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Implementing Community Led Care

In the Non-Linked Isles of Orkney

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

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1. Executive Summary

- The Community Led Care Research project was set up as a partnership between Voluntary Action Orkney, Highlands and Islands Enterprise, Robert Gordon University and the island development trusts of Eday, Hoy, Sanday, Shapinsay, Stronsay, Rousay Egilsay and Wyre and the Community Council of Papa Westray.
- The research aimed to answer the question: *How can community led care solutions be implemented in the small island communities of Orkney?*
- The research aimed to produce the following:
    - A literature review
    - A case study of health and social care for older adults in Orkney
    - Individual case studies of each of the island groups involved in the research, focusing on the island assets and priority areas as identified by the communities.
    - Innovation case studies of health and social care in communities elsewhere in the UK and internationally.
    - Recommendations for development of services in the Orkney islands
- The following methods were utilised: a desk based literature review, meetings with key service providers and stakeholders in Orkney, and research visits to each of the isles. A workshop (based on nominative group technique) was held in each island group, alongside interviews with individuals who had experience of care as service users or providers, and informal meetings with other members of the community.

Background

- Following the Christie report (2011) there is a strong policy impetus for communities and statutory providers to collaborate in the design and delivery of health and social care services. The term 'co-production' is often used to describe this process.
- Personalisation and choice are key drivers in the current health and social care landscape, and the introduction of the Social Care (Self-Directed Support) (Scotland) Act 2013 has allowed individuals greater choice and flexibility in how their care needs are met.
- Home Care services nationally are experiencing challenges in terms of recruitment and retention of staff. Issues of low pay and low status also affect the sector. Regulations are coming into effect that require individuals employed by a care service delivering personal care to be qualified at SVQ2.

Health and Care in Orkney

- Orkney's Integration Joint Board (Orkney Health and Care) is responsible for health and care services within Orkney.
- Orkney like other communities, is facing a critical issue in terms of budget pressures on statutory services and an ageing population.

- Alongside home care, wider health and social care provision can impact on individuals' ability to remain in their own home. In Orkney, services available on the isles differ from services available on the mainland – for example there are no care homes, and extra care housing (a form of housing which includes provision of personal and domestic care) is limited to Westray. In addition, the intermediate care team, the mobile responders, and formal night support services offered through home care are all unavailable on the non-linked isles.
- Home-care in Orkney is a service that has received a great deal of scrutiny. With the vast majority of home care services still provided by the council, diversifying the range of service providers has been a key objective. In addition, capacity of home care services is a particular issue in smaller outlying communities.
- Under the Public Bodies (Joint Working) (Scotland) Act 2014 Orkney Health and Care is required to identify localities to assist with strategic planning. One of the localities identified is the Isles. Despite a recent consultation taken forward jointly with Community Planning, locality working is still to be properly established in Orkney.

Communities and Health and Social Care delivery

- Co-production is an approach whereby communities and individuals are jointly involved in the design and delivery of health and social care services.
- Co-production is challenging, but has a number of benefits in terms of developing service efficiencies and increasing the ownership of, and engagement with, services.
- Recent work in Orkney has frequently identified the need for closer working with communities, and particularly the diversification of health and social care services to include community run and voluntary sector services.

Innovation examples

- With Joint Integration Boards across the country facing significant financial pressure alongside agendas around personalisation of care and co-production, there are a wide range of examples of innovation in health and social care provision for older people in Scotland.
- Innovations may be specific to health and social care services, may include community-agency partnerships, or be entirely community led. In addition, some innovations have sought to more effectively link community and statutory services.
- Innovations specific to health and social care include examples of:
    - Wholescale service redesign following models such as Nuka[1] and Buurtzorg[2]
    - Innovations in roles – such as the development of a generic worker
    - Innovations in services – such as GP beds and step up / step down facilities

  A number of these innovations have been trialled in Orkney.

- Innovations involving community partnerships with statutory authorities or care agencies include:

[1] https://scfnuka.com/
[2] https://www.buurtzorg.com/

    - Community run day care services, run in partnership with statutory organisations
    - Partnerships between care agencies and communities in the delivery of homecare services

  There is some precedent for these innovations in Orkney, with Papa Westray developing a model of home care in partnership with Crossroads, and Rousay in partnership with AgeScotland Orkney.

- Innovations in community led services include:
    - A wide range of examples of communities developing initiatives in areas of care and support which are less highly regulated than personal care. These include community transport schemes, lunch clubs, befriending and handyman services.
    - Innovations in supported housing which utilise peer support and informal support in co-housing or homesharing options.

  Again, there is some precedent in the isles for the first of these options with many running community transport schemes and lunch clubs.

- Innovations in community connections include:
    - Community Link workers – who provide information to health and social care service users about community services that may be beneficial
    - Local area coordination – which is a service that provides information and signposting to individuals about available community led services

Research findings

- The primary research in this project took the form of workshops and interviews with residents from across the seven island groups.
- Previous research in Hoy had identified that running a community led home care service would be very costly (Smith, 2014), but along with research in Eday (Mackay, 2016) identified the possibility for communities to support delivery of wider support services for older adults. Recent research by Brinkhorst and Siderfin (2018) identified the resilience of older residents on the outer isles, but also identified issues around accessibility of home care services, and some challenges with aspects of island living such as transportation around the islands, and off the islands.
- This research project identified a high level of consistency around each individual island's priorities and assets for supporting older people in their communities. Key assets included a caring community, social events (including lunch clubs), primary healthcare and emergency healthcare and community transport. Key priorities included increased availability of home care, availability of extra-care housing, infrastructure improvements (including broadband and transportation around and off the islands), availability of home-help, and additional activities around social inclusion.

- Thematic analysis of the interview and workshop data identified two key themes: the role of the community, and doing things differently. Within each were four sub themes.
- Within the community theme the four sub themes were:
    - Informal community led provision: recognising the amount of provision that was of an informal and purely 'neighbourly' nature
    - Isolation and deprivation: recognising that not everyone in the community was equally integrated into the community and there were individuals who experienced a high degree of isolation, or experienced poverty and deprivation in the islands.
    - Reluctance to access services: recognising that asking for help was difficult for many islanders, with challenges in terms of understanding what services were available, and issues of pride in accessing these services, as well as challenges around confidentiality.
    - Personalised care: recognising that professional care relationships were highly personalised, which both results in a generally high standard of care, and some challenges in terms of access to care. For professionals there are also some challenges in managing personal and professional boundaries.
- Within the theme 'doing things differently' were the sub themes:
    - Understanding true costs: recognising that the costs of providing care in island settings may be different to mainland settings. Questions surrounded understanding relative costs of innovations such as respite facilities considering potential savings in, for example, emergency medical evacuations.
    - Understanding wider community costs and benefits: recognising that some care services are underpinned by wider infrastructure such as housing, broadband and transport, so that innovations in these areas may impact on cost savings in health and care. Similarly recognising that innovations that may require expenditure such as care facilities, or care staff may involve wider community benefit in terms of population sustainability and sustainability of other services.
    - Context-sensitive developments: recognising that each island is different, and that the specific context of an island needs to be considered when considering service developments.
    - Rules, regulations and risk: recognising that rules and regulations may be a barrier to service delivery and innovation in small island communities, but that equally operating outside of rules and regulations in itself constitutes a risk.

Discussion

- The research suggests that there is scope for communities, third sector and statutory organisations to work more closely together in Orkney.
- Specifically, it is identified that community led innovations in delivery of care are challenging unless there is a partnership with an established care provider.

- An opportunity to develop a model of community partnership with care providers is identified in Orkney.
- Community led innovations in other areas including extending community transport schemes, befriending or home visits, and home help are identified as of possible significant benefit to the island communities.
- Increasing the information and advice available to islanders is also identified as valuable.
- Although the communities can take forward some community led innovations themselves, for the full benefits to be realised of community partnerships with care providers, or community led innovations, further engagement with statutory organisations is necessary.
- The benefits of closer partnership working between statutory providers and communities are identified.

Recommendations

- The report makes 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.

2. Context and methodology

The community led care project was set up following a series of meetings held between the Development Trusts from the island communities of Orkney, and facilitated by HIE. Through these meetings the care and support of older people was identified as a core concern for all the island communities. Meetings were held with key local stakeholders to explore options, and Highland Home Carers were invited to Orkney to present their innovative model to the development trusts, Orkney Health and Care and other stakeholders.

In order to build on these activities a bid was made to the Aspiring Communities Fund for a research project to fully scope and explore the options for community led solutions to care in the non-linked isles of Orkney. Seven island groups were identified as partners in the project (Rousay, Egilsay and Wyre; Shapinsay; Stronsay; Eday; Hoy; Papa Westray; Sanday) along with Highlands and Islands Enterprise (HIE) and Voluntary Action Orkney (VAO). Robert Gordon University were also named partners, providing academic support for the project. Interest in the project was identified from a number of the other island communities in Orkney, and from the core care providers within Orkney including Orkney Health and Care, AgeScotland Orkney and Crossroads all of whom freely offered support with the project.

The project took place from November 2017 until March 2018, and aimed to answer the following research question:

How can community led care solutions be implemented in the small island communities of Orkney?

The research utilised a case study design (Yin, 1984; Gillham, 2010), an approach which is particularly appropriate in Health Policy and Systems Research because health policy and systems are "often embedded in contextual factors that must themselves become part of the focus of inquiry" (Gilson, 2012:161). Implementing the case study design, the project identified the 'case' as being both Orkney as a whole, and each individual island group also being a case in its own right. This allowed for a combination of an instrumental design (treating Orkney as a single case), and a collective design (with each individual island being a separate case, allowing for an element of comparison to be built in).

The project involved the following elements:

1. Identification of the key national and policy landscape surrounding health and care
2. Development of a case study of health and care services in Orkney
3. Identification of examples of innovative practice from other remote and rural communities in the UK and internationally.
4. Identification of existing assets and priority areas for the care and support of older people in each individual island group involved in the project
5. Consideration of possible developments suitable for the non-linked isles of Orkney.

The rest of this report is structured around the findings from each of these elements.

3. The landscape of Health and Care

In this first section of the report, the results of a literature review into the policy and practice landscape of health and care in Scotland is given.

3.1 Key Policy Drivers in Health and Care

In recent years health and social care services for older adults have been coming under increasing pressure from the joint impact of an ageing population and increasing financial pressures. In response to these pressures the 2011 Christie report identified the need for radical change in the delivery of public services. The report emphasised the need for individuals and communities to be involved in the design and delivery of services; the value of preventative interventions; and the importance of supporting self-reliance and resilience of communities and individuals. In 2017 the Chief Medical Officer's report into realistic medicine similarly called for personalised approaches to medical care, involving shared decision making and reducing unnecessary treatments for patients (Scottish Government, 2017a, 2018). More recently a focus on the role of the wider community and social integration in mental and physical health has again been introduced through the Scottish Government's consultation on tackling social isolation and loneliness (Scottish Government, 2018). Subsequent to the Christie report, the Scottish Government implemented a range of legislation to stimulate reform, some of which is summarised below.

The Public Bodies (Joint Working) (Scotland) Act 2014 required the integration of 'the governance planning and resourcing of adult social care services, adult primary care and community health services and some hospital services' (AuditScotland, 2015: 13). Jointly planning and resourcing services is important for increasing efficiencies in the care and support of individuals – in theory allowing for budgets to be reallocated to community based services and away from more intensive and costly residential and hospital based services. There are two main approaches to integration - the 'body corporate or Integration Joint board model' whereby NHS boards and councils delegate health and social care functions to an integration joint board, or a 'lead agency model' where by 'NHS boards and councils delegate some of their functions to each other' (*ibid*: 14). Although NHS Orkney and Orkney Islands Council Orkney had originally favoured a lead agency model for Orkney, challenges with agreeing the model meant that in common with the majority of other areas in Scotland, Orkney adopted an Integration Joint Board model (Care Inspectorate and Healthcare improvement Scotland, 2017: 13). Partly because of challenges with developing lead agency models, Highland region have been the only region in Scotland to follow a Lead Agency model, with the NHS taking on the lead for adult health and care services and Highland Council being responsible for children's community health and social care services.

Within the legislation, each integration joint board is required to establish a strategic planning group. This group acts as an advisory group, receiving information, considering service planning and making recommendations. This group involves service users, health and social care professionals, third sector representatives and others. There is also a requirement to divide their area into at least two localities, with a representative from each

locality expected to be part of the strategic planning group. In Orkney the localities identified are the mainland, and the isles. In addition, there is a requirement for integration authorities to include service user representatives and unpaid carer members on their boards, and for consultation to be a part of developing the strategic and locality plans. Although there has been a great deal of support for the ethos and principles of the legislation, the Audit Commission identified challenges particularly around governance arrangements, and workforce issues, which have resulted in delays to fully realising the implications of the legislation (AuditScotland, 2015).

The Community Empowerment (Scotland) Act 2014 was designed to support and enhance approaches to community planning. This legislation identified 'all the public authorities which take part in community planning and place new duties on them' (Scottish Government, 2017b). Local Community Planning Partnerships (CPP) and are required to produce a local outcomes improvement plan (LOIP) which are expected to focus on tackling inequalities. They must also produce locality plans for 'areas experiencing particular disadvantage' (*ibid*), and in Orkney one of the localities chosen is the isles. The act also outlines the right of community bodies to request to participate in decisions and processes about delivery of public services; the rights of communities to buy land; and the right to asset transfer requests.

The final significant piece of legislation has been the Social Care (Self-directed Support) (Scotland) Act 2013 which was designed to help individuals have more control and choice over their social care provision. 'Social care' broadly defined includes care services provided in the community, this may include day care services, home care services, and accessing aids and adaptations. Access to statutory social care services is through an assessment carried out by a care professional, often a social worker.

Eligibility for services is determined in accordance with Scottish Government eligibility criteria, with four categories being established: critical risk, substantial risk, moderate risk and low risk. People assessed as at critical or substantial risk should be provided with services within six weeks of confirmation of need. If a person doesn't meet the eligibility criteria the authority should inform the individual about where else they can find help from organisations, voluntary groups and the community (Scottish Government, 2017).

The Self Directed Support legislation emphasised four fundamental principles in the delivery of social care: participation and dignity, involvement, informed choice and collaboration. The act enables individuals who are assessed as needing social care to choose between one of four options in how this care is provided:

1- The individual or carer chooses and arranges the support and manages the budget as a direct payment.
2- The individual chooses the support and the authority or other organisation arranges the chosen support and manages the budget.
3- The authority chooses and arranges the support
4- A mixture of options 1, 2 and 3. (Taken from AuditScotland, 2017)

In effect the legislation allows an individual to receive funds to arrange their own care through a direct payment, or to allow a third sector or private sector company to be given funds to arrange services on their behalf. The use of direct payments or third and private sector companies often allows more flexibility in care provision, with these companies often offering additional services on a paid or voluntary basis that individuals can use to 'top up' their statutory provision. However, even with services provided through Option 3, the legislation emphasises that the assessment and provision of care 'should be provided flexibly and be personalised around the individual, making use of natural networks with support focused on specific goals and personal outcomes' (Scottish Government, 2014: 6) In effect this means that social care assessments should cover a range of services provided through the statutory, third, and private sectors, as well as community based provision and family support.

As with the other legislation there have been challenges with the implementation of self-directed support. In particular it has been noted that 'changes to the types of [social care] services available have been slow' and 'people using social care services and their carers need better information and help to understand SDS and make their choices' (AuditScotland 2017: 5). In addition, it has been noted that despite the ethos of increasing choice and flexibility, in some cases 'local authorities' approaches to commissioning can have the effect of restricting how much choice and control people may have'. In particular the report notes that 'the choices people have under option 2 are very different from one area to another' (*ibid:* 5), and further that in rural and remote locations there may be a lack of choice (*ibid:* 11)

3.2 Home Care

A key component of social care provision is home care. Home care is defined as 'care provided in your own home to help you keep your independence' (Careinfoscotland, 2018). It may include things like personal care, general housework and gardening, shopping, meals on wheels, paying bills, collecting pensions or prescriptions, laundry, equipment and adaptations, and reablement.

Although originally home care services had a wide scope and were focused on preventative interventions, as budgets have changed services have become more focused on personal care and some aspects of medical care (such as assisting with medication). Services have become focused on 'time and task' delivery, and tend to be planned and scheduled accordingly, despite being focused on an 'extremely complex set of activities' (Scottish Care, 2017). In addition, despite home-care tasks becoming more complex and skilled, home care retains a low status as a profession and low levels of pay and this, alongside antisocial hours, has resulted in ongoing challenges in recruiting and retaining staff.

As a result, Scottish Care has called for new models of care which recognise both the value and contribution of home care services, and their potential in terms of preventative and innovative services (Scottish Care, 2017). In particular moving away from time and task commissioning to outcomes commissioning is identified as a priority. Alongside this, the

professionalisation of the workforce is identified as important, with the workforce having better access to training, being better regarded and also receiving higher levels of pay.

The Scottish Government have also been involved in making changes to the home care sector. In particular a requirement for all support workers in care at home services to be registered with the Scottish Social Services Council and to achieve an SVQ2 within five years of registration has been introduced (Scottish Government, 2017c). This introduction is in part a recognition of the increasing complexity of home care tasks, and the need for staff to be appropriately skilled and qualified, but is also a response to issues of recruitment. Increasing skills and training, and improving career pathways in care are identified as ways of making careers in care more attractive to individuals. Alongside a requirement for individual members of staff to be registered with the SSSC, care services are also required to register with the Care Inspectorate and meet the requirements of the National Care Standards (Care Inspectorate, 2017).

It is notable however that this legislation requiring registration of both services and staff does not apply to individuals who are privately recruited by another individual to meet their care needs through the use of direct payments under the self directed support legislation option 1.

4. Health and Care in Orkney

Having considered the policy landscape surrounding health and care in Scotland this part of the report will outline the health and care landscape in Orkney.

4.1 Orkney context

Orkney is an archipelago consisting of approximately 70 islands of which 20 are inhabited, located approximately 16km off the north coast of Scotland. The population in the 2011 census was 21,349 – which was an increase of 10.9% from 2001 (HIE, 2014). Approximately 80% of the population lives on the Orkney mainland, and 20% in the other islands (HIE, 2018). The population of the outer islands ranges from approximately 600 down to islands with less than ten people. The delivery of health and social care services therefore has to take account of a complex distribution of population, dispersed across non-linked islands reliant on ferry and air transport to connect them to the Orkney mainland.

