Carmarthenshire: A Resilient Community

What is community resilience?

The word resilience seems to be used more and more frequently and whilst the term community resilience is entering the common language there is no agreed definition to its meaning. There are many different views, in fact an academic paper has summarised 47 different definitions, however, these do fall broadly into three themes:

1. The ability to cope with an adverse effect and to positively adapt to change.[1]

2. The ability to cope with an adverse effect and bounce back[2]

3. The ability of communities to help themselves during emergency situations [3]

For us community resilience isn't just a buzz word or an academic concept ……. it is a way of describing the ability of communities in Carmarthenshire and individuals that create them, to be stronger and more empowered to help themselves stay healthy, strong and maintain their wellbeing ……. no matter what the circumstances.

Why is community resilience important?

Community resilience is about how people living in a particular place deal with problems. Going beyond just coping, resilient communities can become stronger and more adaptable over time as they adjust to the problems occurring. This may be by acquiring new skills, strengthening social connections or developing new physical resources. Community resilience is a vital element in preventing the need for statutory services; supporting health and wellbeing before crisis occurs.

Whether individuals are resilient or not obviously depends on personal attributes and skills, but the resilience of the community also has a vital part to play. This includes the nature of relationships between individuals, local authorities, and voluntary groups and has an impact on quality of life and the capacity of the community to contribute to positive social change[4].

[1] Young Foundation, 2012; Platts-Fowler and Robinson, 2013

[2] Omand, 2005; Edwards, 2009).

[3] The Cabinet Office (2006)

[4] Young Foundation, 2012

Here is a brief overview of the evidence available to support the importance of community resilience:

- Low social interaction is as high a risk factor for early death as smoking 15 cigarettes daily or being an alcoholic, and twice the risk factor of obesity. [5]

- Over 7 years those with adequate community links show a 50% greater survival rate compared with those with weaker relationships. [6]

- Loneliness and social isolation have been linked to a 30% increase in the risk of having a stroke or heart disease and increases the risk of high blood pressure[7]

- Isolation puts individuals at greater risk of cognitive decline[8]

- One study concludes lonely people have a 64% increased chance of developing clinical dementia[9]

- Loneliness and low social interaction are predictive of suicide in older age[10]

- Lonely individuals are more likely to:
    - Visit their GP, have higher use of medication, higher incidence of falls and increased risk factors for long term care[11]
    - Undergo early entry into residential or nursing care[12]
    - Use accident & emergency services independent of chronic illness.[13]
    - At higher risk of the onset of disability[14]

- Social networks can not only stop you from getting ill, but that they also help you to recover more quickly you do get ill and regain function that may otherwise be lost.

The right time for resilience?

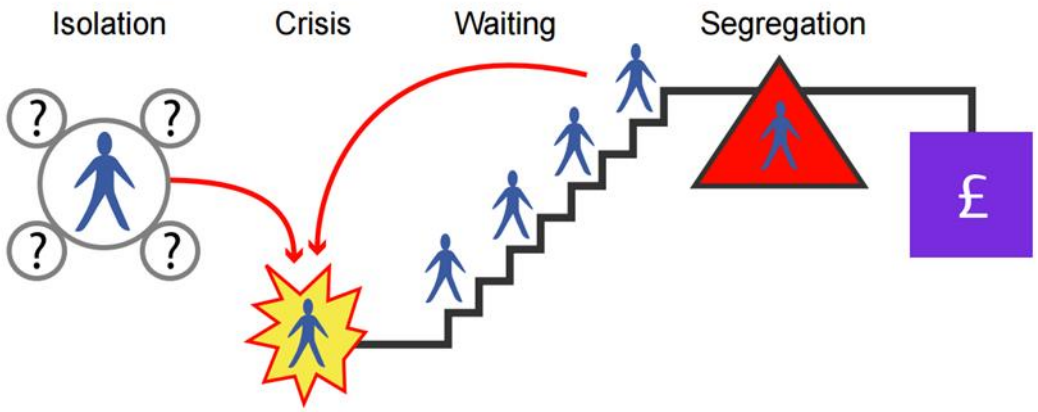
We live in a time of several connected challenges. Some of these are new problems, such as adapting services for an increasingly ageing population and some are of the older and intractable kind, such as inequalities in income, opportunity and health. The time has come however to approach the challenges in health and social care

