Gillian Morrison (Interim Chief Officer)
Orkney Health and Care
01856873535 extension: 2611
OHACfeedback@orkney.gov.uk

Agenda Item: 15

Integration Joint Board

Date of Meeting: 30 September 2020.

Subject: Enhancing Wellbeing in Our Island Communities.

1. Summary

1.1. This report presents the final evaluation of the 'Enhancing Wellbeing in our Island Communities' (EWOIC) project, which took place from January 2019 to March 2020. The project involved recruiting wellbeing co-ordinators on five of Orkney's non-linked isles and was supported by funding from the Aspiring Communities Fund, a Scottish Government fund delivered with European Social Funds.

2. Purpose

2.1. To provide the Board with the findings of the 'Enhancing Wellbeing in our Island Communities' (EWOIC) project.

3. Recommendations

The Integration Joint Board is invited to note:

3.1. The attached report 'Enhancing Wellbeing in Our Island Communities – Final Evaluation Report'.

4. Background

4.1. The 'Enhancing Wellbeing in our Island Communities' (EWOIC) project developed from an earlier research project looking at how community led care solutions could be developed in the smaller isles of Orkney.

4.2. Administered by Voluntary Action Orkney (VAO) and funded by the Aspiring Communities Fund, the project involved the appointment of five, part-time, Wellbeing Co-ordinators in the islands of Sanday, Stronsay, Shapinsay, Rousay (with Egilsay and Wyre) and Hoy, each employed by and embedded within the respective island Development Trust. VAO also employed a Project Manager and Project Evaluator.

4.3. It is important to note that the co-ordinator's role is distinctive from other kinds of support worker or link worker roles in Orkney, in its dual focus on 1:1 support and advice for individuals in the islands, and a focus on the development and support of services in the islands to meet the needs of residents.

4.4. Funding has been secured to extend the project to March 2022.

5. Contribution to quality

Please indicate which of the Orkney Community Plan 2019 to 2022 visions are supported in this report adding Yes or No to the relevant area(s):

Resilience: To support and promote our strong communities.	Yes.
Enterprise: To tackle crosscutting issues such as digital connectivity, transport, housing and fuel poverty.	Yes.
Equality: To encourage services to provide equal opportunities for everyone.	Yes.
Fairness: To make sure socio-economic and social factors are balanced.	Yes.
Innovation: To overcome issues more effectively through partnership working.	Yes.
Leadership: To involve partners such as community councils, community groups, voluntary groups and individuals in the process.	Yes.
Sustainability: To make sure economic and environmental factors are balanced.	Yes.

6. Resource implications and identified source of funding

6.1. Funding of £143,919 was secured by VAO to establish and deliver the project in 2019-20. Additional funding of £247,187 has been secured to continue and expand the project from 2020 to 2022.

7. Risk and Equality assessment

7.1. There are no risk or equality implications directly arising from this report.

8. Direction Required

Please indicate if this report requires a direction to be passed to:

NHS Orkney.	No.
Orkney Islands Council.	No.
Both NHS Orkney and Orkney Islands Council.	No.

9. Escalation Required

Please indicate if this report requires escalation to:

NHS Orkney.	No.
Orkney Islands Council.	No.
Both NHS Orkney and Orkney Islands Council.	No.

10. Authors

10.1. Gillian Morrison, Interim Chief Officer, Integration Joint Board.

10.2. Gail Anderson, Chief Executive, Voluntary Action Orkney.

10.3. Shaun Hourston-Wells, Project Manager, Orkney Health and Care.

11. Contact details

11.1 Email: gillian.morrison@orkney.gov.uk, telephone: 01856873535 extension 2611.

11.2. Email: gail.anderson@vaorkney.org.uk, telephone: 01856872897.

11.3. Email: shaun.hourston-wells@orkney.gov.uk, telephone: 01856873535 extension 2414.

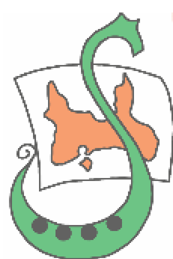
12. Supporting documents

12.1. Appendix 1 – Enhancing Wellbeing in Our Island Communities – Final Evaluation Report.

EUROPE & SCOTLAND
European Social Fund
Investing in a Smart, Sustainable and Inclusive Future

Enhancing Wellbeing in Our Island Communities

Final Evaluation Report



This project is a result of a partnership between Voluntary Action Orkney, Highlands and Islands Enterprise, Orkney Health and Care, Robert Gordon University, and the island development trusts of Hoy, Sanday, Shapinsay, Stronsay, Rousay Egilsay and Wyre and the Community Council of Papa Westray.

This project was funded through the Aspiring Communities Fund, a Scottish Government fund delivered with European Social Funds.

Report prepared by Rosie Alexander, Project Evaluator

Report Prepared: 31st March 2020

Enquiries about this report should be directed to: enquiries@vaorkney.org.uk

The evaluator would like to express their grateful thanks to all who supported with this report, and offered their perspectives and insights into the project.

Executive Summary

Project context

The Enhancing Wellbeing in Our Island Communities project was developed out of an earlier research project exploring the possibility for community led innovation in care in the non-linked isles of Orkney. The project takes place in a context of increasing interest in community led approaches, both nationally and within Orkney.

The project aimed to achieve five outcomes:

1. Older people in island communities will have increased access to activities and services designed to enhance health and wellbeing
2. Older people in island communities will be better informed of the services available to them
3. Communities' confidence, capacity and capability to influence and develop services alone or in partnership has been enhanced
4. Partnerships and networks are enhanced in order to facilitate knowledge sharing and avoid duplication and adopt innovative approaches
5. The pressure on statutory services is eased.

Project model

The project has involved the recruitment of five part time wellbeing coordinators on each of the islands of Rousay (with Egilsay and Wyre), Sanday, Stronsay, Shapinsay and Hoy.

The coordinator's role is distinctive from other kinds of support worker or link worker roles in Orkney in its dual focus on 1-1 support and advice for individuals in the islands, and a focus on the development and support of services in the islands to meet the needs of residents.

Project impacts

Project impacts are apparent in four key areas. These are summarised below and mapped to the project outcomes.

One to one support of older people, improving the knowledge of available services and uptake of these services. Older people in the islands particularly report the value of having somewhere to go for help other than the medical support offered by the GPs and nurses. The coordinators have a key role in terms of liaison between mainland services and individuals, identifying possible sources of support for individuals and how services might be accessed from the islands. Where services prove difficult to access the coordinator has a key role in terms of advocating for individuals

This impact is primarily mapped to project outcome 2: 'Older people in island communities will be better informed of the services available to them'

Support of on-island groups including setting up new island groups and social activities which have a health or wellbeing benefit. This particularly includes identifying possibilities to meet gaps in current provision on the islands. The coordinators have also supported existing groups, most importantly lunch clubs (or similar), when sustainability appears to be threatened.

This impact is primarily mapped to project outcome 1: 'Older people in island communities will have increased access to activities and services designed to enhance health and wellbeing

Systemic support, facilitating a more holistic system of health and social care on the islands. This includes being a key link between the medical practitioners and the community, providing earlier identification of individuals who may be at risk. The coordinators also provide a key link to mainland services, including third sector services, enabling better integration of these services into the island care landscape and clearer understandings of what is or isn't available in the islands. In three cases specific funded projects have been developed out of the work of the coordinators to meet needs in their island communities.

This impact is primarily mapped to project outcomes 4 and 5: 'Partnerships and networks are enhanced in order to facilitate knowledge sharing and avoid duplication and adopt innovative approaches' and 'The pressure on statutory services is eased.'

Co-production of health and social care services: working in partnership with different organisations to develop innovative projects and approaches to meeting the needs of islanders. This includes working with Crossroads to develop the availability of care in Shapinsay and Rousay; working with The Blide Trust to bring befriending to Sanday, working with the Selbro Resource Centre to improve access to equipment for activities of daily living in Hoy and Rousay; and working with a local dentist to improve access to dentistry in Sanday. The coordinators have also had contact with the Community Led Support (CLS) initiative through Orkney Health and Care, and the CLS team have set up a regular 'blether' in Sanday.

This impact is primarily mapped to project outcome 3: Communities' confidence, capacity and capability to influence and develop services alone or in partnership has been enhanced

Learning from the project: facilitators and barriers

A key facilitator in the success of the project has been having the right staff in the roles of coordinators. The most important skills and abilities that these staff require are being approachable, being trustworthy and being a good communicator. The role also requires staff to adopt a facilitative approach and to be engaging and encouraging.

The specific context of the island is also highly significant. A summary of key facilitators or barriers from the island context is outlined in the report. Particularly important are the population size and the distance of the island from the mainland. Despite best intentions the challenges of transportation to the outer isles particularly can prove problematic and may require consideration of innovative or different ways of providing services.

The relative level of island resources is also important, which includes the human resources available on the island (in terms of skills and interests in the project) as well as potential financial resources, and the availability of existing groups and services. The more resourced an island is, potentially the easier it is for coordinators to stimulate further activities. However, coordinators are also a form of resource for island communities and can themselves potentially trigger 'virtuous circles' of activity – albeit from different starting points.

Strengthening the project

In terms of the future, the project is really only in its infancy. A key finding is that the project requires a longer period of time to embed and extend the work that has been initiated and to test some of the models that have been developed.

As the project has matured, a clear and consistent role has developed for the coordinators in their island communities. In order to support this role, develop best practice and reduce isolation, it is recommended that a set of common procedures and role-specific training is

developed for all coordinators. This may require a stronger central coordinating role to be developed, along with improved reporting and supervision. This would provide greater support for the role-specific elements of coordinators' work, while continued the connections with the Development Trusts remain invaluable for providing support with the community-focused elements and dilemmas that coordinators may face.

Finally it is recommended that partnership working is further enhanced. The coordinators have developed strong partnerships with different services and health and social care providers. However, identifying mechanisms for stronger cross-island identification of challenges and for improved communication from the project as a whole to relevant stakeholders would be valuable. In particular there remains a need to identify better channels of communication with Orkney Health and Care.