The administrative centre of Orkney is Kirkwall with a population of approximately 9,000, approximately 40% of the total population of Orkney. Orkney 'appears to be experiencing a centralisation of its population towards the larger settlements' (HallAitken, 2009: 20). The fact that the majority of services are based in Kirkwall has been identified as one of the factors in drawing individuals from the outlying regions to the town (*ibid).* And indeed, in terms of health and care, the town is the location for the island's hospital (the Balfour hospital), and the administrative centre for Orkney Islands Council. The main provider of Further and Higher Education in Orkney, and the provider for SVQs in Health and Social Care is Orkney College, and this is also based in Kirkwall.

The largest employment sector is public administration, health and education which in 2008 accounted for 36% of jobs (HIE, 2018). Compared with the Highlands and Islands and Scotland as a whole, unemployment rates are lower and proportionally more of the population are self-employed or working part time. Orkney has marginally more adults with no formal qualifications and marginally more with graduate level qualifications than the Scottish average (HIE, 2014*)*. The employment context of the island potentially poses a challenge for recruitment of health and social care staff, given the relatively high levels of employment and small pool of potential employees. However, as health and care is a very significant employer in the islands, health and care may be perceived as stable careers (with ongoing high levels of demand) and could be potentially be made more attractive if progress is made nationally with issues such as pay levels, and improving training and progression routes for staff.

4.2 Health and Care Priorities in Orkney

In Orkney, Orkney Health and Care (OHAC) are the local Integration Joint board (IJB), comprising of members from NHS Orkney and Orkney Islands Council and established in 2016. The challenges facing the Orkney IJB mirror the challenges faced in other areas: increasing financial pressures, and an ageing population. However, in Orkney issues of an

increasing older population and a reducing working age population are particularly acute, with the islands having a higher dependency ratio[3] than Scotland as a whole (OHAC, 2016).

OHAC's strategic priorities are considered within a strategic needs assessment, which uses national and local data to examine socio economic issues, lifestyle and risk factors (e.g. smoking and alcohol), health care, acute care and social care (*ibid*). Examining future need, the rising numbers of older people are projected to lead to an increase in 'some conditions such as sensory impairments, mental ill-health, hypertension, asthma, diabetes, dementia and multiple chronic disorders' (*ibid:* 77). A significant projected rise in dementia is noted. In common with other geographical locations, it is noted that issues of multiple morbidities can mean that a relatively small number of individuals are consuming a high proportion of services.

Alongside healthcare the strategic needs assessment also notes specific challenges around housing, housing deprivation and fuel poverty, which are particularly acute on the non-linked isles. The needs assessment identifies a projected rise in elderly single person occupancy households and 'increasing numbers of older people in unsuitable accommodation' (*ibid*: 34). In addition, care home places for people over 65 per thousand of the population are noted as lower than in Scotland as a whole (at 24 per thousand in Orkney, and 39 per thousand in Scotland) (*ibid,* 90)

Building on the Strategic Needs Assessment, the Strategic Commissioning Plan and refreshed plan identify specific developments the IJB wish to see. The refreshed plan outlines elements such as: 'increase[d] capacity in both care at home services and residential care homes', 'help people to be able to remain at home to receive care for as long as is possible' (OHAC, 2017: 5). Specifically issues of care home places are addressed through two new care home build projects, one in Kirkwall and one in Stromness.

4.3 Health and Care Provision for Older People

A wide range of health and care services are available to older people in Orkney. These comprise of GP and nursing services, and home care services, but also intermediate care, telecare, respite services, frozen meals, community occupational therapy, physiotherapy, and residential care. When considering the journey of an older person through health and care services, it is likely that they will utilise a range of different services at different times, and that the way services function together will be critical to an individual's ability to remain in their own home.

A list of some key health and care services relevant to the support of older people in Orkney has been compiled and is given in Appendix 1. This list combines provision from statutory authorities as well as some community and voluntary provision, it is not exhaustive but offers an indication of some of the services available. Considering the non-linked isles particularly, there are a number of notable points.

Firstly, GP services vary between islands – with some islands having resident GPs, some having GPs who operate a rota system (and when they're off duty are generally not resident

[3] The dependency ratio is a statistic measuring the retired population as a proportion of the working population

on the isles), some only having visiting GPs, with Nurse Practitioners (some of whom are resident) offering services on the island for the rest of the time.

Secondly, the provision of hospital care and residential care is only available on the Mainland of Orkney. The Balfour Hospital is based in Kirkwall, with additional specialist services provided primarily in Aberdeen through NHS Grampian, including Aberdeen Royal Infirmary (ARI), Woodend and the Royal Cornhill hospitals. Residential care facilities are available in Stromness, Kirkwall and Dounby. Extra Care Housing[4] (also known as Very Sheltered Housing) is available on Westray (one of the north isles of Orkney) through Kalisgarth, but otherwise is also provided on the mainland only. Respite facilities are offered through mainland facilities and Kalisgarth.

Thirdly it is notable that even considering the wider health and social care services, there are a number that operate on the mainland only. These include the mobile community responder team, the intermediate care team, and night support through home care. Physiotherapy, optician and dental surgeries are also mainland based. In addition, some voluntary services such as transport provided through dial-a-bus also operate on the mainland only. Other services will travel to the isles where necessary but do not have a base on the isles (e.g. chiropody, occupational therapy and social work). Because of the time and cost of getting to the isles, visiting services may not be as readily accessed on the isles, and may require a visit to the mainland.

4.3.1 Home Care Services

Although the broad landscape of health and social care will be important in assisting individuals to remain in their own home, of particular concern may be the availability of home care services. Home care services in Orkney have received a great deal of attention. In the Strategic Needs Assessment it is noted that in Orkney the cost of providing home-care (per hour) is higher than in the rest of Scotland (OHAC, 2016). And one factor influencing this is that in Orkney the majority of home care is still provided through the local authority - which has terms and conditions are more favourable than those offered by many private providers (*ibid,* 97*)*. Although costs of service provision are higher, the OHAC joint strategic needs assessment also notes that satisfaction with home care is also higher in Orkney than in Scotland as a whole (*ibid*).

Despite the high costs per hour of home care in Orkney, a report commissioned in 2017 identified that overall the expenditure per capita on care for those aged 65+ in Orkney was the lowest in Scotland in 2015, and indeed at £45 was almost half the Scottish average of £88 (Davidson, 2017). As a result of his report Davidson argued that rapidly increasing home care demand required further investment into the service, as well as continuing to focus on efficiency measures – including supporting community based activity, providing effective support for carers, the application of reablement and telecare initiatives, and effective care management.

[4] Extra care housing is usually provided via a series of self contained bungalows or flats. It 'provides similar facilities and accommodation to sheltered housing but also offers help with personal care and household chores. This is usually provided by on-site care workers' (IndependentAge, 2018:8)

Within the Self Directed Support legislation, in lieu of services provided by the Council, individuals can choose to receive a direct payment in order to arrange their own care and employ their own personal assistants. In Orkney the Independent Living support service[5] is run through Crossroads Orkney and receives funding from the Council to provide information and support for people who wish to employ their own carers. In common with other rural and remote areas another significant feature of care provision in Orkney is the very high level of direct payments. Indeed, Orkney has the highest number of direct payments per 100,000 of the population than all other local authority areas (Audit Scotland, 2017). Although following the Self Directed Support legislation direct payments should enable individuals to have more choice over how their health and social care needs are met, in small rural and remote communities the high level of direct payments may instead reflect the fact that 'the authority cannot provide the services they need' (Audit Scotland, 2017:16). In Orkney direct payments may indeed be being used in such circumstances where services are not available due to geography (e.g. lack of day care facilities in the non-linked isles) or where existing services are operating at capacity (e.g. a lack of capacity in council provided home care services).

Issues of capacity with home care services in Orkney were also identified as an issue in the Joint Inspection of Services for Older People, who noted that lack of availability of home care was a factor in some cases of delayed discharge from hospital (Care Inspectorate and Healthcare improvement Scotland, 2017). The report noted that there is a need to attract other home care providers to the Orkney market in order to meet growing demand on services. In addition to meeting demand the report also concludes that OHAC 'was likely to struggle to be able to offer personalised support unless new models of care were identified' (*ibid:* 35). Responding to the importance of enabling greater capacity, efficiency, and choice, OHAC has been 'keen to explore commissioning alternative providers'. However, rather than commissioning providers from elsewhere in Scotland the council is planning 'to do this in an incremental way and using service providers who already had an established connection and positive reputation in Orkney' (*ibid: 39*). In addition to address the specific challenges of delivery of care in the isles, it is noted that 'early discussions were taking place to explore the setting up of social enterprises on the islands to develop and deliver self-directed support options' and that 'this approach would be important for meeting the needs of older people, especially those with complex needs on the outer isles' (*ibid*: 36)

Recently some diversification of care services has happened in Orkney through the extension of Crossroads and AgeScotland Orkney services. Crossroads who primarily provide care services for respite purposes have extended their model to provide care services to individuals more generally who are assessed as requiring these services. AgeScotland Orkney have primarily provided home help services through their 'Here to Help' service, but are in the process of launching a new 'Here to Care' service which will provide personal care. In both cases individuals accessing these organisations can secure funding through Option 2 of the Social Care (Self-directed Support) (Scotland) Act 2013 if they are assessed as needing support. In addition, currently Orkney Islands Council spot purchases some services from Crossroads, such as showering, which can enable more efficient scheduling of council based services (Davidson, 2017).

[5] http://www.crossroadsorkney.co.uk/pg/ilp.html

Although Orkney is seeing some diversification in care providers, key challenges remain, particularly in the recruitment and retention of home care staff. The recent inspection of the Orkney Islands Council home care service identified high staff turnover as a concern noting that this has been a 'recurring theme arising from recent inspections of the service' (Care Inspectorate, 2017: 4). Reviewing recruitment and induction processes are recommended in the inspection report. In addition, in Orkney there has been recent discussion of producing marketing materials to promote home care as a career.

Anecdotally, it appears that recruitment and retention of home care staff is a particular problem on the non-linked isles of Orkney. In addition, there are further specific challenges in the provision of services in the smaller isles in terms of workforce management. These include the same individuals working for multiple agencies, as well as potentially also offering care services independently (which can lead to an overestimation of care services, and reduced resilience of services). A further challenge identified in the Joint Inspection is the supervision of staff, where dispersed staffing has resulted in 'less formal arrangements' which are 'less robust' (Care Inspectorate and Healthcare improvement Scotland, 2017). Additional challenges that could be anticipated would be around the management of boundaries, which has been noted as an issue other professionals may face in Orkney, including social workers (Walker, 2011).

Considering the management of some of these issues, an example of good practice identified by the Joint Inspection is the Isles Network of Care in Orkney which explicitly aimed to address some of the challenges of staff recruitment and retention, and the challenges of professional development and support. The network offers shared clinical governance arrangements and professional development through regular videoconference meetings. The documentation surrounding the network also makes it clear that communities are expected to respect the rights of medical staff to time off when they are not on call – a suggestion that implies that there may be challenges to maintaining professional boundaries on the smaller islands of Orkney (NHS Orkney, 2009).

4.4 Locality planning

In line with the integration legislation, Orkney Health and Care has been required to identify at least two localities. In Orkney the localities identified are the isles and the mainland (with East and West sub categories) (OHAC, 2017). The establishment of an isles locality is explicitly identified as "in recognition that the services available on the Mainland cannot always be replicated on the Isles and that different ways of working and solutions are often required." (OHAC, 2016: 16). The purposes of localities is to move away from top-down planning, with each locality expected to develop a plan which feeds into the wider strategic plans of the IJB. Localities should 'help ensure that the benefits of better integration improve health and wellbeing outcomes by providing a forum for professionals, communities and individuals to inform service redesign and improvement' (Scottish Government, 2015: 6).

Despite the importance of recognising the specific context provided by the isles in terms of health and care, in Orkney locality planning has taken some time to establish and in the

April 2017 Joint Inspection it was noted that "the partnership was still in the early stages of its work to develop approaches to planning on a locality basis". (Care Inspectorate and Healthcare improvement Scotland, 2017: 8) In particular, the need for improved data to support locality planning was identified.

4.4.1 Locality consultations: the place standard tool

Central to the approach to locality based planning so far has been establishing a link with the Community Planning Partnership, who are also required to identify localities as part of the community planning process, and who have also identified the isles as one of their localities. In particular a joint consultation took place with the isles in Winter 2016. The guidance for Integration Joint Boards (IJB) on locality planning, specifically notes that 'some locality arrangements already exist under community planning [and] it will be important that localities for integration build upon and take account of such arrangements, and create effective relationships between CPPs and Integration Authorities' (Scottish Government, 2015: 7). In this respect the joint consultation undertaken in Orkney represents an example of good practice.

The joint consultation comprised of a survey based on the Place Standard Tool and was followed up with engagement visits to each of the islands. Joining together the IJB consultation with the community planning consultation through the place standard tool was designed to reduce survey fatigue, and the events in each island were also used by Voluntary Action Orkney to assist with facilitation of a participatory budgeting exercise.

The Place Standard Tool is a national tool developed by the NHS Health Scotland, the Scottish Government and Architecture and Design Scotland (Health Scotland, 2018). The tool provides a standardised approach to thinking about places, and although not directly addressing health, the tool is specifically designed to have a role in healthcare, recognising that 'the quality and design of places has been shown to significantly influence the ability of individuals and communities to live in healthy, sustainable ways' (Place Standard, 2018).

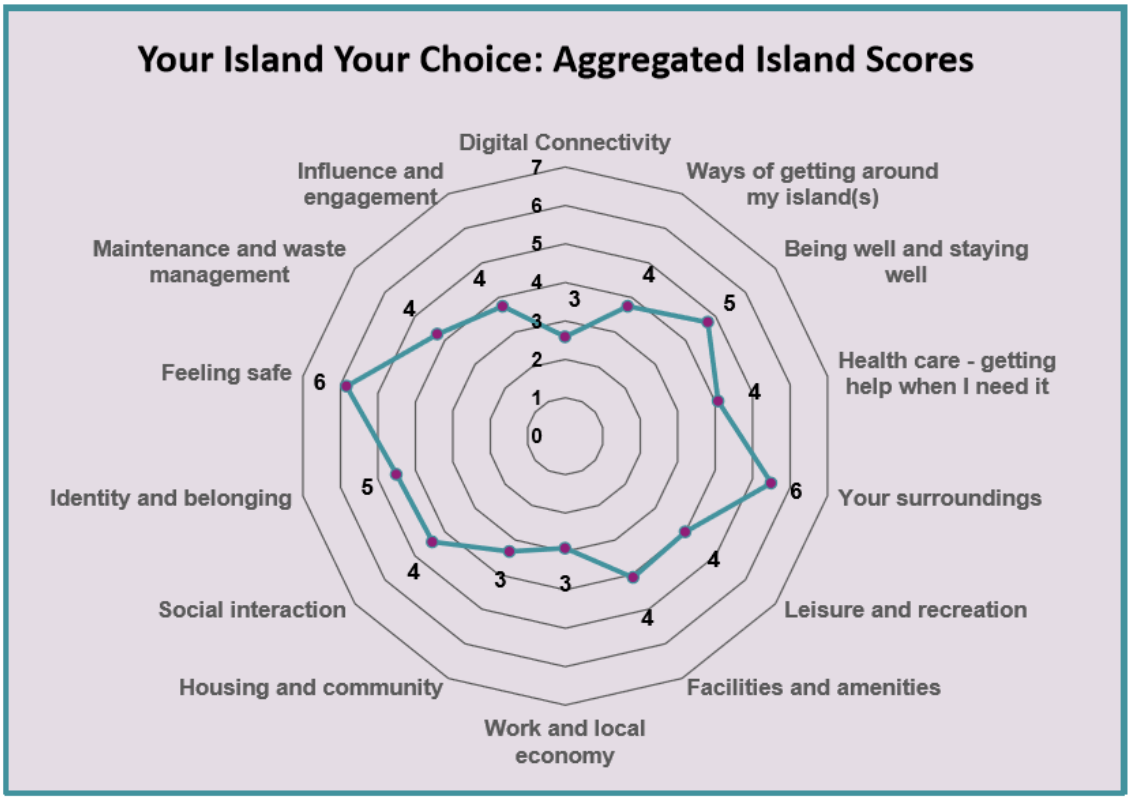
However, in the consultation exercise in Orkney the place standard model was adapted with two additional elements added with a direct reference to health and care – being well and staying well and health care. In addition, some elements less relevant to the island communities (for example 'traffic and parking') were removed. Scores were gathered for each island community, and were also aggregated to give an overall score for all the non-linked isles.

Ranking these aggregated scores, five fell below the mid-point of a score of 3.5 and were therefore adopted as Community Planning priorities: Digital connectivity, Work and local economy, Housing and community, Influence and engagement, Ways of getting around my island(s) (Fig.1).

The two elements added to the Place Standard Tool on health and social care were: 'being well and staying well' and 'health care – getting help when I need it'. The aggregated figures for the islands identified that being well and staying well scored 5 and Health care scored 4. With some other elements scoring lower than 3.5 these two elements were not identified as priorities for community planning. Despite this, the data from these elements – which

comprised an island 'score' on each element, as well as qualitative data - has been used in the IJB locality planning process. In December 2017 a summary paper was presented to the IJB which included only the data from these two elements, by each island group, with the overall scores and the qualitative data from each island group.