[5] Julianne Holt-Lunstad: Social Relationships Mortality Risk: A Meta-analytic Review
[6] Julianne Holt-Lunstad: Social Relationships Mortality Risk: A Meta-analytic Review
[7] https://www.theguardian.com/science/2016/apr/19/loneliness-linked-to-30-increase-in-heart-disease-and-stroke-risk
[8] James et al, 2011
[9] Holwerda et al, 2012
[10] O'Connell et al, 2004
[11] Cohen, 2006
[12] Russell et al, 1997
[13] Geller, Janson, McGovern and Valdini, 1999
[14] Lund et al, 2010

services differently. The overwhelming evidence demands a shift in the way that services are delivered to one that ensures a more preventative and resilient approach to wellbeing.

The Christie Commission (2011) reported that "*as much as **40%** of all spending in public services can be accounted for by interventions that could have been **avoided** by prioritising a preventative approach*". This is significant not only in relation to increasing demand and reducing budgets but in that outcomes for individuals and communities themselves are overwhelmingly more positive.

The figure below illustrates the cycle of crisis that preventative community services seek to avoid.



This has been reflected in legislation and guidance from Welsh government such as The Social Services and Wellbeing Act and The Wellbeing of Future Generations Act where provision of preventative services and focusing on individual and community assets are now a statutory responsibility.

This legislation must be approached from the evidence which indicates increasingly that disconnected communities are having an impact on individuals living in them:

- Loneliness is a particular problem for those with poor health - **59%** of adults aged over 50 who report poor health say they feel lonely some of the time or often, compared to **21%** who say they are in excellent health[15]

- Approximately 10% of people over 65 in the UK are lonely all or most of the time.[16]

- Over 1 million older people haven't spoken to a friend, neighbour or family member for at least a month[17]

[15] Beaumont, 2013
[16] University of York Loneliness and social isolation in older adults
[17] Age UK

- Only 55% of those over the age of 80 in Carmarthenshire have access to a car or van – which makes local support even more vital.

- People over 65 living alone in Carmarthenshire is predicted to rise by 38% in the next 20 years.[18]

- Over half of all people aged 75 and over live alone[19]

- Two fifths of all older people over 55 (about 3.9 million) say the television is their main source of company[20]

- 12% of older people feel trapped in their own home[21]

What makes a community resilient?

Resilient individuals and communities ***cannot*** be created through the action of one particular professional group or area of policy. Actions must be aligned at the level of individual and community as well as services to support it.

It is important to remember that practical issues also underpin resilience, the statutory meeting of need is a precursor for ongoing resilience. A resilient perspective complements rather than replaces provision so that targeted services become more effective at addressing inequalities and the effects of illness and disability.

It is suggested that a range of assets and resources are needed for a community to thrive which are:

1. Human capital (e.g. skills and education)

2. Social capital (e.g. social networks and friendship groups)

3. Built capital (e.g. access to amenities)

4. Natural capital (access to green space)

5. Economic capital (e.g. income)

Evidence suggests that building social capital is vital in the success of building these assets.

Resilience is a dynamic interaction between an individual and their community. Whilst strategic action can be taken to develop resources, individuals must have the

[18] Daffodil Cymru
[19] ONS, 2010
[20] Age UK, 2014
[21] http://campaigntoendloneliness.org/guidance/wp-content/uploads/2015/06/StatisticsGFLA.pdf

skills and desire to take advantage and develop the assets that can help them cope and maintain their wellbeing.

This ability can be defined as individual resilience and this concept has been explored in relation to ageing and people living with long-term health conditions[22]

Research investigating the potential challenges of ageing has developed a new understanding around resilient processes. Interpersonal relationships and a sense of belonging to a community have been identified as crucial to supporting and sustaining individual resilience[23].