Contents

1. Introduction 7
2. Project context 8
 Island context 8
 Project background 8
 Wider context 9
3. Project Model and Structure 11
 Project model 11
 Coordinator roles 13
4. Project impacts 15
 Support for individuals 15
 Support of on-island groups 16
 Systemic support: island health and care 18
 Co-production of health and social care services 21
5. Learning: Facilitators and barriers, strengths and weaknesses, the future 27
 Being a connector: the role of the coordinator 27
 Island contexts: Not all islands are equal 28
6. Strengthening the project 32
 Embed and extend 32
 Consolidate processes and embed further training and support 32
 Build on partnerships 35
7. Conclusions 37
Appendix 1: Approach to the evaluation 38
Appendix 2 evaluation questions 39
References 41

1. Introduction

This report presents the final evaluation of the 'Enhancing Wellbeing in our Island Communities' (EWOIC) project which took place from January 2019 – March 2020. This project involved recruiting wellbeing coordinators on five of Orkney's non-linked isles and was supported by funding from the Aspiring Communities fund, a Scottish Government fund delivered with European Social Funds.

The evaluation involved utilising data from a range of sources, including the coordinators themselves, partner agencies, and individuals in the island communities. An overview of the evaluation approach is given in appendix 1. The report proceeds through a series of sections covering: the background to the project, the project model that has been developed, the impacts of the project, what can be learnt from the project and finishes with some recommendations for future of this project. This report is supplemented by an 'island toolkit' providing guidance for other island communities who wish to implement a similar programme in their contexts.

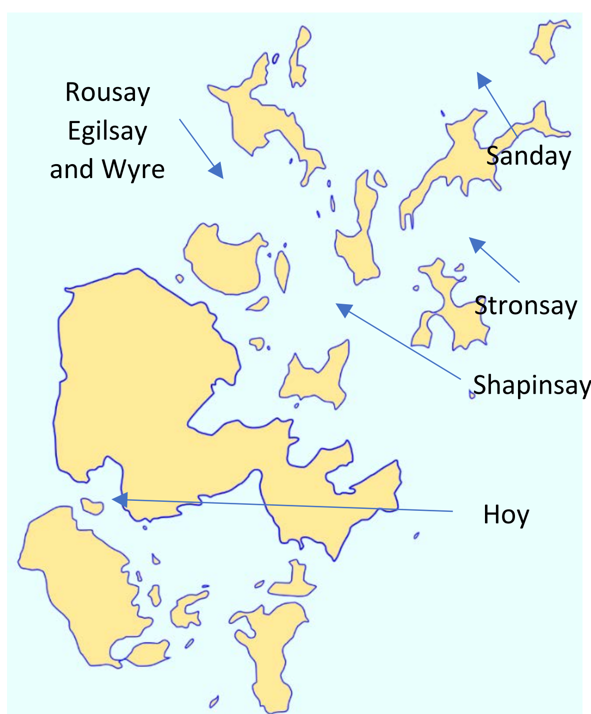
2. Project context

This first section of the report provides some context for the project – where the idea for the project originated, the health and social care landscape and the contexts of the non-linked islands which took part in the project.

Island context

The islands taking part in this project are all 'non-linked' – that is they do not have a fixed link in the form of a bridge or a tunnel to the mainland. Two of the islands (Sanday and Stronsay) are outer isles, with the other three being inner isles. The outer isles have less frequent and more expensive ferry services than the inner isles. The outer isles are also served by air services.

The island populations are small, from the 2011 census figures the populations are as follows (in order of size):



- Sanday: 494
- Hoy: 419
- Stronsay: 349
- Shapinsay: 307
- Rousay Egilsay and Wyre: 271

Concerns about population sustainability in the islands are high – both in terms of maintaining population numbers, and retaining or attracting young people in the islands (HallAitken, 2009)

Project background

The 'Enhancing Wellbeing in our Island Communities' (EWOIC) project developed from an earlier research project which sought to answer the question: *How can community led care solutions be implemented in the small island communities of Orkney?* (Alexander, 2018).

The research project identified key challenges in the accessibility of some services – this included on-island services, including in some places a lack of care provision, as well as challenges with accessing health and social care services on the mainland due to the frequency and accessibility of inter-island transport. There were also challenges in the availability of information about services, and challenges in terms of social isolation. The project identified that community led provision of health and social care on the islands would be 'challenging unless there is a partnership with an established care provider' but that community led innovations could potentially be valuable for other forms of support – including community transport, befriending, home help and information provision. The report made two recommendations:

- Recommendation 1: The isles communities to continue to build and extend existing community services.
- Recommendation 2: Orkney Health and Care to identify potentials for closer partnership working with communities, including co-production.

The 'Enhancing Wellbeing in Our Island Communities' project was developed to specifically address the first of these recommendations. The project aimed to facilitate access to activities and services designed to enhance health and well-being of older people on five of the non-linked Orkney Islands: Rousay (with Egilsay and Wyre), Shapinsay, Stronsay, Sanday and Hoy. The project documentation outlined five key anticipated outcomes:

1. Older people in island communities will have increased access to activities and services designed to enhance health and wellbeing
2. Older people in island communities will be better informed of the services available to them
3. Communities' confidence, capacity and capability to influence and develop services alone or in partnership has been enhanced
4. Partnerships and networks are enhanced in order to facilitate knowledge sharing and avoid duplication and adopt innovative approaches
5. The pressure on statutory services is eased.

The project involved recruiting a part-time island based 'wellbeing coordinator' in each of the islands taking part in the project. Specifically the project aimed to 'improve [island] community led wellbeing services' and was expected to focus on the development / support of services in areas such as 'transportation, social clubs, lunch clubs befriending and information' (project documentation). By supporting island coordinators in a number of islands, scope for sharing of best practice, and support for cross-island innovations was also built into the project design.

Wider context

The wider environment – both in Orkney and nationally – in terms of health and social care provision provides a context for the EWOIC project. The strategic plan 2019/22 for Orkney Health and Care (OHAC) outlines the priorities for health and care services in Orkney. Relevant to this project, the plan makes a commitment to working with communities, specifically through Community Led Support (CLS), stating that through this programme 'we will look at how we work with our communities to work in a different way – letting communities make better sense of how to meet need in their own communities.' (OHAC 2019: 9). The plan also makes a commitment to working in partnership with the third sector.

Community Led Support 'seeks to change the culture and practice of community health and social work delivery so that it becomes more clearly values-driven, community focused in achieving outcomes, empowering of staff and a true partnership with local people' (NDTi, 2020) A Community Led Support 'readiness check' was completed in April 2019, and community engagement workshops were held over the subsequent six months. The development of 'community hubs' is a key part of the project. The hubs take place in community venues and are staffed by different individuals from both statutory and voluntary sectors, individuals are encouraged to drop in and are offered an informal space to discuss any needs or concerns they have. The idea of the hubs is 'to enable earlier, and easier access to services and support for people within their own community' (Healthcare Improvement Scotland n.d.) In Orkney the hubs take place under the name 'blether' – and they have been held in different community venues across the mainland as well as on the island of Sanday.

The increased focus on community engagement and partnership working with the voluntary sector represents a significant development in the health and social care landscape in Orkney since the first research project was completed. Although these developments have been stimulated by a range of factors, overall they represent significant progress in terms of the second recommendation of the earlier research project, that Orkney Health and Care to identify potentials for closer partnership working with communities, including co-production.

3. Project Model and Structure

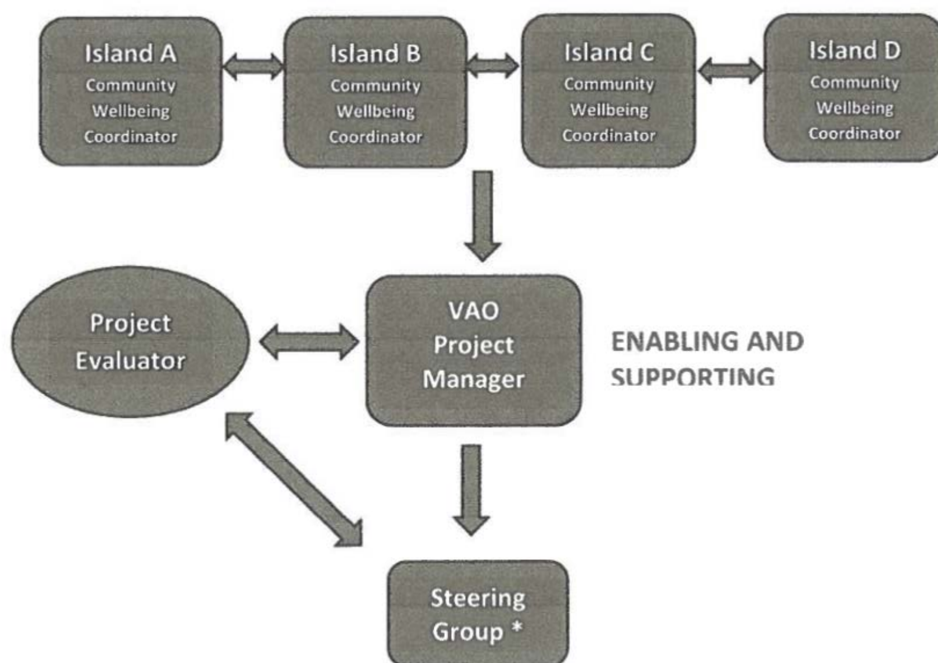
This section of the report considers the project model and structure. An overview of the model is given, followed by a diagrammatic representation of the project in the form of a theory of change.

Project model

The design of the project involved:

- Recruitment of a wellbeing coordinator on each of the five islands. This post was for 14 hours per week and was managed by the Development Trust on each of the islands.
- A project manager was appointed at Voluntary Action Orkney to oversee and guide the project as a whole. This role was also 'to support, train and liaise with local coordinators and to develop networks with a wide range of stakeholders'. This post was full time.
- A project evaluator was appointed to 'monitor and evaluate delivery…. To embed a culture of continuous improvement'. This post was for 7 hours a week.
- A steering group comprising Voluntary Action Orkney (VAO), Highlands and Islands Enterprise (HIE), each of the island development trusts, Robert Gordon University (RGU), Orkney Health and Care (OHAC) and Papa Westray Community Council is in place for the project.

An organigram showing the structure of the project is given below.



Costs of the project

Project funding was granted by the Aspiring Communities Fund of £143, 919. This made provision for the project to cover four islands. On liaison with the island groups who had taken part in the initial research project, it was identified that five island groups wished to take part. Therefore project, additional funding was secured in the form of a contribution of £3402 from each of the five island development trusts to allow the project to extend over five islands.

Management of the project

The Development Trusts in each of the island groups were responsible for day-to-day line management of the coordinator. They were also responsible for providing a space for the coordinators to work.

Wellbeing coordinators were expected to develop, with the support of the project manager, island delivery plans to guide their work.