Figure 1: Aggregate results of the Place Standard consultation



(Reproduced from: The Orkney Partnership 2017: 23)

It is notable that the data presented to the IJB focused purely on the health and social care elements that had been added to the place standard tool, and not the wider results of the consultation. This may have limited the usefulness of the tool for considering wider issues of place in health and social care (which was one of the original purposes of the tool). Indeed, although issues of housing are identified within OHAC's Strategic Needs Assessment consideration of other elements of place and infrastructure are notably absent – particularly transport and broadband coverage both of which have a clear impact on health care provision. Indeed, The Joint Inspection identified issues of transport and noted concerns that the dial-a-bus service was being cut, and as a result specifically recommend that the next review of community transport 'included a focus on the importance of transport in maintaining older people's health and wellbeing' (Care Inspectorate and Healthcare improvement Scotland, 2017: 23). In terms of the isles locality, transport accessibility could be an even more pressing concern, with dial-a-bus operating on the mainland only, and where access to health care frequently means travelling off island on planes or boat services. Similarly, digital connectivity, which is identified as a key priority in the results of the Place Standard for the isles, may impact on the availability of telecare (e.g. a personal alarm), and the accessibility of medical services via tele-conference. It is also notable that

although the strategic needs assessment identifies housing as an issue, this is predominantly due to the impacts of poor housing on health (e.g. cold or damp housing), rather than the wider role of housing development in terms of community sustainability and more indirectly health and social care. This wider role for housing has been identified in other research, in particular The Orkney Population Change Study which stated:

> "The populations on several of the Outer Isles are ageing rapidly and this will require both accommodation and associated health and social care to meet these needs. Planning for residential and supported accommodation in the Outer Isles will also contribute to wider socio-economic objectives by providing more job opportunities and allowing elderly people (and their carers) to remain in their own communities for as along [sic] as possible" (HallAitken, 2009: 10)

Following the consultation and visits it was concluded that 'whilst some issues were prevalent across the isles and Mainland, the isles communities had specific, sometimes unique, issues that could only be addressed on an island-by-island basis' (OHAC, 2017b: 2) In addition the findings 'prompted a review of the adopted locality planning strategy' and it was proposed that 'rather than undertaking further meetings with communities to discuss the findings, specific solutions should be proposed to the issues raised and should be disseminated via the local GP surgery and community council'. It is notable that rather than further discussion the approach proposed is one which responds to individual comments on the consultation. In addition, a revised ongoing approach to community engagement is proposed with 'continuing input and engagement… encouraged via the local GP surgery and community council. This approach acknowledges the role of the GP surgeries and community councils as community leaders and deploys their local knowledge of how best to engage with the island / parish.' (*ibid*). In addition, further opportunities for public engagement and discussion were proposed through regular visits to the isles by health and social care staff. It is unclear from the paper how this approach to engagement will inform locality planning in the future, and it is also noted that 'capacity challenges…. have delayed implementation of the revised strategy' (*ibid)*.

In order to maximise the use of existing data sources, utilising the data from the Place Standard consultation exercise for the seven islands in this research project the research team have conducted some preliminary data analysis (shown in Appendix 2). This preliminary analysis identified four themes under Being Well and Staying Well: Health care provision, healthy living (information, leisure and fitness, healthy eating), fragile communities and sustainability, and lifestyle and the role of the community. Four themes were also identified under health and care: Medical care (mental health, general health, emergencies), specialist healthcare provision, ageing communities, and island culture and infrastructure.

5. Communities and Health and Social Care Delivery

The importance of community engagement in terms of planning of service delivery (through locality plans) is embedded in the policy context for Scottish health and care. However, the role of communities is not just important for service planning, but also potentially for service delivery. In their report *Changing Models of Health and Social Care,* the audit commission reports that current models of care are unsustainable, and that the 'transformational change' required is simply not happening (or happening fast enough) (Audit Scotland, 2016a: 26). Community involvement is identified central to this 'transformational change', but it is clear that integration authorities could and should do more to facilitate change including focusing on funding community-based models (Audit Scotland, 2016a*:* 34). In this section the drive to community co-production of health and social care services will be explored, followed by consideration of community involvement in Orkney.

5.1 Community co-production

Core to the 'transformational change' that is necessary in the provision of health and social care, is the importance of engaging communities both in service *design* and *delivery*. In terms of service design, better usage of local data and intelligence can assist with identifying appropriate innovations; in terms of delivery, community resources and third sector delivery can provide mechanisms for more cost effective and flexible services (Audit Scotland, 2016a). In addition, community engagement is closely aligned with moves towards greater personalisation in service delivery, recognising the value of an individual's personal and informal support network, and community resources (Christie, 2011). Involving communities and individuals in the design and delivery of health and social care services is often termed 'co-production'.

In practice co-production is interpreted in diverse ways by different people, with a 'spectrum' of initiatives ranging from statutory providers simply engaging with service users and communities for feedback and opinions, through to statutory providers engaging more fully with service users and communities in a process of co-designing and co-delivering of services (Munoz, 2014: 9). Effective co-production of services has been identified as having benefits in terms of greater efficiency of service provision - with services more fully designed to meet the actual needs of communities and individuals, and delivered by a range of organisations including third sector and social enterprises alongside statutory providers. As well as improving efficiency co-production has been associated with multiple additional benefits including better health outcomes, patient satisfaction and service innovation (Palumbo, 2015).

However, while the potential of co-production is identified, in practice co-production can be challenging, particularly where communities may 'view empowerment as veneer covering a reality of service disappearance' (Munoz *et al,* 2014: 221). Successful co-production relies on meaningful engagement with communities and may involve equipping and preparing a community to engage in co-production. Munoz's review of the co-production literature particularly identified that 'underlying drivers of successful co-production were related to

participants feeling that they could speak up, contribute meaningfully and drive forward change' (Munoz, 2014: 18). In addition, 'creating a positive and supportive environment' is identified as just as important as the particular methods used (*ibid*).

Other challenges with co-production involve discrepancies between communities and individuals in terms of their personal resources, skills and willingness to engage in community co-production (Munoz *et al,* 2014). In particular where services are delivered by communities, there is a particular need for these communities to have skills in social enterprise – something that has been identified as potentially challenging by the *Opportunities for Older People* project which identified that although many rural communities have a strong tradition of social and community engagement, the ability and interest to formalise this using business principals into an enterprise can be a challenge (Farmer, Hill & Munoz, 2012). In addition, community run services tend to rely on the energy and initiative of a few people – Radford and Shortall (2012) term these 'heroic individuals'. This can be problematic in terms of succession planning for the sustainability of projects in the long run. A further challenge comes from community engagement itself in terms of how communities are defined. Winterton *et al* identify that 'the effective implementation of place-based policy is challenging, partly due to the current homogenous conceptualisations of rural space in policy' (2014: 283). In contrast contemporary rural theory identifies rural space as relational, 'created through connections and flows', and comprising a wide range of different people and opinions (*ibid,* 283).

Although community co-production is challenging, island communities may have specific features which are beneficial when considering co-production. In particular, as Macaulay has shown utilising community resources may be particularly important in small island communities where statutory services can be inefficient and ineffective to deliver, and where a strong history of volunteering offers an alternative source or resource (Macaulay, 2016). With evidence that over 50s are more likely to engage in volunteering (Skerratt, 2012), the fact that island communities often have a demographic skew towards older age groups may also be significant. In particular, island migration patterns tend to show out-migration of younger working age populations, and in-migration of older lifestyle migrants towards the end of their professional careers (Connell & King, 2009). Such demographic patterns are also evident in Orkney (HallAitken, 2009), and a demographic skew towards the 45+ age group is particularly apparent in the outer isles (Appendix 4).

In these circumstances the pool of working age potential employees may be reduced, but there may be a pool of older adults with resources in terms of time, skills and sometimes finance. Utilising 'younger' older people in a voluntary or part time paid capacity has not only been identified as having benefits to service users (who benefit from additional services) but also in terms of improving the health and wellbeing outcomes for the volunteers (who benefit from being engaged and productive) (Munoz *et al,* 2014). Previous research however shows that not all older people are willing to engage, with older people who are better resourced (particularly in terms of education) more likely to participate (Munoz *et al* 2014). Research also offers a note of caution around the capacity of older volunteers noting that 'there are few older people who are willing to help their community that are not already involved in formal participation' and that further research is needed to

identify how to encourage those who are already engaged to step up their level of engagement (*ibid*: 212).

5.2 Community co-production in Orkney

Reviews and inspections of services in Orkney have consistently identified scope for development of services through closer joint working arrangements with the third sector and enhanced community engagement and planning. In the Joint Inspection of services for older people for example, there were recommendations for Orkney Health and Care to more effectively engage with older people in service planning and development (Care Inspectorate and Healthcare Improvement Scotland, 2017). Further, although the report noted that the partnership's engagement strategy was robust, it also suggested a need to strengthen how feedback is used in service planning (*ibid*). Considering data, the joint inspection suggested in particular, that the strategic needs analysis requires further consideration of gaps in service provision and older people's *broader* and *unmet* needs, rather than just focusing on existing service provision (*ibid:* 34). The report also notes that there is a great deal of 'support provided to older people by community groups and organisations' and it 'encourage[s] the partnership to foster and make best use of this as it develops its locality working' (*ibid:* 10).

Similar recommendations are identified by Davidson in his review of home care who notes that engaging with 'the voluntary sector and local people to identify community assets and supports' would 'assist in delivering a holistic service' (2017: 24). This could include supporting additional services with Davidson noting that the Red Cross Get Me Home Service has been adopted in many local authority areas in Scotland, and that Befriending, frozen meals, Food Train/supermarket procurement are 'good and tested responses' (*ibid:* 25). Alongside closer partnership working with the voluntary sector, Davidson also suggests looking at alternative commissioning models, for example locality based commissioning models. He suggests that home care services could be managed through a 'locally based coordinator managing day to day changes and freeing managers to undertake reviews and quality assurance' (*ibid*: 20).

Support to develop community led services for older people is embedded in Orkney's Community Plan (developed by the community planning partnership), which has three strategic priorities: positive ageing; a vibrant economic environment; healthy and sustainable communities (The Orkney Partnership, 2017)[6]. The positive ageing priority in particular covers a long-term vision, medium term outcomes, short term activities and outputs and key indicators which are relevant to the ongoing support of older people in their communities (these are shown in full in Appendix 3). The medium-term outcomes identified include: people living independently in their own homes where possible, and people taking responsibility for their health and wellbeing. The activities and outputs identified include items relating to increasing information and awareness: such as establishing a central information hub about matters relating to older people and establishing a 'know what your options are' campaign to ensure effective signposting to

[6] The Community Planning priorities are currently being reviewed. Although the three priorities are likely to be adjusted, supporting the health and wellbeing of Orkney's population and wider community development are likely to remain as core priorities.

community services. Also included are items related to creating new strands of activity such as: establishing activities related to men's interests to increase health and wellbeing, piloting community garden projects, arranging a walking football tournament and establishing new community activities for older people.

The potential for a closer strategic partnership between OHAC and Community Planning is implicit in the Orkney Community Plan, because despite the outputs and activities being focused on voluntary and community led activities, the outcomes and indicators have a much wider scope – for example the indicators include emergency hospital admissions and mortality rates for people under 75. Although these indicators may well be impacted upon by voluntary and community led activities, it is clear that statutory health and social care services are also central to achieving these indicators. Indeed, without a significant level of strategic co-operation between OHAC and the CPP it is difficult to see how the outputs and activities in the community plan could impact significantly on the indicators. A strengthened approach to locality engagement may assist Orkney to move towards exploration of the capacity of communities to assist with planning and delivery of health and social care services. That is, to move towards a co-production model. With OHAC currently considering moving towards locality or hub based working, and with work on suitable service models for the isles taking place (OHAC, 2017) it is possible that now is a good time to consider ways of moving further towards co-production.

6. Specific Examples of Innovations

Community co-production represents a broad approach to health and social care design and delivery. However, within the broad principle of community involvement in service design and delivery, specific innovations may be necessary address specific challenges of a local context. These innovations may be to delivery of statutory health and care services, they may involve community partnership with health and care services, or they may be entirely community led. In this part of the report a range of innovations will be explored. These have been chosen as examples of innovation which may be of interest in the particular context of delivery of services for older people in the non-linked isles of Orkney, and the list of examples is not intended to be exhaustive.

6.1 Health and Care Services

The ability of older people to remain in their homes is reliant on the broad health and care infrastructure offered in their local area. Innovations in the type of health and care services offered can therefore have a significant impact. Four examples are given below of redesign of health and care services – one at systemic level for island communities on the West Coast of Scotland, one of reviewing and broadening job roles, and two smaller specific innovations in Orkney which have particular relevance for the non-linked isles and are detailed below. It is worth noting that further innovations piloted in Orkney have also included the introduction of a discharge co-ordinator role, and a rapid responder service (OHAC, 2018a).

6.1.1 Systemic Redesign

The Audit Commission report into changing models of health and social care, identifies a range of innovations in service provision in Scotland. A number of these focus on systemic redesign and include discussion of the Nuka and Buurtzorg models. Buurtzorg is a model developed in the Netherlands designed to address issues of fragmentation and financial pressure in the care system. Under Buurtzorg district nurses were given more responsibility for patient care. Small self-organising multi-disciplinary teams of up to twelve professionals are responsible for coordinating care for a particular area. Care is very much localised, with a holistic focus on patient needs (including social and personal as well as local), this allows care services to identify and accommodate informal care provision being offered via the community or other providers.

The Nuka model was developed in Alaska. Again, this model of care is highly localised, using multidisciplinary teams, coordinated alongside wider community services with a broad focus on community well-being. In addition, the community is actively involved in managing and designing services, being part of the management structures, as well as being regularly involved in advisory groups and surveys, focus groups and other mechanisms for giving feedback. (Audit Scotland, 2016b)

Example 1: Highland Region: Nuka and 'Being Here'

The Nuka model has been the basis for the 'Being here' project in the Highland region as a response to challenges of delivering 'safe and sustainable services in remote and rural areas' (NHS Highland, 2017: 4). The project sought to take an action research approach to developing possible solutions – focusing on four different areas. Different models were utilised in the different areas, but were governed by common principles and elements of success – in recognition that 'successful solutions will be grown from local need and local resilience' (*ibid*). The four areas included the Small Isles and Achracle, Mid Argyll, Kintyre and Islay.

In the small isles area a new model of healthcare utilising a rural support team model was developed. This model is led by GPs but also includes advanced nurse practitioners and advanced paramedic practitioners. In addition four members of the community on the Small Isles were trained and employed as Rural Community Health Support Workers. In Eigg the former doctor's house was converted into a health and wellbeing centre (Scottish Islands Federation, 2018) and this was opened during a community health fair on the island which took a holistic focus on care and included sessions such as head massage sessions, qi gong tasters, a wildliife walk and a singing group session.

The project utilised support of academic researchers who were responsible for 'establishing a baseline by carrying out fieldwork in each of the Being Here test sites, with regular follow-up fieldwork across the lifetime of the project to assess progress. Field work in this instance involves visiting the Being Here test sites and interviewing residents, community representatives, and health and social care professionals, as well as attending community group meetings' (University of the Highlands and Islands, 2018). Community engagement was key to developing a model suitable for the specific context of each innovation area, and was also key to gaining community support. The Chair of the Small Isles Community Council commented that initially "We couldn't imagine any other way of working than having a resident GP," but now "We may have lost a resident doctor, but we are gaining access to more services" (Scottish Islands Federation, 2018)

6.1.2 Generic workers

In Orkney the development of Rural Generic Support Workers has been identified as a way of providing more integrated services to older people, and in particular to facilitate new ways of providing support in the outer isles (Care Inspectorate and Healthcare improvement Scotland, 2017: 47). This is consistent with findings from the Scottish Government's Remote and Rural Steering Group that generic support workers are 'an essential component of the emerging nursing model' for rural and remote communities (Scottish Government, 2007: 51). Scotland wide the role has been envisaged to provide support with rehabilitation, health promotion, management of chronic conditions, and to allow for early supported

discharge from hospital as well as providing a 'home based nursing/ care service to support people at home… [and] to prevent unnecessary hospital admission' (*ibid)*. The role was also envisaged to offer some screening and risk assessment functions (*ibid).*

Richardson (2013) describes the progress of a project designed to support the development of a Rural Generic Support Worker (RGSW) role in Orkney. This process involved a mapping exercise to delineate the core functions of the role and how they would relate to other health and social care roles, and a workshop with stakeholders. The project concluded that there 'is a great deal of support for the development of the RGSW role', that practically the role would 'include physiotherapy, occupational therapy, speech and language therapy and nursing activities, with an emphasis on rehabilitation and enablement' and that it has the potential to reduce the need for hospital admissions, facilitate earlier discharge, reduce re-admissions, and allow people to return to their own homes rather than a care home' (Richardson, 2013: 40).

Since 2013, generic workers have been employed in Orkney on a pilot basis, including one in Hoy. However, the full benefit of the model has not been possible to explore, partly because of challenges with how to delegate duties, and accountability. In other parts of Scotland, including Highland region (see for example the Eigg case study) generic workers have been utilised, but this has been assisted through the lead agency model of integration Highland region adopted (with the NHS being responsible for health *and* social care services for older people) (OHAC, 2018a). The generic worker pilot in Orkney is currently being evaluated.

6.1.3 Multi agency working and broadening roles

Identifying ways of broadening roles to allow more flexible ways of working may assist service provision in remote and rural areas. Within Orkney discussions with both the Ambulance Service and the Fire Service have been taking place to identify possible developments in delivery models. In addition, OHAC have noted that 'if we want to maximise our resilience and effectiveness to deal with unexpected circumstances that may arise, we need to engage with national and regulatory bodies for the Islands. Accepting that, in an island context, sometimes there are stark differences and certain rules and regulations are constraining our creativity when it comes to helping our smallest and most vulnerable communities' (OHAC, 2017c).

A positive example of interagency working has been identified in Shetland in the North Isles pilot project. The project tested out multi-disciplinary support to extra care housing, combining 'existing community care support staff with local allied health professionals and nursing staff to support older people' (Care Inspectorate and Healthcare Improvement Scotland, 2015: 80). In addition, 'the Council's housing department had carried out a service redesign. This combined support staff from homeless and housing support services worked under the same terms and conditions. This allowed them to be deployed as required across the isles. The success of the project was built on the principle of not reducing service but widening the scope of the staff group's responsibilities and skills' (*ibid:* 80).

6.1.4 Step up / Step down facilities

A Step Up/Down accessible bungalow at Glaitness, has been piloted in Orkney, providing an "alternative to hospital admission, or as a setting for an extended stay for rehabilitation" (OHAC, 2017c). A further project involved a GP Direct Referral Bed in Dounby as "an alternative to hospital admission for individuals with self-limiting conditions who require low level health care interventions" (*ibid*). Both of these projects took place on the mainland and, despite the Dounby GP bed being discontinued, minutes from the IJB Strategic Group note that the model is potentially positive, with low impact and low use being partly down to the development of other services designed to assist with similar issues. In particular the minutes note: "Had there been similar services on the Isles, there would have been other substantial cost savings such as helicopter, chartering boats, etc. Given enough time, the project would be very successful; however, more time can't be afforded at this current moment' (*ibid).* It is unclear how the partnership intends to take forward services such as this in the isles – and indeed how such facilities may be staffed - but the potential of the model is clearly identified.

6.2 Community Partnerships in Care Delivery

Alongside innovations to the way that statutory health and care services are delivered, some examples of innovation involve community partnerships with statutory health and care providers.

