feedback

#### Initial feedback

- Leaflet provides a resource that they wish they had access to before now. Makes them feel less alone in their journey.
- The leaflet was re-drafted on various occasions due to graphics not meeting DEEP guidelines. Carers reported that the sad faces that were originally on the first draft were not appropriate as they felt this was not an accurate portrayal of how Carers felt. It was stigmatising the whole experience as a Carer. Wording was changed in some areas as too “medicalised”, Carers reported that they wanted simple language that responded to their basic questions.
- The original leaflet had a pathway which was far “too busy” and put Carers off reading it in the first instance, this was simplified. It was difficult to narrow the pathway down as the leaflet tried to address a lot of issues.
- Transport was not addressed and this is a major issue in the Scottish Borders as a whole, leading to feelings of isolation. This was incorporated in the final draft.

#### Following amendments

- The revised leaflet was presented to the Carers Working Group at the end of October. Feedback was very positive. Many of the carers expressed that they wish they had access to such a resource previously. The group requested that the

leaflet be taken to the Community Hubs in an attempt to role it out across the Scottish Borders.

### **Fig 8: 4<sup>th</sup> Generation Evaluation**

#### **Claims**

Identifying shared values at the beginning of the process helped us to agree ways of working, in creating a shared vision for the project and a clear, agreed plan that was helpful. Looking back, this session cemented the key relationships within the group.

The values clarification exercise also identified collaborative, inclusive and participative (CIP) methodologies with the intention of improving collaborative working. As the project progressed communication has improved with many new opportunities developing linking health, social care and the 3<sup>rd</sup> sector. Practice development and active learning enabled the group to relax and bond and all members started to realise that they were coming from a person-centred approach with similar values.

The proposal clearly identified the intention of 'hearing carers' voices' within this project and embedded within our vision was a clear commitment to start from this point. It was good to be involved in an initiative that grew organically from its inception. The process made many of the professionals identify how prescriptive and subjective they were in their working lives, not always listening to what carers were saying and often using jargon terms that were misunderstood.

The project meetings provided a safe and supportive environment where our ways of thinking could be challenged. Many inspiring ideas were put forward by health care students.

The tea party created a relaxed atmosphere for carers, health and social care and 3<sup>rd</sup> sector groups to share their experiences. From this a wealth of information was gathered. At the same time providing the opportunity to support carers at their most vulnerable times.

We involved a carer and her daughter in the project group and they reported how engaged and consulted they felt.

Having an external facilitator felt supportive. The novice facilitator grew in confidence throughout the process

The group enjoyed attending the QNIS event and sharing the ideas of success of other groups and ventures, helping us to plan the next stages. Made us realise how important it is that even with juggling the pressures of everyday workload it is important to keep developing new initiatives and ideas for change.

#### **Concerns**

The novice facilitator, felt like a lone person running at times. Despite having an external facilitator to help she did not share decision-making and delegate due to lack of numbers. She felt unsure about how to navigate some of the governance processes within the NHS Board due to lack of staff involved.

A regular space and time for facilitated critical reflection between the internal (novice) and

external facilitator were not made

Although we began the project with an Advisory Group, inviting senior members of services, this group was not sustained.

Staff sickness, low staffing and external work pressures affected attendance of community nursing team. Some staff reported that sessions felt lengthy. They did not have the opportunity to engage fully with the project and did not fully understand the rationale behind practice development. Time set aside for the project was not always prioritised. The project was therefore not viewed as an integral part of our role as Community Nurses but rather an extra-curricular activity which no one could fully commit to.

This was not specific to the Community Nursing teams, throughout the project, many of the other groups were affected by the same issues. The partnership with Borders Carers centre was difficult to fully develop and engagement with social work (in terms of participation in meetings) was not sustained

Advertising/Communication sometimes created barriers

There were some challenges in engaging informal carers, therefore it was difficult at times to be fully person-centred in our approach

Dates sent out on an adhoc basis – members of the group found difficult to plan ahead and commit at shorter notice.

### Issues

The following questions are those that we will continue to work on in the coming months as a team.

How could we have gained better engagement from the team?

How can we give development work more importance in everyday work?

How could we have made more time to critically reflect together?

What would have created greater ownership within the Advisory Group?

How can the interagency team be helped to understand that learning together can improve collaborative working?

How could we have increased involvement of carers from the outset to ensure their voice was truly heard and reflected in the resource?

How can we disseminate widely and share success?