The project manager tracked activities within the delivery plans and was responsible for providing support and advice to coordinators and development trusts about the project. Four coordinator meetings were also coordinated centrally, where coordinators met face to face on the Orkney mainland.

The steering group met five times and the project manager reported on the progress towards project milestones. The project met all milestones and indicators that had been set.

Adaptations to project design

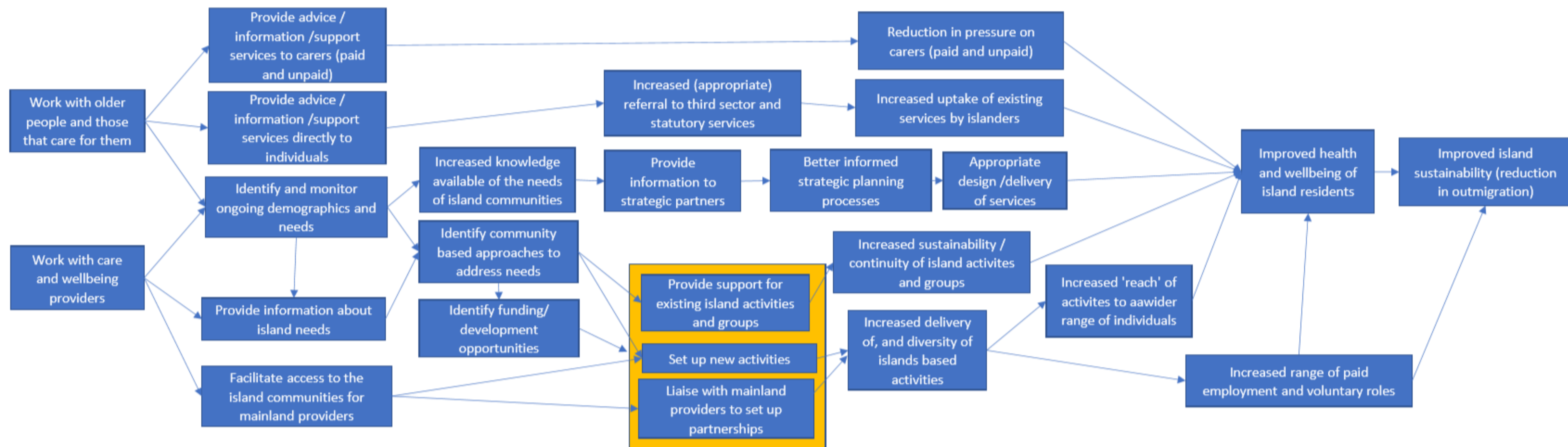
The Project Manager implemented a change to the project design to ensure that as well as central support, the coordinators had access to support on an island basis. This took the form of each coordinator having a 'contact point' at the development trust. This development trust contact was, in some cases a salaried member of staff, and in some cases was a trust director. Trust directors are volunteers and therefore the support they offered was on an unpaid basis. The level of support offered by the Trusts varied. Typically where the contact was a trust director a meeting was arranged once every two- four weeks between the coordinator and the contact. Typically where the contact was a paid member of staff, contact was much more regular (as office space was often shared) and may not have taken the form of scheduled catch-ups. The contact point identified by the Trusts tended to be a person who had a significant interest (and often a level of expertise from previous experience) in health and social care.

Coordinator roles

Through the project a clear model of island-based wellbeing coordination has been developed. The roles of the coordinators are two-fold-

- **Working with individuals or their carers** (paid or unpaid) to provide signposting and advice to to ensure that individuals are receiving the support they need
- **Work with care and wellbeing providers** on the island and on the mainland to maintain, set up and operate effective island-based systems of care and support

The roles of the coordinators therefore combine improving access to established services, as well as setting up and maintaining new services. The coordinator also maintains an overview of all health and wellbeing services available in the island to become a key liaison person for strategic partners (community planning or OHAC for example) as well as for statutory and third sector providers (health services, third sector services). This enables providers to have a better understanding of the island communities and improves their access to communities and the potential for better design of services. An outline of how the coordinator (and their roles) effects changes in the island communities is offered below in a theory of change diagram for the project.



The combination of both one to one support, and the facilitation of services / activities, highlights a distinctiveness of the project compared to other roles that exist in Orkney. Most notably although the GP link workers that are being piloted in two mainland locations focus on one to one support and advice, they are not involved in the facilitation of services or activities.

The coordinator's focus on the facilitation of on-island services alongside one to one support, is not only distinctive, but it is also a critical part of this role. This is in recognition of the barriers that mainland-based services can experience accessing islands populations, *and* the barriers that islanders can experience trying to access mainland services. In effect this results in a paucity of service provision in the islands with difficulties and delays in accessing services. Addressing the provision of services in the islands is therefore vital.

4. Project impacts

A wide range of project impacts are apparent. These broadly focus on supporting the wider health and social care landscape in the islands.

Support for individuals

In all island communities, coordinators are fulfilling the role of key contact point for individuals at need in their islands. This included being contacted by individuals looking for support, concerned friends or neighbours and conducting home visits where necessary. Interviews with a sample of island residents who had received support from the coordinators were conducted and four specific impacts were identified: having somewhere to go, accessing non-medical services, contextualising information about available services, and advocating for islanders.

This impact is primarily mapped to project outcome 2: 'Older people in island communities will be better informed of the services available to them'

Somewhere to go for help

Most commonly older people in this evaluation talked about the value of knowing there was someone they could 'go to' in person and informally to discuss their needs.

> *'Without the coordinator we had nowhere to go to, now we have a person, not just a name at the end of the line. She comes out to me, when I can't make it out…. and it's a person not just a machine, it makes a big difference' – community member*

The impact on older people was commonly a sense of reassurance, and of support. A feeling of not being 'alone' with their challenges reduced stress. In a number of cases this had direct health benefits in terms of mental health and physical health.

The relationships community members developed with the coordinators was particularly beneficial – allowing coordinators to proactively disseminate information to community members they knew would benefit and leading to community members feeling valued and cared for by the coordinator.

> *'I was worrying for months about my benefits, until I asked the coordinator' – community member*

> *'I did speak to the coordinator one day because I was in a bit of a state… and she took the time out and it really helped' – community member*

> *'the coordinator has passed other stuff on to me that she's found along the way and has emailed me things, that she's thought might be of interest… and all those little things are absolutely great' – community member*

Access to non-medical support

The role of the coordinator provided valuable support for areas of need such as financial, housing, social support, domestic and so on – areas that could have a significant effect on health and wellbeing of individuals but which they wouldn't normally talk to a doctor or nurse about.

> *'I've found with [my partner's] health not being great, the surgery will help you to a point, and home care helps you to another point, but there's nobody that actually says this is what you can get help with, have you heard about this organisation, have you*

heard about that organisation, you only find out about these little snippets through somebody else that says something – Community member

Contextualising information and improving access

the coordinator's role is not just relaying information about different services, but importantly also involves contextualising this information – helping people to understand if the service is relevant to them (and how). In the islands a particularly important point is that the coordinators can explain whether services are delivered on the islands or on the mainland only, and can improve awareness of exactly what is available.

'before we thought we weren't able to get services from the mainland, there was a lot of older people especially that were going without' - community member

'…it's fine to read something but a) you've got to have access to the physical reading matter which isn't that easy, and b) it's easy to read something and think 'well do I fit into that category?' So you don't really know what's relevant to you or not relevant to you.' – Community member

Given the challenges with knowing what services provide which services, and whether or how services are available on the islands, the coordinator could provide a supportive intermediary, making contact with services, identifying possibilities and then presenting them back to the individual.

'And the [name of service] I've had no response from them – so I went back to the person, and I said this is the situation, the [service] haven't got back to me, but there's this, here's an alternative. And they were quite happy….' – Wellbeing coordinator

Advocating for islanders

Where services were not readily available coordinators were also viewed in terms of being advocates for the needs of islanders or island communities. They could advocate on behalf of individuals where individuals were struggling to access services

'that has been a big role in what I've been doing is advocating for people and just joining people up with services' – Wellbeing coordinator

'I think it's having one person to contact, instead of contacting somebody and they'll say you need to speak to that department and being shunted round the houses. If you go to the coordinator she says 'right I'll look into that' and she has the contacts to go to the right places and get the right information' – Community member

On two occasions specific issues relating to housing were identified by coordinators, and addressed with the council (or council island link worker on the islands).

'because I can't sort things like paths, but I can pass on the concerns from the residents' – Wellbeing coordinator

Support of on-island groups

In many of the islands coordinators have been responsible for helping to support the development of new group activities and the sustainability of existing groups.

This impact is primarily mapped to project outcome 1: 'Older people in island communities will have increased access to activities and services designed to enhance health and wellbeing

Facilitation of new island group activities

Social activities and groups form an important part of the health and social care landscape in the islands – especially in islands where there are limited places to 'go' (for example no café or pub). The coordinators' knowledge of the needs of their communities and their growing knowledge of activities which are running effectively elsewhere has enabled them to identify possibilities for further group activities in their islands. By bringing together interested islanders and providing support with the practicalities of setting up a new group, coordinators have helped to set up a number of groups including:

- Men's Shed Sanday – there are 16 islanders currently involved in setting this up
- BALL (Be Active Long Life) group in Shapinsay – regularly attracting 6-8 islanders
- Health walks in Shapinsay (weekly) – regularly attracting 4-6 islanders
- Darn good yarn in Shapinsay (fortnightly) – regularly attracting 6-8 islanders
- Carpet bowls in Shapinsay (weekly) – regularly attracting 6 islanders
- Chair exercise group in Rousay – currently being set up, using two group leaders
- Health walks in Sanday

The activities that have been stimulated are important in diversifying the activities which are available, and in reaching new audiences. Carpet Bowls and Men's Shed have both been particularly important in engaging more men in the community for example. BALL group, chair exercises and health walks have also provided additional opportunities for physical exercise.

> *'it's a space for men to meet and be with each other… especially in a place like [this island] you don't have many neighbours, and you don't really see people unless you meet in the shop or the pub, and there are groups like craft things but they are not really for men' – Community member*

> *'…the BALL group reinforces community activities, and just feeling a depth of friendship with people and neighbours by doing activities, and it's physical because it gets you moving, it's social because it gets me out among people and it's invaluable…' - BALL group attendee*

> *'[it's a question of] how do we support those people who don't necessarily want to go to a lunch club… maybe they just want a blether and a cup of coffee…?' – Wellbeing coordinator*

Maintaining a diversity of groups potentially helps provides a 'route' into other community activities, for example a number of individual cases were heard about in the evaluation of individuals who started with one activity, and had moved on to engage in further activities.