6.2.1 Day Care Partnerships

Community Care Assynt[7] and the Howard Doris Centre in Lochcarron[8] are examples of community run day care services for older people. In both cases core funding comes from the NHS, but being community run allows these services to have a flexibility in terms of the services they offer, and their ability to apply for additional funding where necessary. And in Orkney this model has also got some precedent with the noting that in Hoy a decision was taken to "transition day care services on Hoy to the community, although the Council retained the personal care element. Although it took time to implement, the service had seen increased attendance at reduced cost to the Council." (OHAC, 2018b: 13)

Generally, community run day services develop through the community taking on responsibility for a service which has been identified as at risk. However, in Lairg a new development is being established - the Lairg Care and Well-being centre[9]. The intention of this new development is to create very sheltered accommodation like Kalisgarth in Westray comprising of 11 units, serving a population of approximately 900. The delivery of care services is yet to be decided but is likely to be through a private care provider, or through the community themselves. Through the Social Care (Self-directed Support) (Scotland) Act 2013, the community intend to draw down funding to pay for some services, on the understanding that they may potentially need to top this up to cover overheads either from their own reserves or through the provision of other chargeable services.

[7] http://www.communitycareassynt.org.uk/
[8] http://howarddoriscentre.org.uk/
[9] http://www.lairginitiative.co.uk/lairg-care-and-well-being-centre.html

Example 2: Assynt Community Care

The Assynt project was initiated through the Opportunities for Older People project after the local authority expressed an intention to close the local residential care home (Farmer & Stephen, 2012). After investigating various options, and accessing some social enterprise training the community started to consider running the centre as a community enterprise. The process was assisted by the 'willingness of council leaders to enter into a frank dialogue with the community, and by a culture change within the community from resistance to determination to make it work for themselves' (*ibid*: 83). Originally the centre had offered residential care and respite facilities, but this was costly, and would have been a huge undertaking for the community, so at the point of the community takeover it changed registration with the Care Inspectorate and began offering what could be thought of as more day care facilities. This was a practical approach – phasing the development so that rather than undertaking to run a full care facility, service delivery was restricted to within what felt manageable at that time.

Currently the centre serves an area with a population of approximately 900. It offers a daily lunch service, and operates as a location for a range of other activities. In addition the organisation runs a befriending service. On site there are 12-13 sheltered houses, although these are not operated by the centre, residents may access some of the facilities of the centre. The centre employs ten staff, including a manager, deputy manager, care staff and an administrator, staff are all part time, and the majority are trained to provide personal care where necessary. Core funding is provided by the NHS, and in addition spot charges are made to the NHS for care services offered to specific individuals as part of a care plan. Care is only provided within the centre, and there are not currently any plans to extend this to community care facilities. Operating as a social enterprise however gives the centre the capacity to think flexibly about service delivery, and additional funding may be applied for to cover certain projects, in addition wider community-based activities may be considered as ways of generating income, for example currently there is discussion about running a pop up restaurant or fish and chip night using the expertise of staff and the facilities of the centre but for the community

6.2.2 Home care Partnerships

Partnership arrangements between communities and registered care providers also exist in the delivery of home-care. Three such examples are given below. It is notable that all of these examples required negotiation between the registered care providers and the communities. This requires a community to have an identified link organisation – in the case of Boleskine it was the community care charity that was already established, in Rousay it was the Development Trust and in Papa Westray it was the Community Link Worker. In the

case of Rousay, the partnership developed also involved financial investment from the link organisation.

Example 3: Highland Home Carers – Boleskine

An innovative model of home care delivery has been developed by Highland Home Carers and the Boleskine community. NHS Highland describes the development of the model as follows:

> "Boleskine Community Care had been established as a local charity to deliver voluntary care and support to enable older people to remain within their own community rather than move to Inverness – a round trip of some 40 miles mainly on single-track roads. The local community provides a lunch club, other social activities and a handyperson scheme. They had identified the need for a care at home service as neither the independent providers nor the in-house NHS provider had been able to deliver such a service. Boleskine Community Care had identified some local people prepared to train as care workers but did not have the experience or capacity to register with the Care Inspectorate as a provider. With the support of NHS Highland, HHC offered to support Boleskine Community Care to deliver a care at home service using Individual Service Funds (SDS Option 2). This enabled the local community to provide local care in consultation with the community charity and individuals and families who require care and support." (NHS Highland n.d.:1)

In effect then an already established community care organisation which provided voluntary services was able to work with a registered provider of care to enable the development of home care services. The community organisation was able to assist with recruitment of staff (something care providers had found challenging in previous years), but Highland Home Carers took responsibility for employing these individuals (including conducting background checks, and providing training, support and supervision). In addition the carers employed in Boleskine are supported to operate as a self-organising team allowing them a level of autonomy, and allowing them to be responsive to the needs of community members, and the staff.

Example 4: Rousay

In Rousay, the 'Here to Help' service (operated by AgeScotland) has gone into partnership with the Island's Development Trust. The agreement involves AgeScotland committing to recruit local staff for the service, and the Rousay Egilsay and Wyre development trust subsidising the cost of services for residents.

Currently the 'Here to Help' scheme provides home help support only, but with the extension of AgeScotland's service to include a 'Here to Care' scheme, the model may also be extended so that isles residents can receive personal care and home help through the same service.

Example 5: Papa Westray

The arrangements in Papa Westray are not dissimilar to the model developed by Highland Home Carers. Papa Westray Community Council decided to implement a community-led scheme when they became concerned at the number of elderly residents who were having to leave due to insufficient access to care. There was only one resident OIC carer, employed on a relief contract. Recruitment of additional home carers on the island presented a challenge, with a significant issue being the time taken for recruitment, and the requirement for travelling in to Kirkwall to receive training (estimated at two weeks in duration). In order to cover the care provision OIC transported carers from Westray and other parts of the mainland. However, challenges with travel meant that care was not always available. A partnership was created with Crossroads, who agreed to train two carers, with the training provided on the island. This provides capacity on the islands for home care for individuals choosing option two under the Social Care (Self-directed Support) (Scotland) Act 2013 – with Crossroads as the agency providing care rather than OIC.

6.3 Community Led services

Skerratt has noted that statutory services in Scotland (as in other countries) tend to be focused on the 'technical, illness or care-oriented type' and this leaves scope for social enterprises to focus on 'enhanced services aimed at improving quality of life…. or keeping less frail people maintained healthily at home…' (2012: 37). Services provided at a lower level of care need can have significant benefits in terms of preventing escalation of needs and in addition they have the advantage of being less likely to be subject to such a high degree of regulation. A range of examples of these services are given below.

6.3.1 Support Services

The Opportunities for Older People project was an international project designed to stimulate community led social enterprises that would offer support for older people. The kinds of enterprises set up included: an oral history group, a community transport scheme, a community radio station, a drop-in centre and outreach centre, a lunch club and drop in centre, groups for activities such as needlework and befriending, IT training, café and grocery store, a hub for older people's services, a volunteering project (to increase volunteering) (Farmer, Hill & Munoz: 2012)

In the islands of Orkney examples of community led services, particularly in terms of community transport schemes and lunch clubs are already established. Therefore, the examples below focus on two different examples, the first is an example of a community organisation that offers lunch clubs, transport and additional services all within one organisation. The second is the development of a home help service in Westray.

Example 6: Boleskine Community Care

Boleskine community care offer a range of volunteer services from within one organisation including: volunteer handyman service, a volunteer transport scheme and weekly social gatherings including regular walks, a lunch club, a coffee morning and afternoon tea sessions. Through a partnership with Highland Home Carers (see above) the organisation now also offers personal care services.

Example 7: Westray Development Trust

The Westray Development Trust home help service was set up to provide domestic support to island residents. As the support provided does not include personal care there is no requirement for the service to be registered with the care commission, or for staff to have a certain level of training. People can self-refer to the service, or can be referred by a healthcare professional. After referral the manager visits the service user to discuss their needs and develop a work plan. The individual is then matched with a member of staff, - something which is done under discussion with the service user in recognition that small communities are diverse, and some service users and providers will not always get along with each other. Costs of the service are agreed (with the development trust offering a subsidy to enable services to be provided at low cost), and review dates are agreed. As individuals will often ask for home help services before requiring additional personal care services, staff of the service also have an ongoing role for monitoring service users, and encouraging a referral to social work services where service user needs exceed those that can be provided by the service.

6.3.2 Housing options

Sheltered and very sheltered housing are also services which are subject to regulation and can be very costly services to run, accordingly there are also some examples of innovation in terms of community led alternatives, in particular co-housing and home-share options.

In 2013 the Joseph Rowntree Foundation published a report which described co-housing models as follows:

> 'Cohousing is a form of group living which clusters individual homes around a 'common house' - or shared space and amenities. Run and controlled entirely by members of the group working together, it is based on mutual support, self-governance and active participation. Physically, it is designed to promote easy social interaction among its members and generally has a 'common house' or equivalent for shared meals and events. Two cohousing models exist – the intergenerational or family-based model and senior cohousing, for age-peer groups over the age of fifty or so' (Brenton, 2013: 3)

Although the concept of co-housing is relatively new in the UK, internationally senior cohousing has more precedent, developing from the early 1970s in Germany, Denmark and

the Netherlands. In London the OWCH (Older Women's Cohousing) group is establishing a co-housing community in the UK[10].

Home share is an arrangement which 'brings together two unrelated people to share a home for mutual benefit. Typically, an older householder with a room to spare will be carefully matched with someone needing low-cost accommodation who is able to provide an agreed amount of support in exchange' (SharedLivesPlus, 2018). The interest and uptake of homeshare has been growing over recent years (SharedLivesPlus, 2017), and indeed during the time of this project received press coverage from the BBC[11]

6.4 Innovative Community Connections

Alongside innovations to statutory services, community partnerships with service providers and community led innovations, there are also a range of innovations designed to help connect statutory and community services. Community Link workers and Local Area Coordination are discussed below, but other approaches with a similar purpose include social prescribing models whereby patients accessing GP surgeries are linked to activities in the community (which is an approach in development in Forfar); and advice lines which provide nursing advice but also provide information about local voluntary services that can help (which is a development in Fife) (Audit Scotland, 2016a). In Orkney the development of the OHAC 'Adult Services Helpdesk' goes some way towards this last kind of model – the helpdesk is operated through the council switchboard, and provides individuals with support and information about available services including voluntary services, as well as being a mechanism for referrals for care assessments[12].

6.4.1 Community Link workers

Community link workers are employed to work in GP surgeries and help link people up with community based services and groups such as lunch clubs and self-help clubs. The link worker model has received a great deal of attention with the Scottish Government stating that: "During the lifetime of this Parliament we will recruit at least 250 community link workers to work in GP surgeries with at least 40 being recruited in 2017" (Scottish Government, 2017d). In a briefing from May 2017, Community Link workers are defined as follows:

> "A Community Link Worker (CLW) is a generalist social practitioner based in a GP practice serving a socio-economically deprived community, addressing the problems and issues that the individual brings to the consultation, rather than a worker whose domain is limited to a specified range of conditions or illnesses, or one who is based elsewhere within health, social care or other services.
>
> They offer non- clinical support to patients, enabling them to set goals and overcome barriers, in order that they can take greater control of their health and well-being. Using 'good conversations' a CLW supports patients to identify problems and issues they are experiencing and to talk about what really matters to them. They support

[10] http://www.owch.org.uk/
[11] www.bbc.co.uk/news/av/uk-politics-42438530/homesharing-we-get-on-like-a-house-on-fire
[12] http://www.orkney.gov.uk/Service-Directory/S/adult-services-helpdesk.htm

patients to achieve their goals by enabling them to identify and access relevant resources or services in their community" (Scottish Government, 2017d).

6.4.2 Local Area Coordination

The Local Area Coordination Network states that: 'Local Area Coordination is a long term, integrated, evidence based approach to supporting people as valued citizens in their communities (LACnetwork, 2018)[13]. Local Area Coordination is focused on early stage interventions, and 'rather than waiting for people to fall into crisis, assessing deficits, testing eligibility and fitting people into more expensive (and increasingly unaffordable) services, it works alongside people to:

- Build and pursue their personal vision for a good life,
- Stay strong, safe and connected as contributing citizens,
- Find practical, non-service solutions to problems wherever possible, and
- Build more welcoming, inclusive and supportive communities.'

There are some similarities between Local Area Coordination and models such as Community Circles and wellbeing teams[14] – which use trained volunteers to facilitate conversations with individuals and help them achieve their goals through family, friends and community services (SharedLivesPlus, 2018). Both Local Area Coordination and community circles are more widely used with other service user groups (e.g. adults with learning disabilities) but there are some examples of these approaches being used with older adults.

[13] http://lacnetwork.org/local-area-coordination/what-is-local-area-coordination/
[14] http://wellbeingteams.org/the-model/

Example 8: Fife local area co-ordination

In Fife a local area co-ordination service has been set up, in three areas: older people, adults and GP practices. The local area coordinator service for older people is supported by funding from the Health and Social Care Partnership, and is managed as an independent service by the Fife Forum (a third sector agency for older people and adults in Fife). The service employs four local area co-ordinators. Details of what the service does is given in the image below.

What we can't do…

⇒ **Carry out formal assessments (including those for personal care)**

⇒ **Provide a direct service such as befriending or crisis intervention**

Figure 2. Extract from:
www.fifeforum.org.uk/files/8314/9562/3478/LAC_CLIENT_INFO_LEAFLET_GENERIC.pdf

Referrals to the service come from individuals, families and carers and service providers. Approximately 20% come from individuals, families and neighbours. Approximately 75% of referrals come from statutory services.

7. Non-Linked Isles: Research project

Alongside a literature review, a case study of health and care in Orkney and the identification of examples of good practice from other communities, this project involved gathering primary data from the seven island communities which were stakeholders in the project. This section of the report summarises the findings of the research engagement with the isles.

7.1 Background

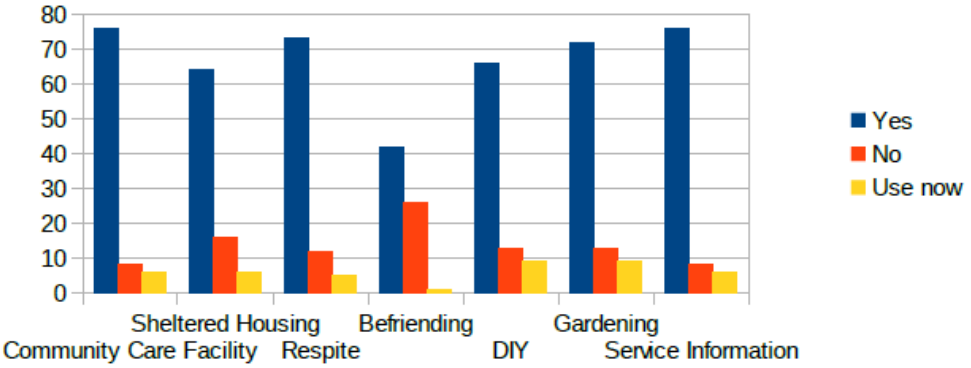
Compared to the general Orkney landscape in terms of health and social care for older adults, the non-linked isles pose a specific set of challenges and opportunities. Some of this has been summarised above. However, in addition, these communities all have wider sustainability concerns, with the Orkney Population Change study noting that although all of mainland Orkney is in a category of 'strong' or 'stable' all the non-linked isles were in the threatened, becoming threatened or marginal categories, except for Papa Westray which was identified as 'strong' (HallAitken, 2009).

The ongoing sustainability of the population of the isles is a particular concern, with islands typically experiencing a reduced working age population and an increased older population (compared to mainland demographics). The Island Development Trusts have been influential in the islands for identifying island development priorities and developing island plans. Common themes in these plans include transport, broadband, housing, care of older people, retention of younger people, fuel poverty, and tourism (The Orkney Partnership, 2017b: 3*)*. They have also been involved in establishing a range of services and initiatives to help support the development of their islands. In many cases, but not all, the Development Trusts have some income from community owned turbines which they use to support the development of their islands. Further background to island demographics, experiences of deprivation and existing community organisations is given in Appendix 4.

A number of pieces of research have already taken place in the isles, covering issues of health and social care and the needs of older residents. These are summarised below.

Hoy Home Care research

In Hoy a piece of research was conducted to identify options for delivery of home care services (Smith, 2014). In May 2013 a survey was sent to all households on the islands of Hoy and South Walls, 89 responses were gained to the 360 questionnaires sent. The first seven questions asked what facilities people, or their families, would use now or in the future, the results were summarised as follows:



Relatively high responses are notable to all services listed, but particularly community care, respite, gardening and service information. Although befriending is the least popular of the options, over 40% still identify that they would use this in the future. The report then describes and costs various models of care including:

1. Setting up a local home-care service: to provide personal care and half an hour domestic assistance per person per week.
2. Combine a care at home service with very sheltered housing
3. Combine a care at home service with a respite service
4. Combine a care at home service with a mobile responder
5. Combine a care at home service with sheltered housing and a respite service
6. Set up a care brokerage scheme: rather than setting up a care at home service, provide a support service for individuals to hire their own carers utilising direct payments.
7. Set up a homecare plus scheme: rather than setting up a care at home service, set up a service to provide the additional home help that is not currently covered through home care.

The research costs these various options on the basis of the running costs of existing OIC services. All options come with a considerable cost implication, with the first option being costed at almost twice the running cost of the current OIC service (£81,579 to £43,588). The brokerage option is relatively low cost (with set up costs of approximately £3,000 calculated, and running costs approximately the same). The report concludes that economies of scale mean that "the provision of a community enterprise Care at Home service based on Hoy and South Walls as an alternative to that provided by Orkney Islands Council is unlikely to be a feasible option." (no page number). Instead the report suggests pursuing a home care plus model may be more effective – 'facilitating third sector services already available on the mainland' and approaching other third sector services[15]. The report also notes that there may be potential to utilise local accessible holiday accommodation for respite purposes, if care services were provided through Crossroads or other organisations set up to provide

[15] The Hoy research references facilitating third sector services 'to provide a local service' as an approach which 'has already been adopted by other isles trusts'. This comment relates to the investment of a number of different island trusts specifically in supporting AgeScotland Orkney's 'Here to Help' services through a subsidy, see section above.

respite. In addition, further investigation of information services, or care brokerage, alongside other ideas for voluntary services provided on the island are recommended for consideration.

Eday Wellbeing and Care of Older Residents Research

In Eday a piece of research was commissioned to identify the wellbeing and care needs of island residents (Mackay, 2016). It is unclear from the report exactly how the research was carried out and what the response rate was from the island population, however there is a range of qualitative data provided about residents' views of health and social care services. The report identifies issues of housing stock and fuel poverty, as well as island transport. A key issue in terms of lack of carers was identified and a key priority in terms of recruiting more carers. The report recommended the employment of a care manager whose role would include visiting residents to provide company, respite for carers and assessments of needs, housework and shopping duties, accompanying residents to hospital where necessary, setting up group activities, and being a point of contact. However, this role wasn't costed and there is a lack of clarity over who would recruit the worker and how this would be managed and funded.