Further evidence has revealed that statutory services can weaken rather than strengthen individual resilience. They can create dependency and overly risk-averse behaviour. It seems that it is essential that wellbeing and independence is supported psychologically as well as physically.[24]

What can we do to help community resilience?

There are targeted plans across statutory services to address areas of intervention such as regeneration that supports economic capital. However, a significant gap in provision seems to be in the area that seems to impact on health and wellbeing the most ……. social capital and focusing on individual resilience skills.

In response key plans have been drafted:

- **Prevention Strategy: Supporting People to Stay Well and Independent** This strategy outlines the approach to preventative services, key themes and objectives. It is intended to be a tool to engage and communicate with individuals, communities and the third sector.

- **Carmarthenshire – A Resilient Community: A Framework for Action** This framework in a more detailed action plan designed for staff and stakeholders involved in working and delivering the resilience agenda in Carmarthenshire.

The plans have three core themes at the heart of delivery:

- **Compassion**
- **Connection**
- **Capability**

They outline the approach to supporting resilience:

1. ***An asset-based approach***: Instead of starting with the problems, it starts with strengths and values skills, connections, potential and what matters to individuals and communities as a whole.

[22] Reich et al., 2010) or in poverty (Garmezy, 1993; Furstenberg et al., 1999
[23] Aldwin and Igarashi, 2012
[24] Anatomy of Resilience

Taking an asset-based approach supports a community to do things for itself and fosters greater confidence and self-esteem. It can build resilience, local confidence, capacity and capability to take action as equal partners with services in addressing health inequalities.[25].

2. ***Working Together*:** Research by the Young Foundation (2012) suggests that community resilience is built through relationships, not just between members of the community but also between organisations, specifically the voluntary sector, the public sector and the local economy. Encouraging connection and collaboration between all stakeholders is embedded throughout the approach.

3. ***Supporting resilient relationships***: The approach to this is across all levels of action and focuses on:
    - ✓ Embedding support for individual psychological resilience across all provision and contact[26]
    - ✓ Putting individuals at the centre of planning, promoting choice, control and co-design.
    - ✓ Strengthening opportunities for community connection
    - ✓ Building and enabling support, social networks and social capital
    - ✓ Strengthening or repairing relationships between communities and health and social care agencies
    - ✓ Improving the quality of relationships of care between individuals, agencies (including third sector) and professionals

4. **A targeted approach:** whilst social capital and individual resilience are important to all members of the community. Research[27] has identified risk factors and areas of vulnerability which include:
    - **Personal** (Living alone; being single, divorced, or widowed; living on a low income or living in residential care or being over 75))
    - **Transitions** (Bereavement; becoming a carer or giving up caring or retirement)
    - **Health and disability** (Poor health; immobility; cognitive impairment; sensory impairment or dual sensory impairment)
    - **Environmental** (high levels of material deprivation, crime or rurality)

    The approach outlined in the plans ensure that these risk factors are acknowledged and prioritised for action.

[25] Kings Fund, 2013
[26] E.G. Making Every Contact Count
[27] http://campaigntoendloneliness.org/guidance/wp-content/uploads/2015/06/Risk-factorsGFLA.pdf

What does success look like?

At its simplest, building strong resilient communities means taking a preventative approach to services; to reduce, delay or prevent people from increased need and reaching crisis point. Its primary focus is not personal care for those with substantial and complex needs and it is not simply re-labelling existing traditional low level support services, e.g. meals-on-wheels.