> *'I love seeing so and so going to a group and she doesn't go to anything else on the whole island… and just getting men going to things… I love the fact it's getting some people out to do things on the island that weren't doing anything before. And hopefully that will have a knock-on effect in the future' - community member*

Some of the groups that have been developed have been from an identified interest on the island. Others like the Men's Shed and the BALL Group come from coordinators identifying what has worked in other places and seeking to establish a group in their own community.

Sustainability

The coordinators have also had a role in helping to sustain existing activities. This is an especially important role in a small island where small populations may threaten

sustainability if new group members cannot be sourced, or committees sustained. Challenges over the changing availability of community spaces to hold groups and other contextual factors (regulatory changes for example) may also pose significant threats which coordinators can help with.

Sustainability is a theme in two of the islands where the coordinators were supporting existing lunch clubs. However, it is likely that with the growth of further on-island groups and activities, the coordinator would also have a role in helping to sustain these, if and when challenges are faced.

> *It's absolutely vital to keep the coordinator in her post, because I don't think it would take much for some things to just crumble…' – Community member*

Systemic support: island health and care

In terms of on-island provision, the coordinators have had a facilitative effect on the health and social care system. This includes supporting health and social care systems on the individual islands, as well as bridging between island and mainland services.

This impact is primarily mapped to project outcomes 4 and 5: 'Partnerships and networks are enhanced in order to facilitate knowledge sharing and avoid duplication and adopt innovative approaches' and 'The pressure on statutory services is eased.'

Bringing care and health together

Typically each of the islands in this project have at least a nurse, and possibly a doctor and a nurse on duty at any point in time. The islands also typically have some individuals who provide social care (e.g. home carers) – but these services are coordinated from the mainland. Other services involved in health and social care may visit the islands on a regular or occasional basis (e.g. podiatry, social work, and a range of third sector providers) and some services typically require a visit to the mainland of Orkney (e.g. specialist medical provision).

In effect in the islands the doctor or the nurse becomes the main point of contact for medical provision, but also aspects of care – e.g. they can authorise care packages temporarily before a Social Worker is able to visit the islands. The challenge for medical teams is that individuals do not necessarily present with social care needs or wider wellbeing issues until they are in crisis – that is their need has become unmanageable or started to impact critically on their health. Arranging services for an individual in crisis is much more challenging than providing preventative services.

Coordinators have a key role in terms of being a contact point for people *before* they are in crisis – when some support would be helpful, but their need is not so acute that they would see the doctor or nurse.

> *'if you try and persuade them to have some [support], then when the day comes and they need more, they've built up trust, they've built up confidence, they know what to expect, who to expect, how it works' – Wellbeing coordinator*

> *'I feel I'm kind of a middle person in the island where its not something you need to go to the Doctor or nurse about but it's not something you would gossip about in the shop' – Wellbeing coordinator*

The impacts on individuals is that there is more support available prior to experiencing a critical medical need. The impacts on medical teams is that there is a better 'flow' of individuals and information through the system, including:

- Better awareness of community and individual needs: including help with identifying individuals at risk
- Improved ability to signpost patients to services or community activities – including signposting patients to the coordinator themselves (as well as some of the new activities that have been established)

The medical teams report feeling a stronger community connection, and an improved sense of being able to be proactive with island needs.

> *'without the coordinator I couldn't have that link, because they see me as 'health' and someone to go to when they're sick, not necessarily wellbeing and 'how can I keep you as well as you are?' – medical practitioner*

There is also some evidence that the improved functioning of the system may result in more efficient use of medical practitioner time, with non-medical issues being picked up by the coordinators.

> *'normally I used to go to the nurse… but it's handy because it just gets handed on to the coordinator now' – community member*

Bridging island and mainland services

Coordinators are viewed as community representatives. They provide a key contact point for islanders to communicate to service providers, and for service providers to communicate to islanders.

For services that run occasional visits to the non-linked isles having a contact point who can help with practicalities such as room bookings and transportation, as well as stimulate interest in services is highly valued. A good example comes from the Advocacy Orkney project on Self Directed Support which has involved a series of visits to the non-linked isles. In islands with a coordinator, the effectiveness of these visits has been maximised, and the number of contacts made with islanders has been notably higher than in other islands. This is because of the coordinator's island knowledge in terms of the best ways to connect with islanders (including the best groups to visit, and the best times or days to visit) and their ability to connect the service directly with individuals who may benefit.

> *'They've been fantastic they've helped guide us to the right people that are requiring a bit of extra help, they've gone the extra mile as far as we're concerned by helping take us about – you know so they'll help us on the transport side of things, they've arranged meetings for us both with individuals and groups, and they've made us so so welcome out there, they really have been invaluable to us, we hope they stay and we just want to build on the relationship with them.' – Advocacy Orkney*

Another example of bridging mainland and island services is the BALL group, which is part of a wider project being run by Adult Befriending. There are two BALL groups on the mainland and one on Shapinsay. The BALL groups are designed so that they are initially supported and run by the BALL group coordinator, but ultimately become self-sustaining through the development of a committee who can oversee and run the group. In Shapinsay, setting up the BALL group has been supported by the coordinator who helped with some of the practicalities of arranging the session as well as generating interest. The coordinator has also been able to hold sessions when weather has led to cancellation of the boats. The group has also moved more quickly to becoming self-sustaining through the support of the coordinator who has

helped to encourage individuals to take part in the committee. This has resulted in time and cost savings for the wider BALL group project.

> *'Setting up the BALL group in Shapinsay, the coordinator's been a huge help – having somebody there that knows the people and they know her… and she knows the opening hours of the gym, yeah she knows everything for Shapinsay!' – BALL group coordinator*

In effect, then, the coordinators have a key role in 'oiling the wheels' of community-provider engagement, and were perceived as supportive by both community members and providers. In particular, the one-to-one support of individuals strengthened the ability of coordinators to support liaison with mainland services – both helping them to understand the needs of the island communities (and therefore understand which services are most valuable at which times), and to understand the needs of individual islanders (enabling them to target these islanders with information about relevant visiting professionals).

Networks - Developing additional funded projects

Through building networks with mainland services and health and social care professionals, the coordinators have gathered a great deal of information not just to help individual islanders but also potentially to benefit their island health and social care infrastructure. In particular in two islands the coordinators have connected their knowledge of the needs of their islands, with calls for funding that have been circulated to them. Typically the coordinators have shaped the project proposals using their expertise, but have been supported by Development Trust officers who have additional expertise in writing funding applications. In addition two applications for dementia projects benefitted from the coordinators' connections with the Dementia Hub at Age Scotland Orkney, and indeed the call for proposals itself was circulated by AgeScotland Orkney. This has resulted in three successful project proposals for specific projects – including the peedie larder project in Stronsay, and dementia projects in Stronsay and Rousay. Together these projects have brought in £31,800, and part of this funding will be used to create three part time roles on the islands to coordinate the project activities.

The three projects funded are:

'Memory Mornings' Dementia project in Rousay

Funded by the Creating Better Lives in Orkney Small Grants Programme from the Life-Changes Trust. This project will involve fortnightly morning activity / coffee sessions themed around topics like: photo morning, sweetie shop, sensory morning, music mornings and games mornings. Transport will be provided where necessary and carers (paid and unpaid) will also be encouraged to attend for mutual support

Dementia friendly island project in Stronsay

Funded by the Creating Better Lives in Orkney Small Grants Programme from the Life-Changes Trust. This project aims to make the island of Stronsay 'dementia friendly'. All public spaces on the island will become dementia friendly through staff education, reorganisation and signage, in addition all community groups will become dementia friendly and a committee member from all existing groups will be designated as a dementia friendly key member. Every household and business to be invited to become a dementia friend – raising awareness of dementia across the island. Finally a dementia aid lending library will be set up on the island.

Peedie larder box project in Stronsay

Funded by the 'Eat Well, Age Well' scheme. This project seeks to address issues of nutrition and the availability of local produce in Stronsay by connecting local vegetable growers with individuals at need in the community. This project aims to enable fresh produce delivery to 20 older adults weekly over 16 weeks. as well as hosting three evening events where a meal will be provided alongside recipe sharing and nutrition information. Transportation will also be provided to the meals where necessary.

Systemic benefits to individuals

The value of the project in terms of supporting individuals was identified in a previous section. However, it is important to note that the value of the project to individuals was *not just* about one-off support, but was related to more systemic benefits. Typically the individuals who were interviewed as part of this evaluation project could describe a range of ways that the project had supported them – including individual advice and support, *and* the access to additional on-island activities and connections with mainland services. They also typically described activities or events that they hadn't (yet) had the chance to benefit from, but hoped to benefit from in the future – typically when their health had improved.

Vignette 1

My electricity bill suddenly increased after some electrical work was carried out incorrectly on my property. I was stressed and concerned about this. I contacted an agency myself for help, but they were not very supportive. When THAW came out to one of the events here, I spoke to them, and they are now helping me with this.

I also contacted the coordinator for advice after an operation left it difficult for me to manage daily household tasks.

I can't take part in the health walks at the moment, but I might do this in the future once my mobility has improved after my operation.

I have also volunteered to help with a local initiative. I am really happy that I can do this, as I used to volunteer a lot in helping roles before I moved to the islands.

Vignette 2

When my husband was alive I had cared for him, and he had cared for me. But after my husband died I didn't know what to do. All my benefits had been paid into his account, and I didn't understand what happened after he died. I felt I had become a 'no person'.

The coordinator brought John Foulis from Advocacy to visit me, and he helped me to understand what I was entitled to in the way of benefits.

The coordinator is also helping to sort out some help for me with cleaning. I had never heard of Crossroads before she mentioned them to me!

I also spoke to Selbro when they came out, and got some things that help me manage in the kitchen.