Highlands Small Communities Housing Trust

The Highlands Small Communities Housing Trust carried out research in 2017 with four island communities: Sanday, Shapinsay, Stronsay and Rousay, Egilsay and Wyre. The research took the form of a housing needs analysis and an options appraisal for each island. The research utilised desktop analysis of demographic and housing demand data, analysis of other reports, and a questionnaire that was sent to every household (with an option to complete online if preferred) (HSCHT, 2018). The survey sought to identify future housing needs by looking at household composition, households considering moving and households where homes did not currently meet householders needs. In addition, the research engaged with stakeholders and businesses, to identify the role of housing provision in recruitment of staff and future economic growth. The survey also secured opinions of residents about what kind of housing the communities need and their priorities.

The reports identified potential sources of support for new housing developments including the rural housing fund, Scottish land fund, infrastructure fund and the islands fund. Although the findings for each island differed, in general a level of housing need was identified in all the island communities. This covered both the needs of older adults (in terms of adapted, sheltered or very sheltered housing) and the needs of younger adults looking for inexpensive houses to buy or rent. In Sanday it was noted that 'there is overwhelming support to address the needs of older people on Sanday, with suitable housing and care provision for the future'. However due to the very small numbers looking for housing and the high diversity of needs, the reports generally recommended building flexible housing that could suit a range of needs, and building this through a phased approach, with a couple of units built at a time by the community trusts, and with these units built up as demand required over the years. The Sanday report notes that: "According to our investigations and discussions with care providers, the greatest barrier to delivering care on the Isles is the human resources to do so, followed by financial constraints.

Therefore, unless an approach to strengthen the community as a whole is undertaken then this will put additional strain on the resources and systems in place" – therefore supporting wider community development is recommended. The report also notes that there might be scope for the community to "offer informal care to older people who require a helping hand but not registered personal care".

Brinkhorst and Siderfin (2018)

Finally, a recent piece of research has been conducted by a trainee GP from the Netherlands looking at the social opportunities, health and access to healthcare of individuals over 75 years old living on the smaller islands of Orkney (Brinkhorst and Siderfin, 2018). The project involved interviewing participants living on eight of the Orkney isles: Eday, Hoy, Papay, Sanday, Stronsay, Westray, Shapinsay and North Ronaldsay. Letters were sent to all residents over the age of 75 in these islands, and a total of 49 interviews were held with a total of 63 participants (14 interviews were held with couples).

This research concluded that older islanders were generally highly resilient – they understood 'the strengths and advantages of an island life' and as a result 'accept the restrictions that come with it' (*ibid*). Respondents are generally positive about access to health care, particularly primary healthcare available on the islands, and are generally happy about the provision of emergency care too. The strength of the community and the range of social activities available is identified very positively. In terms of concerns, challenges for residents who cannot drive in terms of access to facilities such as shops, and social activities are noted. Some issues are also noted with needing to travel in to Kirkwall or to Aberdeen for specialist care, especially in terms of the time and inconvenience this involves and challenges in terms of the accessibility of boats and planes.

The report notes a significant concern from participants around the availability of home care noting that "access to home care or a care home in the future is a big concern, due to a shortage of carers in a decreasing and ageing island population" (*ibid*). Carers are often known to service users, and the quality of care is generally perceived as very high. However, respondents "feel that the carers are restricted by their Kirkwall office. They heard that the carers must call in at the start and end of each visit; they think this is very poor" and respondents "feel the carers do not have time to talk to them" (*ibid*).

7.2 Project methodology

Each of the seven island groups taking part in this research project were visited in January and February 2018. These visits were organised in liaison with the islands' development trusts (with the exception of Papa Westray where liaison took place through the Island's link worker). Each island visit was accompanied by a poster that was used online and displayed in prominent community locations, this poster gave background to the project and details of the community workshop and interviews and invited interested islanders to get in touch with the research team (an example of the poster is given in appendix 4). In at least one location in each community a poster was displayed alongside a post-box and feedback form (shown in appendix 5). This was to allow those members of the community who were unable to attend an interview or workshop, or who wanted to remain totally anonymous, to contribute feedback to the project.

Each island visit comprised of a number of interviews, informal conversations and a workshop. A total of 11 interviews were held with participants from across the island groups. These participants represented both service users and service providers. Interviews and workshops were audio recorded and data was analysed to identify themes. In addition, a range of informal meetings and conversations were also held in each island – these were not recorded, however notes were taken in a research diary and used to inform the data analysis. All participant data has been anonymised in this report.

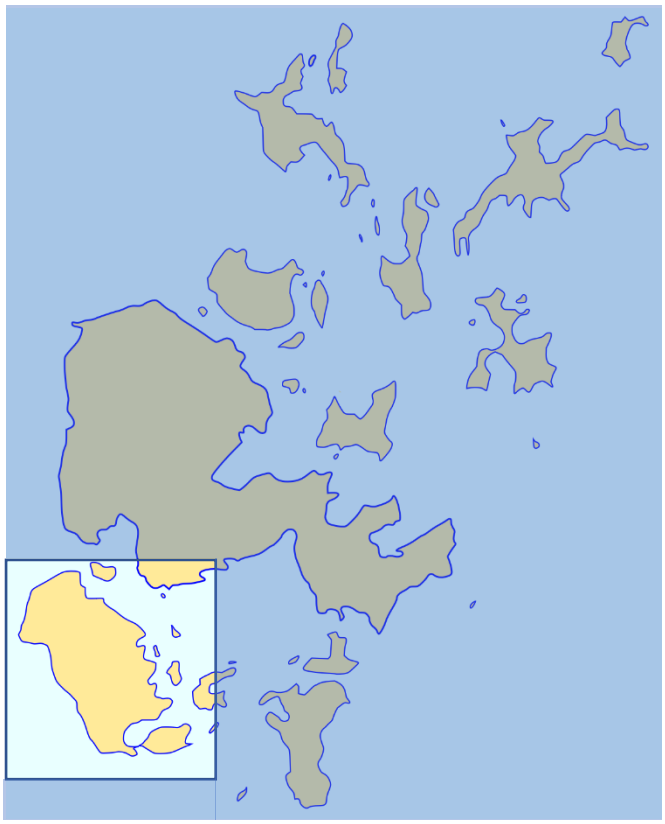
Alongside the interviews and informal meetings, a workshop was held in each community. In most cases participation in the workshop was largely facilitated by the island's development trust, and in Papay, Hoy and Rousay this was assisted by holding the workshop at the same time or just after a lunch club. In Papay two workshops were actually held – one in the afternoon with lunch club and one evening workshop. In Eday a workshop time was arranged, but no participants attended. Therefore there is no workshop data for Eday. The workshops followed a structured approach based on Nominal Group Technique. The first part of the workshop involved participants identifying the island assets for the support of older people. Participants were invited to reflect on this individually and note their ideas on post-it notes. These were then collected in by the researchers, grouped into themes and discussed. In the second stage of the workshop a similar approach was followed, but in this part of the workshop participants were asked to identify their priorities for the development of support for older people in the islands. Once all ideas had been recorded and grouped into themes (with the themes agreed by workshop participants), each participant was then asked to identify and rank their top five[16] personal priorities from this list of themes. At the end of the workshop these personal rankings were collected in and the researchers later totalled the rankings for the whole group enabling a group ranking to be created.

7.3 Findings: Island Assets and Priorities

This section of the report considers the findings from the island visits including the workshops and the interviews. The findings are presented in two parts – firstly the results from each of the island workshops presented as a case study of each island, and secondly thematic analysis of the workshop and interview data to identify underpinning themes.

[16] In Sanday due to the number of priorities identified by participants the researcher asked participants to identify their top 7 priorities individually.

7.3.1 Hoy



Key Information

Population: 419 in 2011 census

Transport from Hoy: ferry services from Moaness (north Hoy) to Stromness daily, and from Lyness to Houton several times a day.

Health care provision: Hoy Surgery staffed by a resident GP.

Home care provision:
OIC: three contracted carers.
Crossroads: one carer, relief contract
Domestic help: no services available (private arrangements only)

Community resources: social clubs including two lunch clubs

Transport in the island: community bus and Haey Hope (lunch club) bus

Workshop findings: Assets and priorities in the support of older people

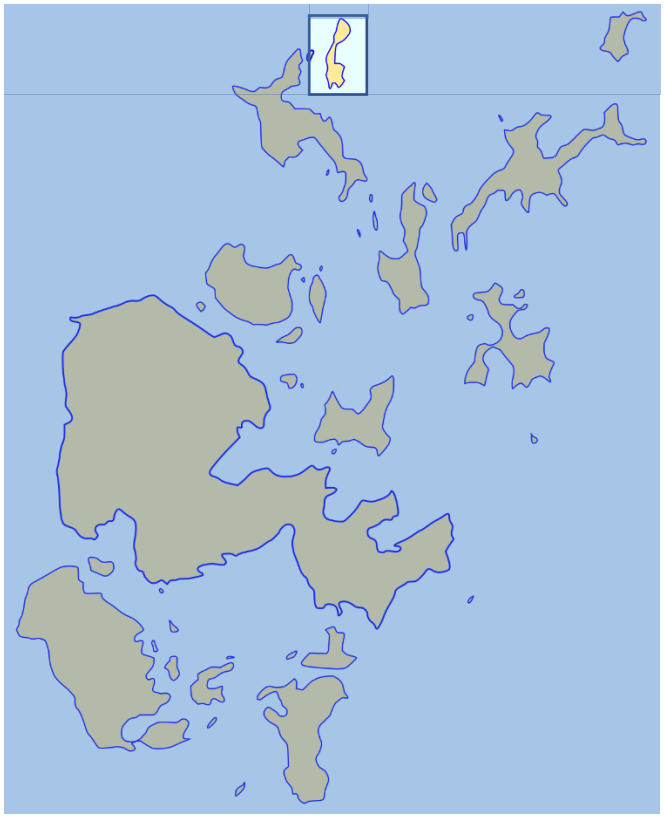
Assets

- Medical care
- Lunch clubs and other activities
- Community bus transport
- Natural environment
- Community and neighbourliness
- Alarm and phone lines
- Home care available

Priorities

1. Improved homecare
2. Respite facilities
3. Sheltered housing
4. Phonelines and broadband
5. Additional support e.g. gardening
6. Visits to elderly e.g. befriending
7. Use of VC in healthcare
8. Maintaining access tracks

7.3.2 Papa Westray



Key Information

Population: 90 in 2011 census

Transport from Papay: daily flights to Kirkwall. Twice weekly ferry to Kirkwall. daily ferry (summer only) and school ferry to Westray

Health care provision: Two nurse practitioners both resident. GP services via Westray surgery.

Home care provision:
OIC: one carer, relief contract
Crossroads: two carers, relief contract
Domestic help: via Crossroads and private arrangement.

Community resources: social clubs including a lunch club

Transport in the island: no community transport available at present

Workshop findings: Assets and priorities in the support of older people

Assets

- Social gatherings
- Lunch club / Thursday club / coffee mornings
- First responders
- Nurse practitioners
- Fire service
- Emergency rest centre
- Isle's liaison officer
- Neighbours /community – Papay people are willing to help
- Family networks
- Meals on wheels
- Transport
- Distances are low
- Gym / library / school / computer
- Social care scheme being developed
- Shop
- Kirk and gospel hall
- Active lifestyle (farming, volunteering)
- OIC grants
- Plane service and cargo boat
- Chiropodist visits
- Natural environment
- Bank visits
- Library boxes and talking newspaper

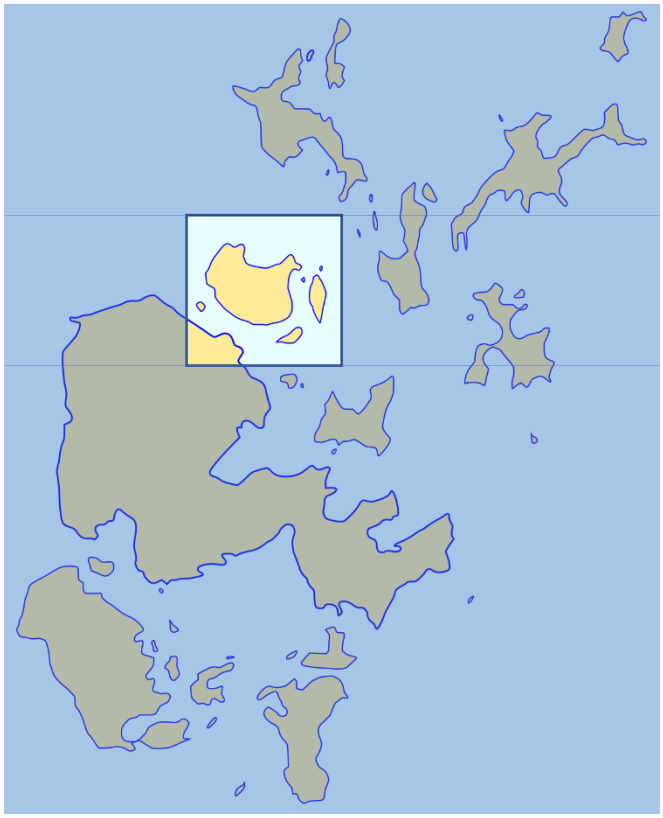
Priorities (group 1)

1. More carers
2. Maintain transport (planes and boats)
3. Housing (accessible)
4. Community transport
5. Supported housing or a warden
6. =meals on wheels
   =maintain bank / library/ chiropody
7. =more chiropody services
   =self help network
   =access in / into transport

Priorities (group 2)

1. Recruit and retain homecare staff
2. Better broadband
3. Flexibility in care training
4. Accessible transport
5. Videoconference facilities
6. Locally organised care
7. Better transport to Westray
8. Availability of home help
9. Adult education (beyond local skills)
10. Island proofing of e.g. council / NHS
11. Exercise classes
12. Local transport for non-drivers

7.3.3 Rousay, Egilsay and Wyre



Key Information

Population: 271 (2011 census)

Transport from the islands: ferry services from Rousay to Tingwall several times a day. Egilsay and Wyre to Rousay and Tingwall daily and more frequently on request.

Health care provision: Resident nurse. GP visits from Dounby surgery three times a week.

Home care provision:
OIC and Crossroads: no carers available.
Personal care mainly provided by private arrangement via direct payments.
Domestic help: Here to Help service available (subsidised by the community)

Community resources: social clubs including weekly lunch club

Transport in the island: no community transport available

Workshop findings: Assets and priorities in the support of older people

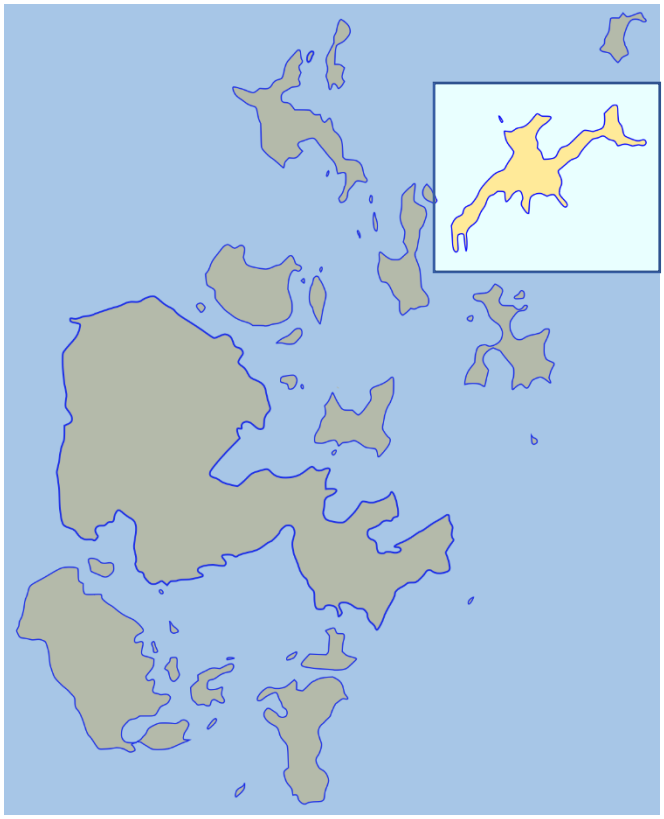
Assets

- Here to Help service
- Good healthcare service
- Education for all
- Physical environment and views
- Home care available
- Frozen meals
- Safe place
- REWDT support for living at home
- Community spirit
- Transport to mainland
- Bus service
- Lunch club

Priorities

1. = Adapted/sheltered housing
   = More carers for personal and domestic support.
2. Improved transport (within island and to town). Accessible transport preferable.
3. Community support e.g. befriending. Health facilities e.g. physio available on island.
4. Re-establish ambulance service on the island

7.3.4 Sanday



Key Information

Population: 494 in 2011 census

Transport from Sanday: ferry services from to Kirkwall daily. Daily flights to Kirkwall.

Health care provision: GP surgery staffed by two nurses and four GPs (with one on duty at any one time, on rotation)

Home care provision:
OIC: four contracted carers, four relief carers
Crossroads: three carers on relief contracts
Domestic help: services available via Crossroads and private arrangements.

Community resources: social clubs including weekly lunch club.