### Fig 9: Novice Facilitators reflections

*It was a privilege to be accepted to develop the Catalyst for change project and to set up the Tweeddale Carers Project with Co-lead Caroline Dickson and in partnership with Borders Carers Centre.*

*As a newly qualified Specialist Practitioner District Nurse (SPDN) I was keen to develop my skills as a facilitator in Practice Development with Caroline as my mentor and Critical Companion. It was hoped that by undertaking practice development sessions involving the Community Nursing Team, Social Care, Carers and the third sector collaborative ways of*

working would be enhanced. Building on a co-productive approach, existing assets in the Tweeddale community could be utilised to create a resource that would enhance the resilience and well-being of Carers of people with Dementia.

As a newly qualified Practitioner I was enthusiastic but uncertain about the process of practice development. The concept was embraced by my University colleagues during my studies but having worked as a Community Nurse for many years I was aware that there would be barriers encountered. Health and Social Care staff working under extreme pressure with few resources and staffing often work in a prescriptive way, having to make quick, medicalised decisions about what is best for our teams and patients. Often unintentionally the principles of person-centredness can get lost in this process. It would be challenging for my colleagues in the Community Nursing Teams and Social Care to take the time to let an idea develop organically without a set clear goal and target of what we were trying to achieve.

The steering group was agreed at the beginning and was to involve Caroline and myself, Management representation from health and social care, the 3<sup>rd</sup> sector and Carers.

Unfortunately from the first meeting it was clear that there would not be high visibility from senior management, stating prior arranged or conflicting work commitments. Our steering group therefore became our Project Development group. This was disheartening for staff involved, detracting from the importance of such projects. This set a precedence for lack of engagement from a number of parties.

Due to staffing issues in the Project Development group, particularly in the Community Nursing team, various members were involved inconsistently throughout the process. As a result it was sometimes difficult to keep momentum going for the project, updating members of progress via email was time-consuming with the group reaching a dip in enthusiasm mid-way during the 8 month period when external work pressures on staff were overwhelming and uptake for the original tea party was poor. Being aware that the group was reaching that stage was disheartening but it was interesting how supportive the group had become of each other at this point. In contrast to the community nursing team there was a consistent presence from various members of the 3<sup>rd</sup> sector groups, Borders Carers centre and Community Capacity Building, their enthusiasm for the project encouraged the group to proceed. On reflection I realise that when the EF was not present I did not always revisit our values and agreed ways of working or vision as a group. Had I done this it may have encouraged greater commitment from all members of the group. It would also have been beneficial to have additional community nursing staff on meeting days to enable regular members of the CNT to attend.

It was difficult to engage Carers in the project. This should not have been surprising, as the background to the Catalyst project had highlighted that while there was a plethora of support mechanisms for carers of people with Dementia in Tweeddale uptake was poor. The Community nursing team were tasked with identifying carers to interview in their own homes. This was more difficult to achieve than predicted. It would appear that the CNT still focus on the patient's nursing need rather than taking a holistic view due to lack of time or resources. Throughout the project identifying carers and signposting to the appropriate support groups became more common and is something that the team all stated that they would like to more time and resources to achieve.

In the early stages of the project I struggled with the concept of holding meetings without a fixed agenda. I now realise these are restrictive in letting the groups creative ideas flourish naturally. As the group evolved we used Active Learning in the form of evoke cards and using artefacts to get to know each other, to take the time to consider our own values and beliefs and to share our visions for the future of the project. Time to talk, written narratives; which stimulated ideas for project progression, and time for reflection were new concepts to many of the project group, particularly for one of the carers. As part of the feedback from the project one of the members from the group expressed that she had found the sessions lengthy and she felt constrained by work pressures still outstanding on the meeting days. On reflection I wonder if we did not fully explain the concept of Practice Development and the time that some of the sessions would take so that people could be

*more engaged. On reflection we could have created the space for members to discuss the reasons that were preventing them from fully engaging and how we could find a way forward as a group.*

*As I was new to the process of Practice development facilitation and new in my role as a Specialist Practitioner District Nurse I was torn between an awareness of the staffing challenges posed to all members of the group while being aware of the importance of undertaking projects that will address inequalities in the community and enhance the lives of others. Being acutely aware of external pressures on the group I was often reluctant to delegate, taking on many of the additional tasks and commitments personally. I am now aware of the importance of sharing of tasks, not only in reducing personal pressures which can become all-encompassing but also in ensuring that it is a “shared project.”*

*As part of the development journey I relied heavily at times on my critical companion, Caroline, not being entirely comfortable at first with silence and wondering which direction to go next. This became easier as the sessions progressed and my confidence developed. It was a poignant moment when a member of the group expressed how much she enjoyed taking the time out of her busy work schedule for personal reflection and to bond and share ideas with other members of the group.*