Co-production of health and social care services

The island coordinators are not just a link between communities and health and care providers, but they can be facilitators of innovative solutions and new models to enable services to be developed in their communities. Coproduced solutions have been developed across the islands in the areas of: social care, daily living aids, befriending and dentistry. These projects have addressed critical issues in the island communities over accessibility to these services. A series of case studies is given below, before key points are identified

This impact is primarily mapped to project outcome 3: Communities' confidence, capacity and capability to influence and develop services alone or in partnership has been enhanced

Social Care

Prior to the Enhancing Wellbeing project, there was a critical shortage of domestic and personal care on the island of Shapinsay (Alexander, 2018). For services, a key challenge was the ability to recruit appropriate staff. During the project the coordinator worked with Crossroads Care Orkney, a local agency, to promote two care attendant posts on the island – helping to spread the word about the posts locally, encouraging people to apply and answering questions about the role. As a result two staff were recruited to posts. Subsequently working with the nursing team on the islands, the improved availability of domestic and personal care was promoted to individuals who may benefit from the service. As such both supply and demand for services was addressed. As a result seven individuals are now receiving a service that was previously unavailable, and two community members have access to paid employment. The Development Trust pays a proportion of the costs of care for each individual, (where it is not covered by Self Directed Support payments or free of charge respite care). All parties agree that there is scope for an increase in the care hours delivered in Shapinsay – as the word spreads in the community about the service, supported by the information provided to potential beneficiaries by the coordinator and the nurse.

In Rousay, a similar partnership with Crossroads has emerged, but following a different route. In Rousay a member of the community secured employment with Crossroads, covering the mainland of Orkney. This person has subsequently gained a number of hours work on Rousay itself, following the coordinator's promotion of the service on the island. Again the Development Trust pay a proportion of the costs of care.

Together these initiatives have resulted in an additional 18 - 20 hours of care being delivered across the islands. They have also resulted in at least one community member being able to stay in their own home, rather than move to sheltered accommodation on the mainland. Employees of Crossroads also report benefits from being able to work in their own communities.

> *'I was at the point of thinking 'I don't think I can live on Shapinsay without support' and there was no support. So I had actually put in to Orkney Islands Council to move, but then of course the Crossroads came along and it just turns it around for me I feel like I can stay in the home that I love and in the community that I love, and it's made a massive massive difference to me' – Recipient of the service*

> *'getting the crossroads job has been the motivation I needed… for me it's made such a difference – I'm really enjoying it' – Crossroads Carer*

> *'we did used to have a care attendant [on Shapinsay] but then she retired, and I did try twice I think to recruit and it just didn't work, so I think if it hadn't been for the coordinator on that island helping, it would never have happened, so we do have two folk there now, she chivvied them on to apply' – Crossroads manager*

Befriending

Social isolation has been identified as a key risk in the non-linked isles, exacerbated by limited social spaces, limited island transport, and poverty. Befriending has been consistently identified as a possible way to address some of these challenges – offering social contact, and also potentially encouragement and practical support (e.g. transport) to access on-island

social groups (Alexander, 2018). Befriending has faced challenges in the non-linked isles because of difficulties of numbers, and difficulties making 'matches'. Services reported challenges of having islands where they had a volunteer befriender but no befriendee and vice versa. Additionally managing ongoing services in the outer isles is challenging because of the costs (financial and time) in travelling out to the islands.

In Sanday the coordinator has worked with The Blide Trust to develop a befriending service. The coordinator has been able to recruit seven potential befrienders. The Blide Trust were then able to travel to the island to deliver a one-day training course. In the future the coordinator will offer ongoing support by helping to identify potential befriendees and advising (from their knowledge of personalities) where the best 'matches' might be. This will offer considerable support to The Blide Trust who would normally rely on a series of meetings / visits to get to know befrienders and befriendees before matching them. In this case, with matches being supported locally there will be limited need to travel. The Blide Trust will, however, undertake the risk assessments of befriendees homes, and provide ongoing monitoring and support of the service – including regular supervision (conducted over the telephone).

The project is in the initial stages, and is being viewed as a pilot project at this stage. However all parties agree that so far the project has demonstrated the value of working together. Volunteer befrienders have reported valuing the opportunity to volunteer and help others in their community. The Blide Trust they have achieved greater 'reach' into the community of Sanday, and future visits to the island will become more cost effective as their work on the islands extends. The community will benefit from access to befriending, as well as benefits from other activities the Blide Trust can offer while visiting the island: for example mental health first aid training and drop in sessions.

> *'I had always volunteered in roles like this before I lived in Sanday… and so when the opportunity to be a befriender came up I jumped at the chance' – volunteer befriender*

> *'I'm really excited to set up a service in Sanday' – Blide Trust Befriending coordinator*

Equipment to support activities of daily living

Across the islands, coordinators have worked with the Occupational Therapists from Selbro Resource Centre. These relationships have varied across the islands.

In Hoy, the coordinator worked with the GP surgery set up a daily living aids centre, the centre is based in the Health Centre, and £2,508.89 was accessed from the Patient Fund to set up the centre. The centre itself is stocked with a range of daily living aids and has been developed with assistance from Selbro Resource Centre. Patients can be directed to look through the aids themselves, or can be referred to the coordinator who will demonstrate the aids, and provide them on loan where appropriate. This initiative was highlighted as an example of good co-production practice at the Scottish Parliament Health and Sport Committee Primary Care Inquiry (Stage 2 9th October 2019). In six months, the coordinator has had five referrals for the daily living aids centre from the Health Centre, has had 12 people contacting her independently and had 9 contacts with people through drop in sessions. She has loaned out 32 pieces of equipment.

A slightly different approach has been taken in Rousay. In Rousay the coordinator invited an Occupational Therapist (OT) from Selbro Resource Centre to attend a triangle club meeting and demonstrate some aids and adaptations. This resulted in a number of those attending taking away appropriate aids. The session was so successful that the OT is planning to attend

the Triangle Club in Rousay on a regular basis. The coordinator also has a small supply of aids which she can demonstrate to individuals and provide on loan – and when she does this she notifies Selbro, providing a flow of information to Selbro about individuals in need who staff can visit if necessary when they visit the island in the future.

> *'it's always sad when you come across somebody who you think you could have had lots of different help and information, but they never knew who to ask. I think having someone locally who people trust and are not afraid to go and speak to is just marvellous really, because they could in many ways be a missing link' – Pam Marwick OT*

> *'the things that the coordinator has told me and given me have been absolutely wonderful' – community member*

Dentistry

Access to dentistry has been consistently identified as a concern in the non-linked isles (Alexander, 2018). The challenge is especially acute in the North Isles where transport options mean that a dental appointment in Kirkwall can require a whole day off the island, and therefore off work or school (for children). Anyone with limited mobility may also face challenges in accessibility of ferries or planes. These barriers potentially stop people from accessing dental services.

In Sanday the coordinator has been working with a local Dentist – Scott Tulloch – to explore options. In the past the islands had considered purchasing a mobile dentistry unit, however after advice from Scott (that these units can be prone to damage), and information from Scott about the availability of a number of suites from redundant equipment in Orkney, the community (via the Development Trust) decided to purchase their own suite at auction. The community also identified a potential space that could be used to house the equipment and are in the process of negotiating purchase / hire of this space. Once the space is set up and the equipment installed, Scott will staff the dental suite on a regular basis to enable the community of Sanday to access dental treatment.

Buying in their own equipment and securing their own space for dentistry potentially benefits the community, because it allows them to have more control over how the service is delivered in their island. For Scott and / or any other dental service, the arrangement limits the up-front costs of establishing a service. In the future, the costs of maintaining a space can be mitigated by the community by using the space for other health and social care activities or visiting services. For the dental service, there will be some ongoing additional costs of serving the island in transport costs (time and financial cost) – however these are not perceived as major barriers because of the potential value of the service, both ethically in terms of increasing the accessibility of dental treatment in Orkney, and in terms of enhancing the professional development of dental staff through the opportunity to travel and work in other smaller island locations. Some employment opportunity in the island has also been identified with the potential for the training of a local person(s) as dental nurse.

> *"I was motivated to address inequality in access to dentistry in the isles… I wanted to help get everything in place for as little cost as possible for Sanday, run the service, see how it works. If we can get one service up and running, we can learn so much. I would see the project evolving over time, and for the community, owning their own equipment gives them more control over the service, and the surgery space can be used flexibly for other services too.' – Scott Tulloch, Dentist*

> *'Dental surgery was beyond our wildest dreams – and it looks like it's on it's way!' – community member*
>
> *"Scott was very supportive with the original concept and kept us advised on how an island service might work in practice. He alerted us to the fact NHS were about to release dental equipment following the opening of the new Balfour Hospital. He advised us on what was available and helped us prepare for the auction where we acquired a dental chair, X-Ray unit, lighting and tools …everything we need to be up and running. The [Development] Trust Board was brilliant, they responded quickly and released the funds for the equipment purchase, realising the benefits it would bring to the community." – Wellbeing Coordinator*

Community Led Support

The case studies in this section showcase a range of partnerships that have developed between communities and service providers. In addition, Orkney Health and Care have been rolling out their 'Community Led Support' initiative which is a programme specifically aimed at community engagement and aims to support a new way of working with communities 'letting communities make better sense of how to meet need in their own communities.' (OHAC strategy). In Orkney the CLS programme has progressed through a series of workshops which were held to initiate the programme. Following these workshops community hubs have been set up in the form of 'blethers'. A 'blether' is an event which enables 'earlier, and easier access to services and support for people within their own community'.[1] Blethers are attended by health and social care staff from the statutory and voluntary sectors and are open to anyone in the community.

When it was first announced The Community Led Support initiative was welcomed by the coordinators who could see the links with their work. In the initial workshops for the programme, a visit to Sanday was included which the wellbeing coordinator had a key role in supporting – including promoting the visit to the community and helping with hosting arrangements. However, subsequently when deciding where to hold 'blethers' the CLS team decided to focus on Kirkwall, as this is the largest population centre and, the team felt, would have the largest potential 'reach' to the population of Orkney. However, in Sanday the community felt at risk of being 'overlooked' – and it reinforced a sense that services do not want to travel to the islands because it is too difficult. Therefore the community lobbied the CLS team and allowances were made to allow for further engagement with Sanday. This experience was challenging for both community members and for the CLS team. The role of the coordinator was highly valued as an intermediary or interface – being able to communicate direct to the CLS team on behalf of the community and vice versa. The result, which is a series of planned 'blethers' in the island, has been highly significant to the community, and the CLS team also report a very positive experience of working with the islands.