Transport in the island: community bus with scheduled service to the ferries

Workshop findings: Assets and priorities in the support of older people

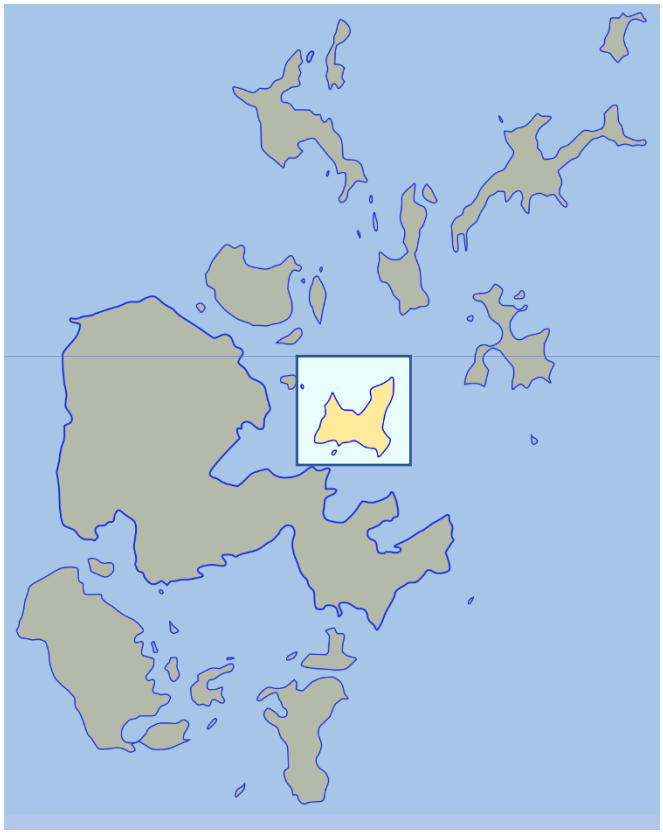
Assets

- Medical care (including first responders)
- First aid in the community
- Home care (OIC, crossroad, private)
- Bus (link to ferry and shopping)
- Help from neighbours
- Shop delivers
- Afternoon club
- Sanday sound (newsletter)
- Social events, clubs and classes
- Community garden
- Health walks

Priorities

1. Better transport between isles / fixed links
2. Extra care housing
3. Services provided in Sanday e.g. physio, optician, dentist, vet
4. Better discharge process
5. =Emergency planning for older people
   =Accessible boats and planes
6. =Earlier intervention
   =More help to adapt houses
7. Respite room
8. Improved availability of aids
9. Improved information about support and aids
10. Quality meals
11. =Respite for carers
    =24 hour care
12. =Palliative care
    =Better use of videolink
    =GP bed
13. =Sanday sound in other formats
    =Day centre
    =Improved bus service
    =Accompanied trips to appointments
    =Regular visits to vulnerable (befriending? Parish visitor?)
    =Mortuary facilities
    =Joined up care (added after ranking process)

7.3.5 Shapinsay



Key Information

Population: 307 in 2011 census

Transport from Shapinsay: ferry services to Kirkwall several times a day. Community run out of hours boat offers evening transport.

Health care provision: One resident nurse practitioner, second nurse practitioner recruited to provide cover. GP services available from Heilendi surgery in Kirkwall.

Home care provision:
OIC: one carer, relief contract not yet fully trained, Crossroads: no carers. Personal care is normally via private arrangement using direct payments. Domestic help: Private arrangements only.

Community resources: social clubs including weekly lunch club

Transport in the island: community electric car, and bus for lunch club.

Workshop findings: Assets and priorities in the support of older people

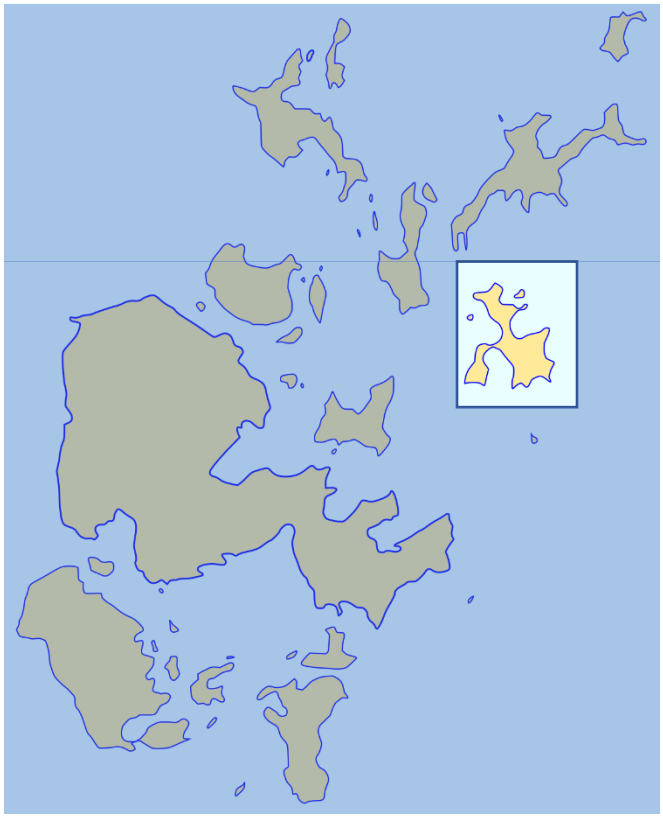
Assets

- Lunch club
- The community: neighbourliness and support
- Community transport
- Nurse Practitioner
- Ambulance service responders and volunteer drivers
- Home care available (although there is only one OIC home carer on the island)
- Existing alarm system

Priorities

1. More home carers
2. GP on-island
3. Addition of a Generic Worker on the island
4. Additional help with adapting homes for older people
5. Improved awareness within community of entitlement for support, and existence of other services
6. Development of Sheltered Housing options
7. Development of Care Home
8. Support with travel to the mainland for hospital appointments and for visiting relatives in care homes.
9. Statutory services (improvement in discharge processes, communications and waiting times)
10. Respite services
11. Social activities

7.3.6 Stronsay



Key Information

Population: 349 in 2011 census

Transport from Stronsay: daily ferry service to Kirkwall, daily flights to Kirkwall.

Health care provision: Two resident GPs and two resident nurses

Home care provision:
OIC: 8 home carers
Crossroads: two carers, relief contract
Domestic help: via crossroads and private arrangement

Community resources: social clubs but no lunch club currently.

Transport in the island: community transport not available – an island taxi service runs as a commercial venture.

Workshop findings: Assets and priorities in the support of older people

Assets

- Daily transport links
- Medical provision – skilled staff and accessible
- Home care team – crossroads, private, OIC
- Small caring community

Priorities (ranked)

1. Retain status quo in terms of medical and social care provision
2. Accessible / sheltered housing
3. Improved accessible transport to the mainland and on-island
4. Extend videoconference and telemedicine
5. Improve IT infrastructure
6. Additional visits to the island from clinical services
7. Development of further social activities and use of bus to allow access
8. Accessibility of funding to support development

7.3.7 Assets and Priorities: discussion

The assets and priorities lists developed by each of the six island groups show a remarkable level of consistency. Items commonly discussed under the assets include:

- **Health Services:** specifically GP or Nurse Practitioner services, were generally reported very positively. This was both in terms of accessibility – particularly the ease of making an appointment – and in terms of the personalised service received.
- **Emergency healthcare**: especially Ambulance Service responders, were discussed as a valuable resource in a crisis, and as a crucial support for isles medical staff (GP and nurse practitioners) especially where these were lone practitioners.
- **Social Activities:** especially lunch clubs. Communities were reported as being vibrant, with a range of social activities which were inclusive of all ages – including older people and children. Lunch clubs were felt to be particularly beneficial for providing social contact and activities for older people, especially as an accessible lunch club bus was normally provided to assist attendance.
- **Community support**: often described in terms of 'neighbourliness' the communities discussed how they looked out for one another, including identifying people potentially at risk (when curtains were not opened, fires not lit etc). Informal supports such as lift giving, shopping, social visits, and odd jobs were all undertaken on a neighbourly basis.
- **The existence of some home care:** despite very low capacity in some islands, the existence of some home care support was identified as positive. This generally represented the fact that individual carers were felt to offer a very positive service, and a recognition that not all islands have access to home carers on the island.
- **Transport:** community transport to assist people with transport to and from scheduled ferry services, for shopping trips and other island activities was identified as positive. However, not all islands have community transport, and it operates differently on different islands.

Items commonly discussed as priorities were:

- **Housing Adaptations**: housing adaptations were identified as important, particularly as most of the isles have a large number of traditional stone-built croft houses, which may have paths, steps, narrow doorways and corridors, and be cold and draughty without insulation.
- **Adapted Housing**: as a result of the limitations to the kinds of adaptations that would be possible to existing housing stock, the development of new-build accessible houses was also identified as a priority. Co-locating a small group of houses was also frequently discussed as a way of offering some of the benefits of sheltered housing – allowing neighbours to look out for each other effectively.
- **Extra-care housing:** on all islands it was recognised that as people aged they may get to a point where they were unable to remain in their own homes, and at this point they would have to leave the island for very sheltered accommodation or for access to residential care. Having extra-care housing similar to the Kalisgarth facility in Westray was noted as ideal, however in the majority of cases it was identified that

funding and staffing would be challenging, and that creative solutions and alternatives may need to be considered.

- **Respite and twenty-four hour care:** in many cases residents can be effectively cared for at home by family and other carers. However, in these cases it was recognised that respite facilities are important, and currently respite is only available on the mainland and in Kalisgarth. Having some kind of flexible facility for respite or step-up step-down beds (to prevent hospital admission and ease discharge) was discussed in the majority of islands.
- **More home care:** Islands generally split into two groups on this item – the larger islands where a small team of home carers are on permanent contracts, and the smaller islands which rely on home carers on relief contracts, or privately provided services. Those islands with permanent home carers generally identified more home care as a priority, in terms of the provision of longer visits to individual service users. Those islands with relief carers (or private carers) only not only identified a priority for longer visits, but also identified a critical priority to recruit more home carers, recognising a vulnerability in having only relief carers present
- **Home help services:** home help services such as gardening and housework were felt to be very important to allowing older people to stay in their own homes, but generally only offered on a private basis. In some islands there were a lack of people offering private services.
- **Home visits or befriending:** the potential value of a 'cup of tea and a chat' was identified in all communities. Specific possibilities for extending opportunities for social contact were discussed in most islands, potentially including a home visits or befriending scheme, alongside discussion of ways to allow carers to spend longer with older service users.
- **Additional visits to the island from clinical services:** increasing visits to the islands from services such as physiotherapy, chiropody and dental services were frequently discussed as priorities. Travelling in to Kirkwall to access these services was identified as off-putting for people, particularly in the case of physiotherapy where by the nature of the services people may experience mobility issues.
- **Improved transport off the island:** the accessibility of planes and boats particularly for people with mobility difficulties was identified as an issue. Transport to and from the piers both on the islands and on the mainland of Orkney was also identified as potentially challenging. The frequency of the boat services means that travelling in for a short appointment can take an entire day, and when travelling to Aberdeen for healthcare being away for at least one and often two overnights is common. Although none of these were felt to be absolute barriers to accessing healthcare it was recognised that combined these issues may mean that people are put off from accessing the care they need. A specific discussion in some islands related to improved transportation between the north isles – to allow residents to access facilities in Kalisgarth for example, which is currently very difficult from the other north isles, even though an island-based facility may be more appealing than a mainland facility.

- **Broadband and increased use of videoconference in healthcare:** individuals from most communities discussed examples of consultations they had received from the Balfour hospital or Aberdeen Royal Infirmary which they felt could have been done through telephone or videoconference. Improving the use of videoconference was felt to potentially offer benefits in terms of cost savings (for the NHS and individuals) and convenience. Broadband and mobile phone coverage were also identified as important for the availability of telecare (including alarms) and for feeling safe when walking or travelling around the islands.
- **Community transport:** even where community transport was available, the island communities discussed improving and extending the services – for example using an accessible vehicle, or increasing the regularity of the service.
- **Other priorities:** some other priorities frequently discussed were: improved information about available services, meal provision including meals on wheels, and in two cases the particular issues of some properties being connected to the main roads by long farm tracks (which were not accessible by community transport).

Once a priority list had been identified in the workshops, participants were then asked to rank the identified priorities in order. In most cases it is important to note that participants found it difficult to separate priorities from one another – so, for example, sheltered or very sheltered housing and recruiting and retaining care staff were often felt to be issues that were interrelated. Further, it was notable that discussions about what would support older people often blended into a discussion about community development more widely – so for example, community transport was of significant benefit to older people, but was also noted as important for wider community development.

Similarly, when it came to considering different care provision (e.g. home care, visiting specialist services, respite provision, very sheltered housing), again identifying a single improvement that would make a difference to enabling individuals to remain at home was challenging. Systemic review, and systemic improvements tended to be identified as important, rather than one or two changes to specific services. In every workshop we heard stories of individuals who had moved away from their island communities because of a lack of services - these stories were often highly emotive, with well-loved members of the community being 'lost' to mainland communities despite their wish to remain on the islands. In some cases ruptured relationships with the community extended to ruptured relationships with families, particularly noted was stress between children and ageing parents (where a parent needed to leave the island but didn't want to), and even break downs of marriages.

It was also notable that the particular flavour of the priorities in each island group tended to be framed with reference to services that they had once had but no longer had access to. So for example we heard a great deal about the loss of the GP in Shapinsay, the loss of the respite facility in Hoy, and the loss of the care home in Sanday. The historical experiences of these communities in terms of the facilities they once had influenced both what they felt was preferable and also what they felt was possible.

7.4 Thematic Analysis

Alongside the assets and priorities, the workshops and interviews also generated a great deal of qualitative data. This was analysed thematically, and provide some underpinning themes and issues for the development of care services in the isles. The first core theme centred around the community providing a specific context for social care, and four key themes within this overarching theme were identified: informal provision, hidden isolation and deprivation, reluctance to access services, personalised care. The second core theme surrounded doing things differently and five key themes within this overarching theme were identified: understanding costs, understanding wider community costs and benefits, context-sensitive developments, and rules, regulations and risk.

7.4.1 Community

i. Informal Provision

The importance of community based informal provision was a strong theme. The role of the community includes informal arrangements for help with housework, shopping and basic DIY as well as a monitoring function:

> *'I think you'll find a lot of the sort of domestic care and the additional care is family based, it's a very strong community in that sense that family and friends will pull together'*

> *'There's willing people around... there's a willingness to make things better generally… word gets round quickly... if they see that somebody's chimney's not smoking for instance they'll say 'oh they've not lit their fire, what's going on here''*

Informal supports from family and friends were particularly identified as vital in terms of lift-giving for access to social events, shops and for ferry transport. In addition, friends and family provide a vital role in having someone to accompany a resident off the island for health care. Given the importance of friends and family, social events in the community had a double benefit to older people – offering a chance for social contact *and* for making arrangements for further cooperative support:

> *'They've got the afternoon club, where older people meet, and I suppose sometimes people organise stuff there and offer lifts and stuff'*

Accompanying a resident is important to facilitate access to transport (e.g. getting on and off the ferry) and has a safety function (in terms of reducing the risk of falls, and assisting for example older patients with dementia who may be disorientated). There is also a social function as attending an appointment can take all day.

In cases where home care provided through the council was problematic (either for capacity issues or due to a lack of carers), the only option for individuals who want to remain on the islands is to arrange their own provision through employing people directly using direct payments. In effect in the islands identifying potential carers who could be employed also relied on community relationships – with individuals knowing who they could ask, and those who were asked being willing to help out. In one case described:

‘The family managed to organise their own night sitters as a rota... it's worked really well, but I think that's partly because of the individuals concerned that there were enough friends and family’

ii. Isolation and deprivation

Although the community is identified as key in the provision of services, participants were acutely aware that not everyone is as embedded in the community as everyone else, and that some individuals may be very isolated. This was particularly the case with some incoming residents who had no family in Orkney, and older single residents with no children and no remaining close family members.

'Certainly there's some people just really... they have that choice, they don't want to engage, they want to be solitary they want to live alone and they don't want anyone intruding as they might see it...’

For incoming individuals with no pre-existing relationships on the islands, engaging with the community while they are still able, supporting the community and developing friendships were all identified as helpful, resulting in a pay-off in terms of the community reciprocating support when they became older and more frail.

‘The people I see thriving most in the older age group often are those who bring a skill and offer that skill to the community either in a paid or unpaid... those people get much more embedded in communities, accepted and therefore looked after as things, as they get older and are less capable of looking after themselves'

A lack of friends and family may not be a significant problem while someone is fit and well, however, when someone becomes more frail, the lack of informal supports *and* a lack of formal provision can cause acute problems in accessing services.

‘If someone can't get an escort there's no service for it, so you know like if you were on the mainland if you were elderly and needing help you might get picked up by an ambulance and taken to your outpatients appointment, there's nothing comparable to that here’

With a lack of service provision and a lack of personal supports, examples were reported of people living in significant pain and discomfort or [only just managing]

'Trying to get into Kirkwall is a major problem' - 'and then you get to a point where as you start to need these services more and more, you start to think... you might actually be in pain or discomfort or you then have to think well do I need to leave my home'

Isolation is also discussed a particular issue for those who are suffering mental health issues – who may choose to isolate themselves. Mental health generally is identified as an issue on the islands and often has an interrelation with isolation, although whether it is a cause or effect is sometimes unclear.

As well as people choosing to be isolated, community based provision has some limits, with people being cautious about asking for too much help. This can result in varying degrees of isolation particularly for those who are unable to drive. For these individuals the only reliable social contact they may have can be weekly lunch clubs (where accessible transport is provided). Otherwise they are reliant on visits from friends and relatives, and being given lifts. However, where this is the case, individuals report a caution about taking advantage of the good will of the community, and a reluctance to ask too often for lifts.

iii. Reluctance to access services

If people are cautious about asking for help from friends and family, this caution is even more apparent when accessing formal health and care services:

> *''Here to Help' could be rolled out a lot more but people aren't asking for it'*

One barrier frequently identified was a lack of information about what services are actually available:

> *People are struggling at home, and they could have a trolley with a tray on it, but they don't know that it's available... it's available in town but it's getting the knowledge to those people isn't it… - there isn't any information to give them, that I know of.'*

Information, where it exists is conveyed through informal means:

> *'…And I said 'you know have you had an assessment done to see what care you're entitled to? and she'd been paying privately for some care to be provided, with absolutely no idea that if she got an assessment that could have been provided free of charge and wasn't aware of self directed support....'*

Another commonly mentioned barrier was a sense that residents didn't want to bother anybody, alongside issues of pride, of not wanting people to think that they couldn't manage. Fears about confidentiality, about it becoming publicly known that they are not coping were also commonly mentioned. Confidentiality is a particular barrier given that simply accessing the surgery, or having the nurse's car outside the house would be enough for individuals' personal circumstances to be known or at least speculated about:

> *'They don't want to bother anybody that's a big thing in small communities... There's also a confidentiality thing as well big thing on an island which... is very tricky because folk know other folk, it's who do you go to for help and maybe you need to say look I need to contact somebody else and that might be a bit of a barrier...'*

Barriers to accessing services are sometimes linked to the culture of the island, of people being used to being self-sufficient and making do, and of not complaining or asking for much:

> *'I also think there's a lot of people on this island probably who are entitled to benefits but it's not in their nature, it's not how they work, they've never asked for benefits so they don't ask for them'*

This culture in some ways seems to permeate the delivery of health and care services on the islands too, with the limitations to health care services generally being accepted by islanders and understood.