Success would mean a holistic or whole-systems approach to prevention through community resilience, where people are enabled and supported to maintain and improve their own wellbeing. It would involve a paradigm shift from traditional service provision as outlined in the table below:

We want to move from a system that…	**…...to one where that:**
Focuses on treating illness and ill health.	Promotes health, wellbeing and independence
Does things to/for people	Focuses on working with and enabling people to do things for themselves (e.g. re-ablement).
Focuses on need and vulnerability	Identifies strengths and assets as a means to manage and support health and well-being.
Provides support and intervention only at crisis point.	Has an embedded approach to prevention and resilience that acknowledges increasing need but avoids crisis.
Focuses statutory intervention on addressing limitations to physical ability and health.	Acknowledges and promotes community, social capital and psychological resources as vital to maintaining wellbeing.
Looks towards national targets and central government initiatives	Emphasises looking outwards to the community: engaging people locally; focusing on the strengths and needs of the local population and aligning priorities to these.
Commissions for volume and price	Commissions for quality, effectiveness, value and outcomes.
Focuses on inputs and processes	Focuses on outputs and outcomes.

What we have achieved so far…….

Whilst there has always been prevention and community engagement embedded in service provision targeted action on a holistic approach to community prevention and resilience began in November 2015. Since then a number of key actions have been achieved in partnership with public health:

- **Community Resilience Co-ordinators:** Three permanent posts were established in each locality of Integrated Services through ICF[28] funding. They are directly aimed at supporting communities and the third sector to build strong resilience networks and promote social capital. One of these posts in the 3Ts area is currently vacant but is currently being recruited as a senior.

- **Wide scale asset mapping exercise:** Asset mapping of community resources has been conducted across Carmarthenshire, including third sector provision, community resources and groups. This work has been supported by ICF funding where CAVS has populated an on-line directory of these assets called info-engine. Asset mapping has been prioritised in the 3Ts area to mitigate the risk of the vacant post.

- **Co-design events**: Events were held in Llanelli and Ammanford to engage with stakeholders and third sector to inform the strategy and framework.

- **Consultation**: An on-line consultation exercise was undertaken in the form of a survey and distribution of written material. However, feedback revealed that this consultation had not reached the intended audience – as a result a revised strategy has been drafted with a wide scale public engagement event and workshops planned in 3 locations on the 1st of October 2016 to celebrate National Older Persons Day.

- **Roll out of Time Banking**: Funding was agreed to support the extension of the SPICE Time Credits model across Carmarthenshire, focusing on supporting resilience through greater integration with community health, social care and primary care. A number of significant successes have already been delivered:

    - ✓ Co-design event delivered with third sector organisations
    - ✓ 6 training and planning events delivered to internal staff.
    - ✓ Established relationship with primary care and referral pathways
    - ✓ Developed a model of social prescription
    - ✓ Established pilot group based in GP surgeries of a group entitled ***"Feeling Well ……. No Matter What!"*** where identified individuals are supported to develop community and individual assets through time-banking model.
    - ✓ Planned training event with care management and health staff in May

[28] Intermediate Care Fund

- **Increased funding and support for the third sector**: A successful bid for ICF funding established funding for the third sector to build capacity around community provision and preventative services. This has included:

    - ✓ **Age Cymru Sir Gar:** To explore establishing a Primary Care navigator scheme across the County, to provide highly targeted support in GP surgeries to identified individuals with the aim of preventing hospital admission.
    - ✓ **Care and Repair:** To increase capacity in the Handy-van scheme carrying out low level adaptations to allow frail elderly individuals to remain independent at home.
    - ✓ **CAVS:** To support an asset mapping exercise of community and voluntary provision across the county that supports preventative services.
    - ✓ **Cross Roads Care**: To deliver a Carer Demonstrator Programme in Llanelli.
    - ✓ **Menter Cwm Gwendraeth**: To provide a 7day enhanced discharge hospital transport service.
    - ✓ **Royal Voluntary Service (RVS):** To support independence in older people to access good nutrition in the community with a 'Wheels to Meals' service which supports reduction of social isolation.