> *'The Community Led Support meetings have been excellent. It's a feather in [the coordinator's] cap to have got them to come out to Sanday, because they came out and it looked like it was going to stall at the first hurdle, because they realised that life wasn't that easy of just jumping on a plane and popping here when they wanted to… I think because everybody said hey you've got to come out here, and this is what we're trying to say to you, life isn't easy in the isles arranging things, and now you're realising*

[1] https://ihub.scot/media/7003/working-with-communities-in-orkney-case-study-v10.pdf

that's actually the case. And in fairness to them they took that on board and came back. I think there's a lot of things that can run on from that, because there's a lot of things that need to change in the way that care and health works here' - Community Member

'From a Community Led Support perspective Magda has been instrumental in getting us set up on the island because you need to have someone on the island who knows the set up and knows how people feel about things' – CLS representative

'I would have no hesitation in contacting Magda and saying 'we're coming to Sanday do you need anything?' and I don't think she'd have any hesitation in contacting me if there was a query.' – CLS representative

Community Led Support in Orkney is just beginning, and the intention is to build further community engagement from the events held so far. The evidence in this project is that the island communities are very keen to support this engagement, with the other islands commonly expressing an interest in working with the CLS team.

In a number of cases islands felt that they had been effectively building their own blethers, by inviting people out to their islands to meet with their community. This potentially creates a 'warm lead' for the CLS team, and an opportunity for enhancing the existing good practice in the islands through additional input from CLS. Given that engagement between communities and statutory bodies is not always easy, the coordinators also provide a key mechanism for assisting with communication, and working as an interface between providers and the community.

'it's kind of building our own little blether' – Community member

5. Learning: Facilitators and barriers, strengths and weaknesses, the future

In this section of the report key learning will be drawn out from the project, leading to some recommendations for future projects of this kind. There are three key areas to consider in terms of facilitators or barriers. These are: coordinator attributes, island context, and wider health and social care context.

Being a connector: the role of the coordinator

When asked what has contributed to the project's successes, communities and services will invariably answer 'the coordinator'. It is, of course, not as simple as this, but it is clear that there are certain skills or attributes that help coordinators to be effective in their job. The following attributes are particularly important

- **Being approachable –** which includes a sense that coordinators are open, friendly and non-judgemental, and have good 'reach' to all parts of the island population.
- **Being trustworthy / confidential –** being able to handle sensitive information appropriately is important. This includes respecting confidentiality, but also includes doing as you say you'll do, and having integrity.
- **Being a good communicator –** being able to convey information to individuals, and to motivate and encourage individuals. Being able to gather ideas from people, listen and respect different viewpoints and convey messages clearly.

These three attributes were the most commonly mentioned. Confidentiality is a particularly important attribute given the small size of the island populations – which can significantly heighten the caution of individuals in approaching a service. Importantly these same attributes were identified by services as important – being able to build a positive relationship with a coordinator is vital, and maintaining a strong channel of communication between the service and community members (and vice versa) can be very important to ensure engagement is positive. Additional important attributes are:

- **Facilitative rather than directive –** this includes being able to 'hear' the needs and perspectives of different individuals in the community, and identify how these can be best met rather than meeting these needs directly. Similarly the 'best' ideas for community led initiatives are understood to be those that come from the community, either directly or indirectly through a close understanding of the community and their needs and interests. In these cases the coordinator has a role to stimulate ideas, gather information and feedback, bring interested parties together and so on. They may also have a role in identifying potential solutions or models that may be viable in order to present these back to community members for their consideration.
- **Engaging and encouraging –** supporting individuals to take part in activities or engage with services is very important. This includes being able to research information and build networks, and being able to present information clearly and persuasively. It also involves garnering support and bringing people on board with community led initiatives.

Where a coordinator is 'well known' in a community they may have an advantage over less well-known individuals in the speed with which they can establish connections within the community. Being trustworthy in particular is an attribute which communities feel may be proven over time. For all coordinators there was a sense in which over the duration of the project people had begun to trust them more and were more forthcoming.

'she has a way of talking with people rather than at people and really engaging people - people immediately warm to her, you can see that they trust her, they know her, they feel confident with her' – community member

'she's very good at getting people involved… she's not bossy but she can put the idea over to you, and it is a good idea for you and you might not have thought about it before' – community member

My role is to assist them not to be the lead… with every community project, it's better when people feel it's their project rather than somebody else's – Wellbeing coordinator

'she's been here a long time, she knows a lot of people, she has an idea of what could be done, with inside information if you like rather than coming in from outside, and she's trusted' – community member

'we live in a diverse community where there's poverty, and she reaches out to people who wouldn't normally ask in a very non-judgemental way' – community member

Island contexts: Not all islands are equal

Although the attributes of a coordinator are important, the nature of their individual island context is highly significant in influencing what can be achieved.

Island context – facilitators and barriers

Through this evaluation a number of 'facilitators' and 'barriers' which stem from the island context have been identified and are presented below.

Facilitators	Barriers
An island which is: - Close to mainland with regular and less costly transport connections - Has supportive GPs and Nurses / Nurse practitioners - Has a larger population - Has existing social groups and activities - Has a functioning lunch club or afternoon club - Has a strong and well supported Development Trust - Has a Development Trust with more resources (staff, finance and physical space) - Has strong community physical infrastructure e.g. physical spaces (community hall or similar) to host visiting practitioners. - Has community members with a knowledge / interest in health and social care	An island which is: - Distant from the mainland with irregular and more costly transport connections - Has GPs and Nurses / Nurse practitioners who are less supportive - Has a smaller population - Does not have a wide range of existing social groups and activities - Does not have a functioning lunch club or afternoon club - Does not have a strong or well supported Development Trust - Has a Development Trust with limited resources (staff, finance and physical space) - Does not have strong community physical infrastructure e.g. physical spaces (community hall or similar) to host visiting practitioners

	- Does not have a wide range of community members with a knowledge / interest in health and social care

This represents a highly simplified schematic, but is included for its potential value to stakeholders. The demographic profile and population size of an island are of course highly significant here – larger populations for example provide a bigger 'market' for some services, and for social groups and activities, and they may also provide a bigger market of potential employees or volunteers. Some caution is needed though because simply taking the population size of an island as a marker may mask differences in how engaged or cohesive island populations are, or how available for work individuals within the community are. However, alongside population size there are two very important key points here in terms of island context:

- Firstly, the more physically distant from the mainland an island is the more challenging it is to work with mainland services due to issues of transportation[2]
- Secondly where islands have resource, they may be more able to attract and build on this resource.

Distance from the mainland

The services that were engaged as part of this evaluation report all demonstrated a strong motivation to provide services to the islands. This motivation typically stemmed from an ethical and ideological standpoint whereby services wanted to address issues of potential inequalities in access. However, not all services were equally motivated, and in practice coordinators described challenges with engaging mainland services, which stemmed mainly from issues of transportation and cost effectiveness.

> *'I feel like on the surface everyone is willing to help, it's then when you have a specific problem, a lot of them say 'oh well, we have to wait for more people, we can't go out for just one person" – Wellbeing coordinator*

Even for the services that took part in this evaluation, they sometimes found that practical issues around travel limited the ways that they were able to engage with different island communities. In particular, this evaluation focused on activities over the winter period when ferry cancellations had impacted on a number of planned visits to the outer isles.

> *'originally at the beginning of the year we had a date for every isle – just the way it's worked we've only managed to get to the inner isles, the others have been rescheduled or cancelled' – Advocacy Orkney*

In other cases, although visits to the outer isles were planned, the possibility of *regular* visits to the outer isles was more questionable, given the significant cost (in terms of finance and time) in accessing these islands. For these islands therefore, the coordinators have a particularly important role as they can help embed the value of a small number of visits by ensuring that these visits are as productive as possible, providing a contact point for ongoing communication, and, where necessary taking forward additional activities.

[2] Those whose workers are all based on the mainland.

> *'Obviously with it being Stronsay, it's a distance it's a cost, I'm 14 hours a week, If I was to go out on the boat at 7 and back at 7 at night, that's a lot of my hours, so I'm realistically only going to be able to go out a few times so the coordinator may need to help run a group from her end with my help from this end. So yeah if I didn't have that person there then it probably wouldn't happen.' – BALL group coordinator*

> *'we can't afford, out of our working week, to go off to an island for a day or half a day to potentially see one or two people, so this is a really exciting project and we're really keen to make it work' – Blide Trust Befriending Coordinator*

In several cases where boat cancellations had resulted in last minute cancellations of visits to the islands, the coordinator had been able to host an event in lieu of the service – this happened both with a CLS Blether in Sanday which had to be cancelled at short notice, and with a BALL group.

Although transport was an issue for *all* islands, the additional costs and time taken for travel for the outer isles makes travel a much more significant barrier. Importantly this is not just in terms of services going *out* to the islands, but is also a barrier for coordinators themselves if they need to have meetings with services. For these coordinators a whole day can be taken up with one meeting in town.

Virtuous circles – attracting resources

There is evidence in this evaluation report of the development of potential 'virtuous circles' of activity – that is the more activity that is taking place in a community, the more activities it may attract. Four particular mechanisms by which this happens are identified:

- **Higher engagement leads to more regular visits:** where services have a positive experience of an island visit they are more likely to visit again in the future. In particular where island visits lead to service referrals, services may visit again to meet the needs of these individuals.

'They said they'd done it before and basically hadn't had much success, so why try it again' – wellbeing coordinator

- **Visits providing opportunities for 'spin off' activities** – especially in the case of the North isles where transport times mean that staff are often on the island longer than the time they need to be, staff can maximise their time by providing other activities e.g. running a drop in, providing a workshop and so on.

'I have gone out to Sanday to see one person on a home visit, and I flew out that day to see them… and the GP surgery in Sanday are great, I had a room in the surgery free, and we advertised mental health surgeries as a drop in and a couple of people came along, and that makes it more viable.' – Blide Trust befriending coordinator

- **Activities providing channels for services to access the islands:** the existence of a service on the islands, or an event on the islands allows an opportunity for other services to 'piggy back' – providing a ready made opportunity for engagement. This is clearest in the BALL group activities where other services are invited along for example fire safety or physiotherapy. Lunch clubs or afternoon clubs are also key contact points for some visiting services. Considering the evidence that physiotherapy continues to be a major concern in the islands, it is notable that Shapinsay has

received a visit from a physiotherapist through the BALLgroup, and that Sanday has received a visit from a physiotherapist through the Blether.

'when someone comes out to the BALL group, then they'll also have a chat with the nurse because they're out there anyway… and Jo who does the dance, has done a session with [Shapinsay] school as well because she's out there anyway' BALL group coordinator

- **Communities providing additional capacity –** coordinators in the islands have access to different levels of resource from their communities. Key areas of resource include the resources of the Development Trust, the availability of volunteers, and the expertise and interest in available to the project locally. Where islands have well-connected community members who bring expertise and are engaged in the project this can be a significant support to the coordinator and to future activities.