> *'Up until now I think things have worked very well, largely because the culture leads people to understand what can be reasonably provided.'*

However, it is possible that a general acceptance of limited services may be resulting in lower demand and requests for help. In particular in islands with very limited home care services or any formal home help service, it is possible that a sense that there 'are no services' here might prevent people asking for help, getting assessed, and potentially accessing direct payments in lieu of statutory services. Similarly the knowledge that residential care is only available elsewhere may result in a fear of asking for help:

> *'I believe at present the option is once it becomes impossible to live at home you are looking at care facilities elsewhere off -island erm and I'm finding that people would much rather put themselves into a negative situation or something detrimental to their health just to remain at home'*

Given the reluctance of people to ask for help, a role for encouraging people to take support was identified:

> *'They need for you to be like, just kind of show them what it's like for someone to clean your house and then they start enjoying it and then they start looking forward to you going round and things so sometimes they just need that first step.'*

> *'At first she refused to have a carer... but gradually came round... and she got to know the carer... and got on great guns'*

In some cases encouragement for people to take up services took the form of more proactive persuasion, such as taking someone along to a social group or lunch club.

Encouraging people to access help at a lower level of need was also identified by health and social care professionals who on a number of occasions spoke of the difficulty of putting in place care packages once a person's care needs had escalated to crisis point:

> *'….and then when we get to like a crisis point we realise that we've not got anything in place...'*

In addition communities identified the importance of actively increasing demand on services to increase sustainability of services being offered on the islands.

> *'It's not sold enough to the elderly, what they're entitled to... If more people were trying to utilise it [home care] there would be a bigger demand for another person to be taken on, its a kind of vicious circle…'*

iv. Personalised care

The services provided on the islands are highly personalised, typically individuals were not referred to by their roles but by first names (with the possible exception of nurses and GPs). The care staff being well known, and familiar, and knowing service users well was also identified as a key strength, and services provided by visiting professionals are not so widely valued:

> *'The locums don't know you, all they can do is look at your notes if they can be bothered, so there's no continuity...."*

For care staff working on the islands, in many cases there were close working arrangements between medical and care staff, which had developed organically and which were facilitated by individuals knowing each other. These arrangements were typically informal and often existed alongside (or despite) formal arrangements. In effect in some cases there were examples of local coordination of services:

> *'It works fine because we all communicate with one another the carers, if we didn't do that it could be different'.*

The experience of being a professional in these circumstances poses specific advantages and challenges. On the up-side, nurses, GPs and carers alike reported that their work is highly rewarding.

However, the experience of care staff, especially those resident on the isles reported some challenges. These challenges mostly surrounded managing their professional identities alongside their roles within the communities as neighbours and friends.

> '*Sometimes it can be intrusive because boundaries of when I'm not at work... and trying to have a normal life off duty, having friendships on the island can be difficult...'*

Home carers in particular reported these challenges. This may be because unlike many of the GPs and nurses (who tend to work on a rota) home carers were more likely to be resident on the island. In fact due to the nature of the work which involves early morning and late night visits, these roles are very rarely filled with staff from the mainland. In addition, because of wages, where nurses and GPs were likely to earn a full wage, or be main earners in their families, carers were more likely to be on relief contracts, managing several jobs, and have other family links to the community (e.g. through working partners, and children). Being a neighbour, a friend and a carer was potentially challenging, and it was common to hear comments like:

> *'You do do extra things that you're not supposed to do.'*

This included both staying for extra time, and doing some extra jobs. These experiences were also reported by privately employed home help workers, who occasionally identified undertaking jobs that were beyond what they would normally offer too:

‘I was cleaning one lady's house and she'd said, when I was chatting to her she'd mentioned she hadn't had a bath for over was it two weeks or something crazy, so I said do you want me to run you a bath now?'

In the instances of private arrangements going ‘above and beyond’ these arrangements could be negotiated and paid for as part of the private arrangement. However, for home carers employed by the Council, there was a sense of unease about the challenges of managing boundaries, because staff were unable to offer a flexible approach within their contracts. Indeed in most cases it appeared that additional activities were undertaken on a voluntary basis outwith contracted hours, but this could result in real pressures for staff, and we heard of at least one case where a carer had left their role because they felt unable to restrict the support they offered people to the terms of their contract.

In terms of personal-care, where Council home carers work to clear boundaries, a greater deal of flexibility exists with carers employed by individuals themselves through direct payments. In these cases negotiations around what jobs can and cannot be done can again take place between staff and the service user. This means that where additional duties are identified as necessary or desirable they can be accommodated – with payment coming either from the direct payments or ‘topped up’ by the service user:

‘*Company's a really really important factor… and I've stressed that to all my lasses, I said don't be in a rush to go anywhere just put your time down we'll pay you if mum's happy to yap just sit and yap to her it's all about her wellbeing.’*

The challenges of going beyond boundaries was not commonly discussed by GPs or nurses. This may partly be due to the fact that many are not resident on the isles, however, these professionals did describe a level of variety and flexibility in their work which was beyond their experience of work on the mainland:

'So you end up doing all the weird and wonderful things that you wouldn't normally do....'

The difference for carers and medical staff is potentially between the way these roles are scheduled (and valued) – ‘time and task’ scheduling does not allow for a flexible approach to service delivery, and clearly delineates duties, whereas nurses and GPs experience a greater degree of professional autonomy.

The provision of personalised care services in small island communities, and particularly home care, was also identified as challenging because of personal dynamics outwith the formal care setting. Again this was identified as a particular challenge for resident professionals, and again particularly home-carers.

'There's a few people on the island... that probably would like carers, but the carers who are currently employed don't want to go to them because of interpersonal relationships... or there's people that could do with care but they won't have the carers who are already employed because of some other issue.'

The flexibility offered through direct payments also potentially offers some solution to these challenges – if a service user has the ability, and wishes to employ their own staff, and is able to identify people who can provide personal care (all of which are significant potential barriers) then they may be able to source other people, who they choose, to provide their care.

7.4.2 Doing things differently

Throughout the workshops and interviews there was a recognition that the accessibility of health and care services on the island was, generally, limited. Although it was reported that some islanders had very high expectations of services, these tended to be identified as people who were new to the islands (and therefore didn't understand what could be provided), or who had unreasonable expectations for other reasons:

> *'Middle-aged people who have moved to the island bringing their parents up who are often in very poor health with complex needs coming to the island, and their expectations I would say are out of kilter with what has been provided to date.'*

Islanders with unreasonable expectations should be distinguished from the much more common perspective of participants – who recognised that their access to *some* services was actually much better on the island than on the Orkney mainland (e.g. the accessibility of GP or nursing services) but who also recognised that access to other services was much more difficult (e.g. specialist medical practitioners). In many cases the islands had a recent history of services being apparently 'cut' – for example replacing GPs with nurse practitioners, or the removal of the respite facility in Hoy. The lack of home carers in other islands was felt to be a critical issue. This led to questions about sustainability, and equality – how far is it acceptable for services to be reduced on an island? How far is living on an island a choice through which you accept that your access to services will be reduced?

> *'Nevertheless having no provision on an island is not acceptable, and to some extent they've got away with it for years because there wasn't much demand.'*

> *'I do wonder whether there's an agenda that it would be a lot more convenient for everybody if the isles just depopulated, so let's not put the services there and eventually people will get sick of it.'*

Questioning the motives of the 'powers that be' and their understanding of the isles perspective was apparent on a number of occasions. This raised a question of how far the isles have felt appropriately listened to in previous consultations and decisions about health and social care:

> *'There's this requirment from us, that people operating on our behalf on the mainland, understand some of the limitations that we have.'*

What was very striking in the workshops was that there was not a sense that all the isles should have the same services as on the mainland, but rather a recognition that the same services cannot be provided, and that there is a need to look at ways of doing things differently. Ideas for innovations included community led innovations, community

partnerships with health and care services, and innovations to health and care services. Some of these are given below:

- '*a red cross type pick up'* service for older folks on the island to take them to the pier, or all the way in to the mainland for access to hospital service. Alternatively a list of willing people who would accompany people to hospital would be useful.
- A befriending service, or visits service run by volunteers, allowing for some of the social needs of older people to be met, particularly those who are isolated.
- Arranging a home delivery service for food or other goods either via a supermarket in Kirkwall or via the local island shops
- Extending the community transport scheme, or setting up a community taxi or lift sharing scheme to enable more effective transportation around the island
- Setting up a local meals on wheels scheme or providing locally produced frozen meals
- Running exercise or balance classes for older people in the community.
- A version of the mobile dentist that was previously used on the isles – and a question about whether a similar thing could be done for other visiting services.
- Extending the role of the ambulance service responders so that they could be used for e.g. double up visits provided by home carers.
- Local coordination of home care services – to allow for greater flexibility accounting for journey times, personal relationships and the needs of relief workers.
- The use of a generic worker to support healthcare professionals and potentially to provide some access to services with support from Kirkwall (potentially via video-conference) such as physiotherapy.
- Use of volunteers for some aspects of care e.g. particularly palliative care.
- Building some form of adapted housing, which could potentially be staffed or unstaffed depending on capacity.

Several sub-themes were identified around potential developments, understanding costs, understanding wider community costs and benefits, context-sensitive developments, and rules, regulations and risk.

i. Understanding true costs in healthcare provision.

Questions about innovations to the operation of health and care services focused on the hidden costs of some elements of the care system currently – for example the costs of airlifting people to hospital, and the costs of hospital admission. Questions focused on how much these things cost, and whether additional services such as a step up / step down facility or a respite facility would actually lead to cost savings.

> '*The thing with respite, argue that in the long term it would save money... cos if you could use that respite either to get out of hospital more quickly or to prevent them going in in the first place, then you're cutting health costs... then it could potentially pay for itself*'

Other questions were raised about the costs of helicopter evacuations, and how much might be saved if there were a reduction in emergency evacuations.

ii. Understanding wider community costs and benefits

Issues such as the building of accommodation raised further questions about the wider costs and benefits to the island communities. Building a care facility for example was identified as having potential benefits in terms of population sustainability through the creation of jobs. Further the more a community could be stimulated to grow, was identified as impacting on potential future demand on care services – the idea that if a facility was built it might *become* sustainable in the future, as it generated further employment, and potentially further demand.

Other discussions identified the role of transportation to the island both in terms of accessibility of health and care services, and also in terms of wider sustainability of the island.

> '*If you can bring the isles closer together so that you can share facilities the chances of you getting these facilities is much greater*'

Improved links between the islands were discussed both in terms of more regular and easier access between islands via a foot passenger ferry or existing ferries, or through fixed links. The islands were aware of the costs of such infrastructure developments but also aware of significant potential savings – through increasing the markets for services and the cost effectiveness of delivery. Health and care services and education were commonly discussed, but wider benefits in terms of trade and skills sharing were also discussed (with participants remembering when the North Isles were more effectively linked to each other and they could more easily visit and trade with one another). Further community and sustainability benefits were identified, with existing limited health and social care and education provision being identified as reasons that people would leave the islands, and also being reasons people chose not to move to the islands.

In Papa Westray similar discussions focused on the relative costs and benefits of improving broadband provision. Having identified that sending a resident to Aberdeen might cost five or six hundred pounds, and that residents also have to travel to the Orkney mainland for council services, the discussion questioned whether investing in broadband might actually lead to cost savings:

> *'If you went with satellite broadband you'd be looking at something like maybe, let's be pessimistic, a thousand pounds per year... that would allow you to do all sorts of things that wouldn't require lots of flights to Aberdeen and Inverness.'*[17]

Later the discussion also identified the possible use of broadband and video connections to provide access to adult education '*that needs to be provided by skills off of the island.'*

Other ideas centring around developments that might have an initial cost but a wider community benefit included ideas of blocking together, multiple jobs or roles into one contracted job, or 'topping up' a relief job into a single contracted job. Relief work was

[17] Since the research visit to the island a new broadband provider has been secured to deliver service to Papay using microwave links at a cost of £33 per month.

identified as an issue because it didn't allow enough of an income to attract people to the island to live, whereas permanent contracted roles might bring in working age individuals or families, and therefore have a wider benefit in terms of community sustainability.

iii. Context-sensitive developments

The importance of local knowledge in developing new services (and in the running of existing services) was noted. Existing care staff frequently identified that a greater level of local organisation would be useful

> *'Even [homecare coordinators] sat in Kirkwall in the council officers haven't got a clue, have never been to [the island] never mind knowing the logistics of [the island]*'

And discussing potential developments in befriending and time-banking, the workshop goes on to discuss the value of a coordinator on the island who could coordinate all these services, and *'bring care back to the island'*.

In addition, considering future developments, island residents frequently discussed what would or would not be possible considering the services they already had and the people who already existed on the island.

> *'[Discussing delivery of goods]: but I think we also have to look at things as well, like the erm are we stepping on the person who does the … the local courier...and the local shop'*

> *'There was talk at one time of having an island dial-a-bus type thing but that would upset the taxi service that we have'*

Managing personal relationships on the islands was also identified as important, with participants aware, for example, of the positive work undertaken by community minded individuals, but how this wasn't always unproblematic:

> *'Perhaps there's a perception that... if there's any community initiatives it's perceived it's the same group... in every committee, you know they're doing everything and you know that's seen quite negatively by others sometimes you know that it's the same core of people'*

However, services that use local people rather than sending people in to an island community was also felt to be more positive. Discussing an initiative elsewhere one participant commented:

> *'So now they are local people going to local people and they're delighted on the whole... 'oh I knew her mother she was a lovely lady, so I'm really happy about her coming' it's quite the reverse of what the social work department seemed to be unhappy about'*

iv. Rules, Regulation and Risk

The challenges of rules and regulations were noted in terms of developing new services. Rules and regulations were perceived to be barriers to innovation, and to developing the flexible services the islands require. These regulations were particularly discussed with

relation to training for carers.

> *'The worry for me is the changes coming in the education requirements... that everybody needs an SVQ is it... how on earth is that supposed to work for folk whose, if you want to have a career fine, but for somebody just wanting to go in and help.*

Employing carers directly using direct payments is identified as a possible alternative, but the level of responsibility passed to individuals as employers in these cases was felt to be off-putting (*'that would scare me')*, and in addition, the lack of training, support and regulation is also felt to result in some level of risk.

> *'Care needs that require two people... there's no one other than family and willing helpers really, but we need to, you know, look at then safety, risk assessment liability accountability, so I'm looking at training because you know if it's just volunteer helpers say... who's accountable for them?'*

Being able to run services which are regulated, supported and 'above board' is important to the island communities, but equally identifying flexible ways of delivering services is vital.

> *'It's finding that balance with completely unregulated care which wouldn't be right either.'*

In particular finding ways of building on the strengths of island communities, their neighbourliness and strong communities, in order to make this support more consistent and more supported *without* regulation becoming a barrier was identified as a priority:

> *'You can just literally be a good neighbour... and pick up the phone and say do you want me to take you to do your shopping... but then that's not consistent enough for what we're talking about here'*

8. Discussion

The aim of this research project was to answer the following question:
How can community led care solutions be implemented in the small island communities of Orkney?

The literature review and isles visits demonstrate that the community can have a real value in the provision of care services, but that implementing community led care solutions is not straightforward. Community involvement is most effective where communities work in collaboration with statutory authorities and where the specific context of a community is accounted for in any model of care developed.

In contrast to much of the coproduction literature, this research project was relatively innovative as it was supported by the communities themselves, rather than being driven by the statutory authorities. The data collected from the communities demonstrated their desire to find models of care services that are appropriate for their specific contexts, and a willingness to engage in creative problem solving. Indeed in a number of the workshops information and ideas were shared that made an immediate impact – for example in Papay, discussion of the difficulties getting on and off the planes, led the group to identify that a step with an integrated grab rail would be helpful. As a result the community is now looking at options for organising such a step.

The communities also possess a great deal of resource, both in terms of human resource and knowledge and in some cases in terms of financial resource. The capacity and willingness of the communities to help support each other in an informal manner is particularly evident. There is also clear experience of community involvement in social enterprise – which is something that previous research (such as the Opportunities for Older People project) has identified as important for supporting further enterprise. This suggests the context is strong for enterprise development in terms of health and social care. However, there are also some challenging factors – rules and regulations, particularly surrounding the registration and training of care staff are challenging, and there is also a question of capacity, with communities already offering a great deal of support informally, what is the capacity of islanders for further voluntary and social enterprise activity? A further important note is that there is considerable variation between the islands in terms of the resources they possess, and their specific contexts. As a result it is suggested that it would be useful to identify ways of building on existing community support while being cognisant of the risks of over-burdening communities, and recognising the specific contexts of individual island communities (meaning that a 'one size fits all' approach is unlikely to be effective).

In terms of existing health and social care provision, statutory and informal or voluntary supports are already working together in many cases. The key strengths of the island communities lie in the commitment of their health and social care professionals, the value and respect that communities afford their healthcare professionals, and the informal community supports that are offered. Although the personalisation of care services was a key strength, it could cause some challenges for staff working within professional

boundaries. For medical staff the Isles model of care has assisted with some of these issues by providing a network of support and governance, however a similar mechanism does not exist for care staff. Informal supports such as lift-giving between friends, accompanying individuals to hospital appointments, monitoring vulnerable individuals, and sometimes direct support in the provision of care were all discussed by health care professionals who recognised that their work, especially in the smaller communities was assisted by these informal arrangements. In addition other formal support mechanisms including the ambulance service responders were frequently identified by both medical professionals and communities as a valuable resource.

For these communities, building partnerships between statutory and community services, and finding flexible approaches to the delivery of services was identified as vital. The existence of rules and regulations were identified as barriers to service provision, but equally the provision of services through completely informal means (neighbourliness) or solely through personal arrangements (e.g. employing personal assistants through direct payments) was identified as undesirable. It was felt that in some cases restricted care services in island communities was leading to an increased pressure on informal and personal arrangements, and that there were risks inherent in this – particularly in terms of safeguarding and equality (of access to services). Finding ways to extend informal provision through existing 'community spirit' without imposing an unwieldly level of regulation, and finding ways of communities and statutory providers working together to address the well-recognised challenges of service delivery in the isles were identified as important.

8.1 Home Care Services

This research shows the challenges of managing personal relationships alongside professional relationships is perhaps more acute for home care staff than for other medical staff. This is because medical staff retain a greater degree of autonomy (and are less subject to time-and-task scheduling), because they are more likely to earn a full-time wage from their work (rather than managing multiple roles) and because they are also more likely to be resident off-island. Although managing boundaries can be challenging, the personalised nature of care provision is also a key strength, with communities very positive about the quality of care that is provided. Recognising the very real challenges of managing boundaries in small communities for care staff (in the same way as has been recognised for medical staff) is important – and identifying mechanisms to support staff in these communities is also important. This may involve statutory providers identifying mechanisms for supporting staff through training and networking (perhaps utilising a similar model to the isles model of care). However, it may be that considering different models of care provision, utilising some of the options provided through the Self Directed Support legislation, may also assist with the provision of more flexible care services.