- **Funding proposals 16/17:** The following funding proposals are being developed:

    - ✓ Delivering a holistic community preventative service based on the PIVOT model in Pembrokeshire, where third sector organisations create a co-operative model of holistic community support to reduce and prevent hospital admission and facilitate timely discharge.
    - ✓ A joint initiative between public sector organisation to employ staff to support vulnerable individuals to engage in the community and reduce areas of identified risk.
    - ✓ Delivering training and ongoing support at locality level to front line staff on how to encourage individual psychological resilience with techniques such as Brief Intervention Training and Making Every Contact Count.
    - ✓ To further develop and embed the Time banking model to link more directly with GP practices to create a robust social prescription service.
    - ✓ An innovation grant that provides community groups and organisations with a 'start up pack' to create community assets. This will include as appropriate financial support, time credits to encourage volunteers, venue hire and practical ongoing support from Community Resilience Co-ordinators.

- **Draft prevention strategy and framework for action**: A copy of both plans are attached for reference.

- **Engagement and awareness raising**: Engagement conducted with the following groups:

- ✓ Primary care – doctors
- ✓ Third sector
- ✓ 50+ forum
- ✓ Domiciliary care workers
- ✓ Care management staff
- ✓ Physiotherapists 25/05/05
- ✓ Residential care staff 09/06/16

Glossary

Assets	Any resources that are available to use e.g buildings, community groups, green spaces, personal assets such as cooking skills
Asset mapping	This provides information about the strengths and resources of a community and can help uncover solutions. Once community strengths and resources are inventoried and depicted in a map, you can more easily think about how to build on these assets to address community needs and improve health.
Asset based approach	These are an integral part of community development in the sense that they are concerned with facilitating people and communities to come together to achieve positive change using their own knowledge, skills and lived experience of the issues they encounter in their own lives.
Brief Intervention	A technique used to initiate change for an unhealthy or unwise behaviour such as smoking, lack of exercise or alcohol misuse.
Community Resource Teams CRTs	Integrated teams of health and social care professionals such as nurses, social workers, Occupational Therapists and Physiotherapists that provide care and support services to older adults, those with a physical disability, chronic health condition or sensory impairment.
Domiciliary Care	This is also known as home care, this service provides personal care and support to people in their own home.
Co-production / co-design	Participatory design (originally co-operative design, now often co-design) is an approach to design attempting to actively involve all stakeholders (e.g. employees, partners, customers, citizens, end users) in the design process to help ensure the result meets their needs and is usable.
Intermediate Care Fund	The Intermediate Care Fund was announced by the Welsh Government in December 2013 to drive forward integration between health, social care, housing and the voluntary sector. One of its primary aims is to avoid unnecessary hospital admissions, or inappropriate admission to residential care, as well as preventing delayed discharges from hospital.

Infoengine	A website that lists the available community assets and is universally accessible
Dewis	A website promoted by Welsh Government that lists all the health and social care related assets in the community and is universally available.
SPICE	This is a registered charity which has developed a Time Credit scheme. For each hour that an individual gives to their community, they earn one Time Credit, which can be spent on an activity, help from another person, or gifted to others.
Primary Care	Health care provided in the community for people making an initial contact with a health care provider for example the GP or community pharmacy
MDT Multi-disciplinary Team	A meeting of health and social care professionals that discuss and plan appropriate care and support.
Locality	There are 3 localities in Carmarthenshire integrated services that are based around GP clusters. These are 3Ts, Amman Gwendraeth and Llanelli.
Making Every Contact Count	Every day front line health, local government and third sector staff see tens of thousands of members of our community collectively. Making Every Contact Count (MECC) is about encouraging and helping people to achieve positive long term behaviour change by: Systematically promoting the benefits of healthy living Asking individuals about their lifestyle and changes that they may wish to make, when there is an appropriate opportunity to do so, (for example when a patient, client or customer lights a cigarette or mentions smoking). Responding appropriately to the lifestyle issue(s) once raised Taking the appropriate action to either give information, signpost or refer individuals to the support they need.
Place based system of care	Where services and organisations collaborate to address the challenges and improve the health of the populations they serve.
Rowntree Foundation	The Joseph Rowntree Foundation is an independent organisation working to inspire social change through research, policy and practice.

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