'it's about connecting all the dots and using all the other bits of community resources that we've got' – community member

The notion of 'virtuous circles' is important as it identifies how having a coordinator can help to stimulate activity which can then bring in more activity. However, it is also important to note that a coordinator on an island where there is already more happening (for example social groups and lunch club(s)) may have more opportunities themselves to connect with individuals, and may find it easier to generate interest or find forums for visiting services to connect with individuals. For this reason, this evaluation report has avoided comparing the activities in different islands in terms of measures of impacts (e.g. people reached, activities stimulated etc) as this interpretation would be too simplistic. Instead the coordinator's role is to stimulate interest and activity, and support individual community members, but at a speed or in a way which is appropriate in their context.

Different island needs – different solutions

A final important note about using this schematic outlined above is that it is important to note that the *specific* nature of an island must not be overlooked. Not only do island resources differ, but island needs also differ. As a result the strategies and projects that might provide solutions in one context will not always translate to other contexts but may need adaptation.

The projects and strategies taken forward by the coordinators in this project are context specific. So, for example, Home Care as a concern in Shapinsay and Rousay was identified in the initial research project at a level which was greater than in Sanday and Stronsay (due to different levels of staffing on the islands by OIC). The development of enhanced care provision through Crossroads Care has, therefore, been appropriate in these islands. This is not to say that other forms of care provision or other partnerships are not important in other islands, but that these have not been the priority at the moment, and ultimately they may 'look' quite different. Another example is BALL groups – like Shapinsay, Rousay was involved in initial discussions with the BALL group coordinator, but following a visit to the island, Rousay decided to proceed with chair exercises facilitated by two individuals on the island rather than a BALL group per se. This approach was chosen because individuals to lead the exercises had already been identified, and potential participants too, so this was felt to have the most potential at this point in time. Similarly in Sanday, the existence of a good range of physical activities through local groups and individuals meant that the coordinator did not view BALL groups as a priority.

6. Strengthening the project

The evaluation has pointed to a number of considerations for the future of the project.

Embed and extend

The coordinators have been in post for a year, and a strong theme in the evaluation is that communities feel they have only 'scratched the surface' of what they are capable of in that time. In terms of one to one support, as news spreads about how coordinators have helped community members, there is an expectation that there will be increasing demand.

> *'it could be opened up a bit more if you had the hours' I've definitely got more people coming to me now than I did in the beginning' – wellbeing coordinator*

> *'I think it works as it is. I think it will grow' – community member*

Indeed the project has, for some community members, demonstrated how *much* demand there is likely to be – more than they had expected.

> *'I think there's a lot more need out there than you think of' – Development Trust representative*

> *'I wasn't aware of so many people on this island needing this kind of help until this project' – Development Trust representative*

Where coordinators have developed additional projects or co-produced solutions, these partnerships are just in their infancy and the majority have not started to deliver services to community members. Retaining a coordinator in order to 'see through' these projects was felt to be very important.

Further, the project has demonstrated different initiatives in different islands, and over time, there is scope to share the models that have developed with different islands and embed these. Typically partner agencies have only wanted to focus their work on one island at a time, as a 'test of change' but as projects reach maturity, partners have expressed an interest in developing similar projects in other islands.

Embedding and extending the project is partly about having more time. But there is also a common theme from partner agencies that they would like to see the project extended to other island communities. Islands like Eday, North Ronaldsay and Westray were all mentioned as islands that partners felt they needed to reach with different projects and would benefit from a coordinator.

Consolidate processes and embed further training and support

As the project has matured it is clear that the coordinators although working in different islands have common aspects to their role – most notably providing one to one support and facilitating community connections with mainland services. Although policies and procedures are in place via the island development trusts to support this work, further support could be provided to strengthen the work of the coordinators, minimise risk, and embed good practice. This could be done through a much stronger central role in terms of coordinating processes and procedures, overseeing training and development, and coordination of activities across the islands. Clearer centralised processes would result in efficiency savings, provide stronger consistency across processes across the islands, and result in better support of coordinators. Specific areas for consideration are identified below.

Training needs

Although coordinators are working within a clear policy framework provided by the Development Trusts, due to the nature of their work they would benefit from further training and support with some role-specific elements.

> *'there's probably a core set of training that needs to be thought about' – Development Trust representative*

Coordinators have in many cases accessed relevant training either through a previous role, through self-directed research and / or through the identification of opportunities (e.g. in liaison with the Development Trust). However, a core set of training would be beneficial, which is specific to the role of the coordinator. Areas where additional training would be valuable are:

- Adult support and protection training
- Data protection & Record keeping
- Advice giving and referral processes
- Confidentiality and boundaries
- Lone working & Risk assessment

Although working in line with Development Trust policies in these areas, the provision of training would help coordinators to think through the implications for their roles. Training should certainly be available during a coordinator's induction period which is role-specific, and should be complemented by ongoing training and development. Providing training to all coordinators at the same sessions would also help the sharing of best practice between coordinators.

> *'if you were to get all the coordinators together and do a training session on mainland then you make the best use of time' – Wellbeing coordinator*

> *'I think if at the beginning if we'd had an induction day, don't do this, or do this, or that's okay, or if you're unsure… and how to approach people, and if somebody starts speaking to you in the shop how you say 'stop this isn't the place to discuss this!" – Wellbeing coordinator*

Further guidance may also need to be developed by the project team centrally about the expectations of Development Trusts, both in terms of best practice in ensuring the necessary policies and processes are in place, and ensuring that coordinators have access to the resources they need. On this latter point, two specific issues may be valuable to consider – the importance of coordinators having access to appropriate work spaces and storage spaces (for notes), and accessibility to equipment including ICT (and confidential file storage) and potentially a work mobile phone too.

Alongside a suite of training, there is scope to further develop the networking meetings that have been held in Kirkwall. Over the duration of the project four meetings have been held. Typically coordinators have identified the value of these and suggested that building on these would be valuable. This includes more regular meetings.

> *More coordinator meetings definitely for us to bounce ideas off each other – Wellbeing coordinator*

It also includes potentially maximising the value of these meetings by including a series of invited guest speakers from different agencies. In two cases the meetings have involved guest

speakers, but this could be extended. Currently coordinators are arranging their own separate meetings with different agencies, which creates the potential for a disjointedness to be experienced by both co-ordinators and agencies, and a duplication of work for agencies. There would be cost savings in meetings with agencies being planned centrally (and followed up by individual coordinators).

> *'it would have been helpful if we'd all got together and we'd had THAW and Selbro and Age Concern and Crossroads come to us with a presentation or something and we could air and share and talk things through together, whereas we've all had to go in individually, and that's not been very efficient…' Wellbeing coordinator*

It would also assist a stronger cross-island planning with the different services. This is important given the findings that agencies typically want to pilot activities with one island at a time, rather than covering all islands. As well as invitations to agencies, meetings should also allow time for individual coordinators to report back on the specific interventions they are trialling.

> *'I think having the other coordinators who are doing the same job even if they're doing it in a different way it does help to motivate and facilitate and gets you thinking about other options and how that might work on your island' – Wellbeing coordinator*

Ideally the coordinators should also be given the opportunity to visit each other's islands. This is challenging due to transportation, but an annual learning visit to one of the islands should be planned for, with additional visits arranged if necessary.

> *'I think it would be nice for us to go to each other's islands as well so that we can see the physical aspect of what they're dealing with the layout of how things are, and meet some of the staff too at the development trust to know who's who… I think that would be really good.' - Wellbeing coordinator*

Management and supervision

The monitoring of activities of coordinators could be more effective. Currently co-ordinators are typically producing a regular report both for the development trusts and the central team. Although the Development Trust contact and the Project Manager have both been perceived in all cases to be highly supportive and hugely valuable in helping coordinators think through their work, coordinators are less clear about where they should go to talk through decisions relating to the support of individuals. Currently in most cases co-ordinators are raising issues of risk or concern directly with GPs or nurses on the island (once consent is gained from an individual). However, it would be valuable to have a much clearer process for reporting and discussing concerns relating to individuals in the community. This should either involve regular management supervision with the development trust contact, or through a central contact. Currently in some cases staff have a form of management supervision arrangement set up with their development trust contact, but not always. In addition this arrangement is often dependent on having sufficient skills and good will within the Development Trust to enable this to happen as there is no formal requirement for supervision as such from the Trust. It may be that management supervision is more appropriate through a centralised role who can give role-specific guidance, but supported through a local development trust contact who can provide additional support if necessary (and according to their ability in terms of time). Management supervision would involve regular mandatory meetings, where coordinators share information about the clients they are working with confidentially, and for their supervisor to be able to give guidance on challenging issues which the coordinators face.

Regular supervision is important because of the challenges of working with individuals who may have significant needs, and especially in contexts where there is a lack of service provision – it is exacerbated by perceptions of community members and some stakeholders that there are limited risks in working in small communities. This can also make it difficult for coordinators to feel comfortable to ask for further guidance.

> *'I think a lot of people who live and work in a small community like this think that the chances of them getting involved in a tricky situation which could be put them at risk is limited, they'll not envisage that that might happen… and people often find it difficult to raise things' - Wellbeing coordinator*

Management supervision provided centrally would also provide the central team with a better oversight of the project, the issues that are being faced, and enable increased capacity for responding to common issues across the island, and improved identification of potential cross-island collaborations, with a greater oversight of the activities in different islands. The training needs of staff, and the allocation of budgets for training and other activities may also be made more effective through stronger coordination.

Build on partnerships

The project has made significant progress with establishing strong partnership working between OHAC and communities – specifically through the work with Community Led Support in Sanday and the scope to extend this to other islands. Partnerships have also been developed between third sector partners and individual islands.

However, there is still scope for building on partnership working. In particular island communities (and coordinators) have had greater success engaging with some services than others.

> *'if you're signposting people you've got to have places to signpost them to… and that's a lot of problems we've got here a) getting people to come and visit here and b) some of these places have a six month waiting list before you can get someone to come out' – Wellbeing coordinator*

Where services have engaged with the coordinators this is often driven by a strong ideological commitment to working with the islands – despite the additional work, time and cost that might be involved. Not all services or individuals are as strongly motivated as others. Taking the project forward, it would be beneficial if centrally the responsiveness of different services could be monitored, and where concerns are raised, it should be possible to escalate these where appropriate. Again this is likely to require heightened central coordination – potentially with the project making requests to partners for input where individual coordinators have struggled.