*Through the project we explored how we could hear the voices of carers and develop a resource that was sustainable but achievable within our budget. The tea party that we held to collate feedback from carers was an informal event and provided the opportunity for Carers and their loved ones with Dementia to talk with the project group and other carers. The session made us aware of how much we had bonded as a group and shared ideas of ways of working. It was rewarding that two very vulnerable Carers were able to make contact with our partners the Borders Carers Centre for support. .*

## Discussion

*Participating in the QNIS Catalyst for change project in Tweeddale has been a challenging but enlightening process. We have met the project objectives. Using this methodology enhanced collaborative working between health, social care and the 3<sup>rd</sup> sector. Keeping ‘the person’ explicitly and the centre of the project has meant that we have responded to the expressed needs of carers in Tweeddale, whilst building productive, person-centred relationships between colleagues. We feel proud to have produced an evidence-based leaflet that has the aim of enhancing carers’ health and wellbeing. The funding of this project has enabled this leaflet to come to life in an animation, which is currently being developed. The impact of this will reach carers within the whole of the Scottish Borders.*

*Ensuring the full commitment and engagement of all project group participants has been difficult, in particular within the Community Nursing Team. This is consistent with other development work reported in the literature. Evaluation using the concept of claims, concerns and issues within the team highlighted how difficult they had found to juggle workload and take part in the project. Encouraging staff to engage should be viewed part of our everyday workload and not seen as an additional pressure. Giving the staff space, time and the resources to flourish both as a team and in the wider community, addressing health inequalities should be a consideration in all projected staffing budgets. In future I will be more vocal, ensuring that these opportunities can be created and fulfilled.*

*Next Steps- to attend the Living with Dementia day hosted by Health and Social care in the Scottish Borders mid November to celebrate success and launch the leaflet.*

*Develop Animation*

*Liaise with the Communications Departments in NHS Borders, Scottish Borders Council, Borders Carers Centre to 'house' animation on website to make available for all*

*Plans for updating leaflet. Due to the leaflet being Tweeddale specific it is difficult to get parties to commit to taking ownership and updating the leaflet in the long term. With the assistance of the Borders Carers Working Group we are currently looking at how the leaflet could be adapted to incorporate the Scottish Borders as a whole to encourage wider dissemination and sustainability of the leaflet.*

*Tweeddale Community has benefitted from the funding from the QNIS and I feel privileged to have been part of the process. If there was a question that I could take back to the stakeholders as a novice practice development facilitator it would be: By what means can we create and support viable, sustainable opportunities in both the workplace and in the wider community; ensuring that person-centredness can be embedded in every aspect of our practice rather than being seen as additional workload pressure?*

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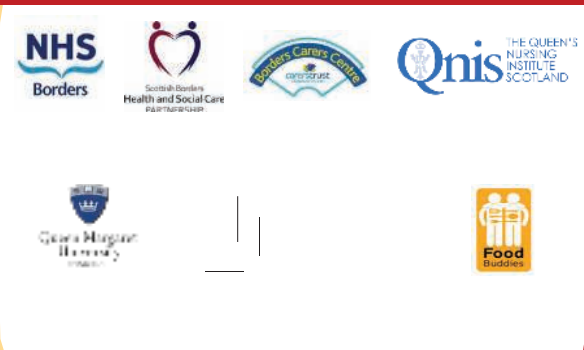


## Appendix 1: Leaflet

# WHAT ABOUT ME??



A signpost for people caring for loved ones living with dementia





## Background

This leaflet has been developed for carers of people with dementia. A project funded by the Queen's Nursing Institute Scotland brought carers together with practitioners from health and social care.

We listened to service users and carers talk about how they experience wellbeing and the things that help them stay well.

Carers talked of feeling lost at the point of their loved one being diagnosed with dementia. They said they did not know where to turn to or who to contact for support. Feeling well and resilient was dependent on how well their loved one felt.

We held a tea party in Tweeddale for service users and carers of people with dementia and they made suggestions about what might have helped them in these early stages. We explored what helps carers stay well and feel resilient. Together we developed this leaflet that we hope you find useful.

Carers reported that they don't know where to turn when they suspect their family member may have dementia. Receiving this information, they felt, "What now...?"

### **Make an appointment with your Doctor**

If you suspect your loved one may have dementia, go with them to their appointment with the GP so you can both hear any information together.