With islands reporting the importance of care developments which are context-sensitive and allow for some local co-ordination, models of care delivery that involve a partnership between a care agency and a community such as that developed in Boleskine may be worth further consideration. The value of a partnership with a care agency for the community is that some of the responsibility (and cost) of providing care in a highly regulated context are taken on by an agency. Previous research into isles based care services (e.g. Smith, 2014) has identified that if a community were to set up a care service themselves, the costs of

running such a service would be very challenging to meet. In addition running regulated care services can put pressure and responsibility on communities that is off-putting. For care providers partnerships with communities can also assist with recruitment of care staff, and utilising local knowledge in the coordination of services. In addition, because care providers such as Highland Home Carers (who partnered with the Boleskine community) are funded through Self Directed Support Option 2, there is also greater flexibility in the choice and delivery of services – allowing individuals to access additional services if they wish (which they may pay for). In the case of Boleskine, the model also allowed integration of care provision with wider community based voluntary services.

Although in the past this model has been considered challenging to implement in Orkney because it relies on the existence of care providers who can partner with communities, in recent years the diversification of the care market in Orkney means it has become more possible. Indeed, in essence, the model is relatively similar to the Papa Westray partnership with Crossroads. Although in Papa Westray the partnership was implemented to address issues of capacity in terms of care services, in larger islands this model may also be worth considering as it would allow for greater flexibility in terms of the services that are delivered. This would potentially address some of the challenges for care staff in terms of managing boundaries (because additional services could be negotiated), and for individual service users in terms of accessing additional services.

In order to establish a model of care involving a partnership between a care provider and a community would require some community resource. In particular having an individual who is able to be the contact point, representing and negotiating on behalf of the community is important (as was the case in Papay). In addition in Boleskine, Highland Home Carers were able to connect with a community based care organisation, who provided additional services such as a handyman service, community transport and lunch clubs. This kind of partnership enables wider voluntary and community based activities to be provided along with personal care. Currently in the non-linked isles of Orkney some of these community based activities exist (particularly lunch clubs and transport), and there may be scope to provide more (see below). However, identifying arrangements whereby one organisation or community contact becomes the contact point for a full range of community run and personal care services would assist with seamless provision.

A further consideration for community partnerships with care providers is the challenge posed by regulation and the increasing costs of training carers (through the introduction of mandatory SVQs). Mandatory training to SVQ2 in small island communities, is problematic because in very small communities the amount of personal care work requiring this qualification may well be small, meaning that carers are likely to be employed only on a part time or zero hours basis. As a result employers may find covering the costs of training (compared to the potential income from services) challenging. Indeed in Papa Westray two carers have been trained but there has, as yet, been no demand for the service. In addition, staff employed on this basis are unlikely to be pursuing a career in care as such, and indeed, given the demographics of small islands, may well be nearing retirement. If training requires a commitment in terms of personal time or finance then these individuals may choose not to undertake the training, even if this means leaving their employment. Despite a mandatory requirement to train at SVQ2 being problematic in island communities, equally

this research found that island communities and individual carers were keen to provide good quality services which were appropriately supported.

Addressing the challenge of training, there are three potential actions – firstly to lobby regulatory bodies for flexibility and innovation to assist with identifying potential solutions for small communities, secondly to increase demand on services, and thirdly to identify innovative methods of funding and supporting the training of staff. In terms of the first of these areas, exploring the potential for flexibility and innovation with regards to the training and regulations surrounding care delivery, specifically in very small communities is important in terms of ensuring that these communities have access to appropriately supported care services – currently the risk is that with regulations rigidly applied, it will be challenging to train care staff in the islands, and trained carers will only be available if they travel in from elsewhere or if individuals who need care services move; alternatively the only option for individuals in small island communities may be for them to employ their own (untrained) carers. OHAC has already noted a 'need to engage with national and regulatory bodies…. Accepting that, in an island context, sometimes there are stark differences and certain rules and regulations are constraining our creativity when it comes to helping our smallest and most vulnerable communities' (OHAC, 2017c: 5). Continuing to explore options, and to encourage flexibility to is important.

In terms of the second action, increasing demand, this may enable care services to become more sustainable in small island communities. It could involve increasing demand from those who may be eligible for personal care services (but who are cautious about requesting them) - this is likely to be a small but potentially significant proportion of most island populations. However, with agency provided services typically including domestic care as well as personal care, and with the facility for individuals to access paid-for services, there may be also be much greater scope to increase demand in terms of paid-for domestic care – indeed in the Rousay workshop such potential additional demand was identified. The provision of a local contact point, and enhanced services in a community may assist with increasing demand (see below).

In terms of the final action, when it comes to innovative methods of funding and supporting the training of carers a true partnership model may need to be explored – between statutory services, care agencies, communities, community development representatives and training providers. The challenge for care providers is that effectively oversupplying communities with care staff and training them to SVQ2 when there is low demand for services is costly, and may not be viable in terms of potential income from care services. However, on wider grounds this level of investment may be justified. So, for example, ensuring trained staff are on island may provide benefits to OHAC in terms of futureproofing – as when care needs *do* arise if there are no staff on-island, the costs of services imported from the mainland, or the provision of residential care on the mainland, may be very significant. Similarly, in island communities where the development trusts have an income, this is often used to subsidise some forms of training, and it may be that for development trusts providing some form of investment for care training may be a more cost-effective approach to the provision of services than, for example, subsidising care services provided by other agencies. Training island residents in provision of care rather than importing care services from elsewhere also has the benefit of increasing the human capital available on an

island, potentially also increasing the capacity of island communities, and the knowledge of care services.

Considering how statutory authorities, care agencies, island trusts, and potentially individual islanders may be able to join together to jointly fund training may offer some scope for addressing the financial challenges of provision of training. In addition a partnership approach is necessary because of the nature of the training – on their own, individuals and development trusts cannot solely support SVQ training, because SVQs require practical experience. In islands where there is very low demand for care services, even if funding is available, accessing the experience necessary for training may be challenging. For this reason it is suggested that the islands as a group, statutory authorities, care providers and the local training provider (Orkney College), ideally need to collaborate to identify models of training (considering the costs and the experience requirements) that may be suitable for the isles. The College has a great deal of expertise in flexible training delivery, including supporting learners at a distance and via technology. Building a model of training that helped individual carers to network with each other and build experience, and enabled them to access training flexibly would be beneficial. Flexible approaches to training are also necessary to accommodate the different needs of learners, it may be possible for instance to consider one or two apprenticeships for school leavers in some of the isles, or training some staff at a higher level than is strictly necessary (such as SVQ3) which may be more cost effective (allowing individuals to access the part time fee grant), and allow further progression onto higher education courses (with the SVQ3 including an HNC – equivalent to first year degree). However, this latter option would certainly require enhanced partnership working to enable an individual to access the level of work experience necessary for achieving this qualification.

To pursue the development of home care services in island communities it is therefore recommended that establishing community-agency partnerships are further investigated. This would require communities to have an identified contact point for establishing the service, and preferably for this contact to also connect with and develop existing community services too. The ongoing resourcing of this model potentially includes some challenges around training, which would require statutory authorities, care agencies and the island groups to all work together to resource (in terms of provision of experience, and managing costs).

8.2 Community Led Innovations

Although the development of care services may require a partnership approach in the islands, there are clearly some possibilities for the communities to innovate in areas where care regulations are not so prohibitive. Services which provide social contact, support with daily living and support to access resources and services may be particularly valuable. Services like these are important for providing for the social and well-being needs of older people, and potentially preventing or slowing the escalation of needs. Indeed the development of services in these areas has some precedent in other communities (such as Boleskine and Assynt), and community led provision in these areas is likely to grow, as gaps have appeared in the provision of these lower level services as statutory services become more and more focused on higher levels of need.

In the communities we spoke to a great deal of support was already occurring on an informal basis (e.g. informal lift giving, odd-jobs, shopping etc). However the informality of these arrangements resulted in potential inequality with those who had greatest social connections most likely to benefit. Finding ways of building on these informal arrangements and creating services that are accessible to all island residents represents a clear possibility. In the majority of cases the islands are already running community transport services and lunch clubs, and these were consistently identified as of considerable benefit in the workshops. Expanding these services was also identified as a potential priority – particularly in the case of community transport. However, the island communities also identified a range of new services that could be investigated, these can be grouped as follows:

- A lifts / accompaniment service for individuals accessing hospital treatment on mainland Orkney
- A befriending / visits service for older residents in the community
- A meals service
- Help with household odd-jobs, cleaning and gardening

In addition to these possibilities, the research also identified the importance of increasing the awareness of residents about available services. Understanding which services are available on the island, which are only available on the mainland, and how to access services were all identified as challenging. Particular areas where better information is needed are entitlement and access to personal care and domestic support, and also information about aids and adaptations available, and housing adaptations. With information about services generally being shared through personal contacts, rather than more formal means, having a local contact on the island who could offer information and advice about services is worth considering. Developing a local contact point for information about services may also help with providing an additional contact point for services visiting from the Orkney mainland.

The provision of services which involve some form of home visit (e.g. befriending, home help or meals on wheels), or the extension of accessible island transport services may be particularly valuable given the findings of this research project about the potential isolation of some individuals in the community, particularly those who are housebound, with a less extensive social network and who live at some distance from the main settlements. In addition the provision of lower level services would potentially help act as a 'gateway' to accessing further services, something that this research identified as a potential priority. With some community members being reluctant to ask for support, and only requesting help at crisis points, offering services at a lower level, where staff could informally monitor individuals and offer information and encouragement to enable them to access additional services would be valuable. Considering how services are described and pitched is important given the reluctance of some islanders to ask for help. Focusing services on areas which may carry less stigma (e.g. home help or transport services) or which are available to *all* islanders (younger and older) may be beneficial.

The development of these kinds of services could be taken forward by communities themselves – so for example, the Westray domestic help service run by the development trust. Alternatively they could be taken forward in partnership with an existing organisation – for example the befriending service on the mainland could potentially support islands to develop services. Critical in the development of any services is that they are informed by the

context – and even in the case of a partnership with a mainland organisation should preferably should be locally run and locally delivered. This is important for a number of reasons – firstly services on islands are inherently personalised, and managing personal relationships is easier to do from an on-island perspective. A good example of this is the Westray domestic help service which takes a sensitive approach to setting up services, checking that the service user is happy with the service provider before making the match. Secondly, management of services on island can help with coordination and logistics, and also can help with partnership working, linking in to other services running on the island.

The scope for potential developments on an island is best understood and developed from an on-island perspective. Context-sensitive development has been identified as critical in previous projects (such as Opportunities for Older People) and was also identified in the findings from the isles visits – where it was emphasised that specific contextual factors would allow some services to work in some places, but not in others, and also that there can be sensitivities around developments which are best understood at a local level. The challenges in any service development will be around identifying the potential demands for a service (with, for example very small island populations also likely to have only low levels of demand) and the resource for delivery of a service (in terms of people able to provide the support, and finance). Again the scoping of demand and capacity is best done at an island level – potentially through a basic market research exercise. Grant funding for setting up further services should initially be considered, however any services developed should be fully evaluated for impact. Demonstrating impact in terms of health and well-being will be central to securing ongoing funding.

This research therefore recommends that communities investigate the potential to develop further community led services that focus on wider wellbeing and social inclusion and domestic support. These findings are consistent with previous research in Hoy and Eday that identified a role for further support with daily living. Such services would at least partially address the challenges of hidden isolation, deprivation and reluctance to access support which were identified in this project. If the provision of lower level services assisted in the creation of greater demand on statutory services or uptake of direct payments or benefits, this then may also support the sustainability of care services on the island. Building up further community capacity, and particularly establishing a community contact for health and care may also support partnership working with statutory authorities, especially the developing approach to locality working being established by OHAC.

8.3 Wider partnerships with Statutory Providers

Despite identified potential for island communities to establish further activities themselves, for the full benefit of community led services to be realised partnership working with statutory authorities needs to be embedded, potentially through a process of co-production.

On an individual island basis community engagement with medical and care staff was identified as very positive, and care staff and medical staff also frequently worked closely together. From an island perspective, it was understood and accepted that effective service delivery involves informal, community and statutory providers. The communities also understood that provision of services was costly in their communities, and there was an

appetite for innovation and a willingness to support statutory providers. Indeed in many island communities the pressure for innovation was felt acutely, with the sustainability of the island felt to be at stake. However, there was frustration apparent in the communities, with a question over how far statutory providers understood the island context, and how far they were willing to innovate in the ways required.

When discussing potential innovations, it was notable how the suggestions, and the questions, raised by the communities demonstrated synergy with those identified by OHAC. Discussion of flexible working practices, generic worker roles, and step-up step-down facilities were all common – and are also some of the areas currently being looked at by OHAC. The questions that were raised in these discussions covered two particular areas – what innovation is possible within the rules and regulations governing care? And what are the relative costs and benefits of providing different kinds of services? Again, in terms of OHAC, the need for better data surrounding the needs of the island communities has been identified as a priority. The particular question posed by communities about what the costs or cost savings might be from providing, for example, respite or step up and step down services in terms of reduced hospital admissions and emergency evacuations is one that particularly requires consideration by OHAC.

In previous examples of co-production enhanced understanding of communities about the health and social care landscape, including regulations and costs has been identified as a positive outcome. Given that the communities in this research were identifying questions in these areas, it may be that for OHAC to share data and engage in conversations about what is and is not possible, would be highly valuable. Indeed *engagement* itself has been identified as a positive outcome of co-production, and in the case of the isles, simply being engaged, particularly in a context where they haven't always felt understood or listened to may be valuable. What is important to note here is that engagement is not simply about surveys and consultations, but about truly engaging and discussing priorities with communities. If the communities progress towards delivery of further community led services, discussion with OHAC may be particularly valuable to help inform the development of the services, and ongoing partnership arrangements.

In Orkney some positive moves towards involving island communities in the design and delivery of services are clear – particularly in the establishment of the isles as one of the IJB localities. However, the full potential of a co-production model is yet to be explored. At this current time, when locality planning is still to be properly developed, and with current moves to hub based working, and identifying a model of care for the isles, it could be a good time for OHAC to explore further possibilities for co-production. It is of course possible that the positive experiences of the workshops and interviews in this project were partly due to the research being undertaken by an impartial third party, and a university research team. So in taking forward engagement with the communities it may be valuable for OHAC to consider different approaches and methodologies for engagement, and also who takes forward this engagement – for example it is notable that in the Highland region university researchers have been employed on a number of initiatives, including the 'Being Here' project. Academic researchers do not necessarily need to be employed, but impartial facilitators may be valuable.

A further key consideration for co-production is how NHS Orkney and Orkney Islands Council can ensure that they are prepared to engage in reimagining service delivery in the islands. It is notable that examples of community led innovation elsewhere in Scotland, such as Assynt Community Care have often had significant support from statutory providers, both in terms of establishing services, and in terms of the provision of ongoing core funding (which can be topped up through additional activities). The number of examples of innovation in the Highland region can perhaps be traced to the Lead Agency model that their IJB established. As a result health and social care services are more truly led by 'one system one budget' thinking, and innovation has potentially been more forthcoming which increases community based (and sometimes led) provision in order to potentially reduce expenditure on residential and hospital based services.

In addition to OHAC partners engaging with service models for the isles, it is further recommended that in developing locality based models, the wider relevance of place, particularly in terms of infrastructure is considered. Broadband, transport, and housing all have a clear impact on health and well being and on the delivery of health and care services. The findings of this research show that consideration of these areas is absolutely critical. Given the importance of these areas there may be scope for improved partnership working between OHAC and community planning and community development. It is also possible that proper consideration of these areas in terms of OHAC planning would lead to more radical and innovative approaches.

A particular area for radical consideration surrounds issues of housing and care. It was notable that in all islands very sheltered housing and respite facilities were discussed. These conversations were framed in many cases by the Highlands Small Communities Housing Trust (HSCHT) research that had recently taken place. The communities understood that respite and very sheltered housing are costly to run, prohibitively so if the service is compared to similar facilities on the mainland. However, the communities were keen to explore different options. In particular questions were raised over whether there would be a wider benefit in the creation of a care facility – if it provided employment, this might bring people to the island, and create further demand on other services, making them more sustainable – e.g. the shop or the school. Other questions covered whether there would be a demand for such a facility from people in other parts of Orkney – that is the question of whether the islands could 'build it and they will come'. There was also a willingness in the communities to explore different models of service provision – would there be ways of using volunteers for some services? Could developments be phased so that co-located housing providing some informal support was established first of all, and if demand allowed formal care services could be engaged? With a number of islands having identified capital budgets for the development of buildings, understanding what is possible in terms of provision of care is a critical question. Therefore it is recommended that OHAC work with the island communities to jointly scope possibilities. Even without financial investment, it is suggested that a joint scoping exercise, and identification of ways of working together utilising existing resources would greatly assist the communities in terms of their knowledge and confidence to take forward projects. It would also show a commitment to working with the isles on the part of OHAC, addressing that question that emerged in the research of how far the isles are important and understood.

As a result of this project it is therefore recommended that OHAC substantially enhance their approach to locality planning. In particular, identifying scope to establish co-production approaches would be beneficial, especially given the critical need for innovation in the isles and the wish of the communities to engage in design and delivery of services. Securing better data for the isles, and being willing to engage in service innovation are important components of moving forward with co-production. In addition it is recommended that locality planning within OHAC includes a stronger focus on wider issues of place, in particular the role of infrastructure, and seeks closer partnerships with community planning and development functions.

9. Conclusion and recommendations

This research demonstrates a strong appetite for meaningful engagement with statutory authorities on the part of the island communities. In addition, with OHAC yet to fully embed locality based planning and actively exploring possibilities for hub-based working and services in the isles, now may also be a good time for exploring a co-production approach with the communities. Without further engagement from OHAC it is possible for the islands to take forward some potentially very beneficial work in establishing further community led services, however for the full benefit of these services to be realised a coproduction approach would be beneficial. For this reason the report makes two key recommendations:

Recommendation 1: The Isles communities to continue to build and extend existing community services, including identifying the potential for the development of further services. The isles to also consider the potential for bringing services together into one community led care service.

Recommendation 2: Orkney Health and Care to identify potentials for closer partnership working with communities, including co-production.

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