> *'if we stuck together as a group, as a voice, we'd be listened to more.' – Wellbeing coordinator*

Here, the steering group may also have an important role in monitoring challenges and discussing and agreeing strategies to address these. Although challenges have been apparent engaging with both statutory and third sector agencies and services, the management of this project by the TSI has assisted with third sector communication. A stronger presence at the steering group from OHAC or regular reporting from the project to an appropriate OHAC contact would be beneficial for also highlighting concerns or issues for the statutory services.

In particular although the 'blethers' are a highly valued channel for liaison between islands further engagement with OHAC is also desired by the communities, particularly where they have an interest in community led innovations, including in Sanday, the 'Care for Sanday' project. The kind of support that communities are looking for is very similar to the support offered by the dentist in helping to set up a dental service – the communities have a certain amount of resource, but need support in the form of advice in order to be able to understand how best to utilise this.

> *'the biggest challenge is trying to get Orkney health and care to look at things differently – community member*

> *'NHS commitment to using the facility would give us a better chance of success with funding applications, project planning etc. We hope to be able to sit down with them and secure a tangible sign of their support, in recognition of the value of the project to us all, NHS and community alike.' – Care for Sanday commentary*

Alongside identifying appropriate communication channels to OHAC, a formal working relationship between GP practices and the coordinators in the islands would be beneficial. Currently the project benefits from a great deal of mutual support between GP practices and coordinators negotiated on a local level. Coordinators also typically report issues of concern to their local GPs primarily, but the extent to which they can share information is potentially limited by data protection legislation. In comparison the 'link worker' project has data sharing agreements established between the link worker (employed by VAO) and the GP practice. Considering a similar more formalised data sharing agreement with GP surgeries may also be valuable for the island coordinators.

> *'the biggest achievement is the collaborative working between me and the health centre, because life would be really difficult doing this job without that, because they know their patients, they know I'm working with their patients and if I can't feel free that I can go to the doctor at any time and say 'I'm concerned about so and so' then that would make my life really really hard because who would I tell?" – Wellbeing coordinator*

Considering the Link Worker pilot, it is notable that this pilot is funded through OHAC, whereas the island coordinator project is European funded. Given that the island coordinators at least partly fulfil some of the roles of a Link Worker, a question is raised about whether the island based coordinators should also be core funded. Currently the Link Workers work from specific GP practices, and the wellbeing coordinators have a different role being community based rather than practice-based - therefore appropriate funding arrangements may be different, but it remains the case that there are significant benefits to statutory provision, and to the functioning of the whole health and social care system from the island coordinators. It is notable that in other geographical areas comparable roles have been funded in other communities by council funds. The project has secured funding for an additional two years from European funds, however, it is important that from the early stages of the next project communication with OHAC, the NHS and the Council is established, to identify potential sources of funding for the continuation of the project.

7. Conclusions

The 2018 'public health priorities for Scotland' outline five principles for public health: reducing inequalities; prevention and early intervention; fairness, equity and equality; collaboration and engagement; empowering people and communities; intelligence, evidence and innovation. These principles also underpin the strategic plan for Orkney Health and Care 2019/22. The evidence considered in this evaluation report demonstrates how the Enhancing Wellbeing project has delivered outcomes relevant to all of these principles.

- **Reducing inequality**: the project has provided a 'bridge' between communities (and community members) and services delivered primarily from mainland locations. Improving access for individuals to services, and for services to communities.
- **Prevention and early intervention:** coordinators have helped to support individuals before their care needs become critical – providing a source of help before individuals seek help from GPs or nurses.
- **Fairness, equity and equality:** coordinators have worked with individuals across their communities in an inclusive way – addressing 'hidden' issues and supporting those who are least likely (or able) to seek help for themselves.
- **Collaboration and engagement**: partnerships have been developed between the islands and services in areas such as dentistry, befriending and access to daily living aids. The coordinators also provide the Community Led Support initiative from OHAC with a community interface – allowing for productive and positive relationships to be developed.
- **Empowering people and communities:** coordinators represent their communities – allowing communities to have a clearer 'voice', and provide a contact point for services who wish to work with communities. On a one to one basis, coordinators have supported community members to access the support they need from services.
- **Intelligence, evidence and innovation:** the project has delivered an innovative approach to community support, and has resulted in the further development of a number of innovative projects. The intelligence that coordinators have developed about their island communities and their needs has helped inform these developments.

It is important to finish by observing that this project has been an initiative that has stemmed from communities themselves, however the communities could not have achieved what they have achieved *without* the resource provided through the project. Having a paid coordinator post on the island is, in all cases seen as critical – having someone with dedicated time and in a dedicated role means that activities can be taken forward, some of which had been ideas the community had had for a long time, but had been unable to take forward.

> *'having the project has enabled things to develop that we wanted to do but always just fell to the side' – Development Trust representative*

Recognising that communities can effectively support statutory health and care provision, *but* that this requires a level of resource is important – the resource to appoint paid coordinators is one form of essential resource, but the resources of volunteers in the communities, and resources from services who are willing to invest time in supporting island communities is also important. In future planning for community engagement this needs to be taken into account.

Appendix 1: Approach to the evaluation

This report presents the findings of the final project evaluation for the Enhancing Wellbeing in Our Island Communities project. Project evaluation has been undertaken using a theory-based approach to evaluation, which is an approach that is widely used in health and social care, including similar community led projects (see for example, Farmer and Bradley 2012 and Brown, Carrier, Hayden & Jennings, 2017).

Theory based approaches to evaluation seek to understand the theory of change behind a project or an intervention. Evaluation has been built into the project from the beginning, and was initiated by developing a theory of change for the project. The theory of change outlines how an intervention is expected to produce results, and includes consideration of the environmental and contextual conditions as well as the underlying assumptions in a project. Through ongoing evaluation activities, the theory of change has been explored and adapted as assumptions are tested, and effective approaches are identified. Using a theory based approach means that ultimately the adapted final theory of change for a project can provide a clear overview of the components and processes in a project that have supported change.

After developing a theory of change, project evaluation continued through the development of an evaluation framework. The evaluation framework identified a series of evaluation questions (APPENDIX 2), and mapped evaluation activities against these questions. A mid-term evaluation was completed in summer 2019 and the findings used to adapt and guide the final stages of the project.

This final evaluation was completed in early 2020, and was guided by the evaluation plan. Data provided in the report is drawn from four key sources / activities:

- Documentary evidence, including: the project delivery plan, project reports, monthly monitoring forms from each island, applications and proposals written through this project.
- Workshops held on each of the islands with key stakeholders
- Interviews with the coordinators, project manager, and representatives from the development trusts, Highlands and Islands Enterprise, Voluntary Action Orkney and Orkney Health and Care.
- Meetings and interviews with health and social care providers

In addition, the evaluator has maintained a diary relating to the project, including notes from project meetings and other activities that have helped to inform this evaluation.

Appendix 2 evaluation questions

Appropriateness

1. **To what extent was the project design (ie different communities developing their own approaches) suitable for assisting the development of community led services?**
    a. To what extent were the management and reporting arrangements suitable?
    b. To what extent were co-ordinators able to access appropriate support and information to help deliver the project?
    c. To what extent were the design(s) of the island-based program(s) able to meet the needs of older people (65+) in each of the island communities?
    d. To what extent were coordinators able to engage with the whole island community?
    e. To what extent was inter-island collaboration in programme delivery achieved?

Effectiveness

2. **To what extent have older people in the communities benefitted from the project?**
    a. To what extent has the target group: older people (65+) individuals been reached by the project?
    b. To what extent have low income and workless households also been reached by the project?
    c. To what degree are older people better informed of the services that are available to them as a result of the project?
    d. To what degree do older people in island communities have increased access to activities and services designed to enhance health and wellbeing?
    e. To what extent do voluntary and statutory agencies have improved access to communities and individuals?

Efficiency

3. **To what extent was the implementation of the project effective and efficient?**
    a. To what extent has implementation been as intended?
    b. What were the barriers and enablers of the effectiveness of the project?
    c. How did the approaches taken in the different islands different and why?
    d. How far was a collaborative inter-island approach taken?
    e. What are the characteristics of successful community led projects?

Impact

4. **To what degree has the project facilitated the long-term health and social care sustainability of the islands?**
    a. To what degree have partnerships and networks been enhanced in order to facilitate knowledge sharing, avoid duplication and adopt innovative approaches?
    b. To what extent has the pressure on statutory services eased?
    c. To what extent does the community show improved health and wellbeing outcomes?
    d. To what extent do the projects show the potential for further employment / voluntary activities?
    e. To what extent have those involved in delivering the projects experienced additional benefits e.g. health and wellbeing
    f. What other impacts (expected or unexpected) are evident from the project?

Sustainability

5. **To what degree is community confidence, capacity and capability to influence and develop services alone or in partnership been enhanced?**
    a. To what degree did the program develop capacity?
    b. What factors contributed to or prevented the achievement of ongoing benefits?
    c. To what extent can and should the program model be replicated in other settings?
    d. To what extent should or could the small islands of Orkney collaborate to address health and social care needs in the future and in what way?

References

Alexander, R. (2018) *Implementing Community Led Care In the Non-Linked Isles of Orkney.* Voluntary Action Orkney. Available from: http://vaorkney.org.uk/information/orkney-information-hub/1659-research-project-community-led-care-in-orkney

Brown, H.; Carrier, J.; Hayden, C. & Jennings, Y. (2017) *What works in Community Led Support? Findings and lessons from local approaches and solutions for transforming adult social care (and health) services in England, Wales and Scotland. First evaluation report.* NDTI

Farmer J. & Bradley (2012) 'Measuring the value of social organisations as rural service providers' in Farmer, Hill & Munoz (eds) *Community Co-Production: Social Enterprise in Remote and Rural Communities* pp133-158. Edward Elgar: Cheltenham.

HallAitken. (2009). *Orkney Population Change Study: Final Report*.

Healthcare Improvement Scotland (n.d.) *Working with communities to develop a community led approach to health and social care in Orkney.* Available online: https://ihub.scot/media/7003/working-with-communities-in-orkney-case-study-v10.pdf

NDTi (2020) 'Community Led Support: an NDTI programme'. Available online: https://www.ndti.org.uk/our-work/our-projects/community-led-support/cls-in-scotland

OHAC (2019) *Planning for our future: Orkney strategic plan 2019/22.* OHAC. Available from: https://www.orkney.gov.uk/Files/OHAC/IJB/Strategic_Plan_20192022_OHAC.pdf