## RECREATIONAL

### **Community Capacity Building Team**

CommunityCapacity@scotborders.gov.uk, 01835 825 080

**Dementia Friendly Cafes** – approved by Borders Food Buddies  
The Garden Café, Traquair House, Dawyck Garden Café, Eastgate Theatre Café, Kailzie Gardens Café, Whitmuir Café, Lamancha

### **Outside the Box**

Initiatives such as Food Buddies, eating well for people with dementia and in later life and gardening for people with dementia and their carers. ruth.n@otbds.org or see: www.otbds.org

### **Cycling without Age**

Trishaw rides around Peebles CWAPeebles@gmail.com

### **Meet and make**

Free crafting classes for people with dementia and their carers. Monthly every Friday 10.30–11.30am. Peebles Community Hall. Mandy Durkin, Red Button Arts, 07958158181

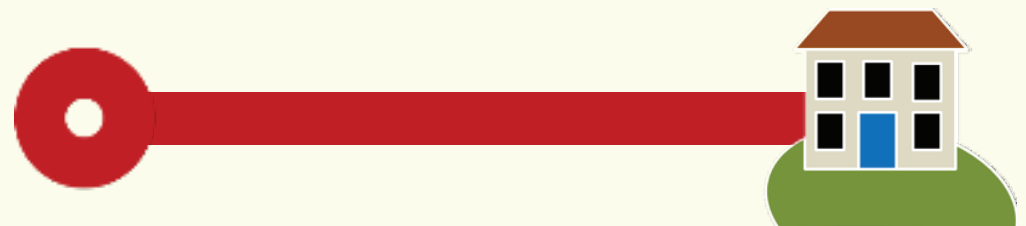
### **Walk it groups**

Dementia Friendly Health Walks in Tweeddale. Contact Denise Carmichael. 01835 826702, 07813535394, denise.carmichael@scotborders.gov.uk

**Alzheimer Scotland Borders.** See above.

## TRANSPORT

**Tweed Wheels** Volunteer Resource Centre, School Brae, Peebles. 01721 723123



**Carers said they felt well if their loved ones felt well. They said it was important to know who to ask and where to go for support.**

## **HEALTH AND SOCIAL CARE**

**Ability Borders** - Information and signposting service for people with a physical disability or long-term conditions

0300 999 2273, enquiries@abilityborders.org.uk

**ALISS** (A Local Information System for Scotland) - Online network aiming to increase the availability of health and wellbeing information for people living with long term conditions, disabled people and unpaid carers, aliss.org

**Alzheimer Scotland Borders** - 19 Bridge Street, Kelso, 01573 400324, also on Facebook, alzscot.org

**24-hour Dementia Helpline** - freephone 0808 808 3000

**Borders Carers Centre** - borderscarerscentre.co.uk, 01896 752 431

**Borders Care Voice** - borderscarevoice.org.uk, 01896 757 290

**Borders Independent Advocacy Service** 01896 752200

**What Matters Hub** 2–4pm every Wednesday, Eastgate Theatre, Peebles, scotborders.gov.uk/whatmattershubs

**Scottish Borders Council Health and Social Care**

0300 100 1800, scotborders.gov.uk/socialwork

**The Red Cross** - 01896 751 888

Befriending Services

Jacqui Rammage Befriending Connexions Borders

BefriendingBorders@Alzscot.org, 01573 400 324

## **FINANCIAL**

**Citizens Advice Bureau, Peebles**

peeblescab.org.uk, (01721) 721722

**Borders Carers Centre**

Free and independent advice and support plan (as above)

Your GP may do various tests – such as a memory test. It may take more than one appointment for a diagnosis.

Your GP can refer you to the **Mental Health Older Adults Service (MHOAS)** for support if this is appropriate. You will be entitled to support from a Post Diagnostic Link Worker for a year after diagnosis. Your doctor can also offer support if you are feeling very stressed, low in mood and are finding it difficult to cope.

## **Support Networks**

**Speak to family, friends and neighbours**

- they may want to help more than you realise.

**Borders Carers Centre** provide free and independent advice to unpaid family carers for people with any disability or illness over the age of 18 years. They offer the carer support plan.

**Health and Social Care** provide professional support and advice on available support and services in your area.

**Community nursing teams** based in your Health Centre.

Provide support for you if your loved one is housebound, attending to their nursing requirements.

**What Matters Hub** weekly in Peebles. Health and Social Care and third sector professionals offer advice and support.

**Alzheimer Scotland** is an organisation that offers advice and support if you suspect your loved one may have dementia. They have a 24-hour helpline.

**Third sector and community groups** - there are many of these in your area to support you and your loved one. See contacts list for more information.

**Befriending groups** trained groups of volunteers to provide you and your loved one with friendship and respite.

**Resources** - ask your Post Diagnostic Support Link Worker for the information booklets regarding all aspects of dementia that you are entitled to at the point of diagnosis.

