WHAT WORKS SCOTLAND

Action Research Report

November 2016

Learning about community capacity-building from the Community Links Worker approach in Insch, Aberdeenshire (2013-16): a collaborative action research inquiry (cycle 1)

Partnership Innovation Team, Aberdeenshire Health and Social Care Partnership

What Works Scotland (WWS) aims to improve the way local areas in Scotland use evidence to make decisions about public service development and reform.

We are working with Community Planning Partnerships involved in the design and delivery of public services (Aberdeenshire, Fife, Glasgow and West Dunbartonshire) to:

- learn what is and what isn't working in their local area
- encourage collaborative learning with a range of local authority, business, public sector and community partners
- better understand what effective policy interventions and effective services look like
- promote the use of evidence in planning and service delivery
- help organisations get the skills and knowledge they need to use and interpret evidence
- create case studies for wider sharing and sustainability

A further nine areas are working with us to enhance learning, comparison and sharing. We will also link with international partners to effectively compare how public services are delivered here in Scotland and elsewhere. During the programme, we will scale up and share more widely with all local authority areas across Scotland.

WWS brings together the Universities of Glasgow and Edinburgh, other academics across Scotland, with partners from a range of local authorities and:

- Glasgow Centre for Population Health
- Improvement Service
- Inspiring Scotland
- IRISS (Institution for Research and Innovation in Social Services)
- NHS Education for Scotland
- NHS Health Scotland
- NHS Health Improvement for Scotland
- Scottish Community Development Centre
- SCVO (Scottish Council for Voluntary Organisations)

This is one of a series of papers published by What Works Scotland to share evidence, learning and ideas about public service reform.

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This first cycle of this Inquiry (June 2015 to August 2016) has been researched and the report written by an Aberdeenshire Health and Social Care Partnership PIT (Partnership Innovation Team). A further cycle(s) of the Inquiry that aims to build on the learning so far is anticipated (see section 3.2).

Acknowledgements

The Partnership Innovation Team or PIT members for this first cycle of the Inquiry are as follows:

- Jane Warrander, Senior Improvement Officer, Aberdeenshire Council
- Alison Knight, Community Health in Partnership Team Coordinator, Aberdeenshire Voluntary Action
- Alison McPherson, previously Community Links Worker in Insch with the Friends of Insch Hospital and Community, now Community Health in Partnership Team Officer, Aberdeenshire Voluntary Action
- Sharon Van de Ruit, Senior Improvement Officer, Aberdeenshire Council
- Sophie Humphries, Strategic Development Officer (Community Planning); Policy, Performance and Improvement, Aberdeenshire Council
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- James Henderson (Researcher), What Works Scotland
- Nick Bland (Co-Director), What Works Scotland

Others who've contributed, informed and supported this cycle 1 of the Inquiry:

- Friends of Insch Hospital & Community and ICAN (Insch Community Association)
- Seven interviewees connected to Insch Community Links and local services (see Appendix 2)
- Jude Richards (Aberdeenshire Voluntary Action and Aberdeenshire Council)
- Paul Gleisner (Aberdeenshire Council)

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- Fiona Soutar, NHS Grampian
- Bill Stokoe, Aberdeenshire HSCP
- Erin Wood, Aberdeenshire CPP
- Nom Wright, ICAN

Notes for the reader

Abbreviations

- CPP – Community Planning Partnership
- HSCP – Health and Social Care Partnership
- PIT – Partnership Innovation Team or team carrying out this local Inquiry/research
- WWS – What Works Scotland

Research notes

(1) The quoted material (in quotation marks) in this report is drawn from transcripts of interviews, but will not be exactly word-for-word. It has been edited to support readability. We have, however, worked to sustain the meaning of the material.

Contents

Executive summary

Introduction

This report details the first cycle of work by the Partnership Innovation Team (PIT) of its Inquiry into community capacity-building that improves health and wellbeing and supports the process of health and social care integration. It is set within the broader context of the Christie Commission's 2011 report for the Scottish Government and Scottish public service reform. The PIT included staff from across the community planning partnership (CPP), health and social care partnership (HSCP) and third sector: those with experience of improvement methodologies, policy and strategy, the third/community sector, public health and research – including two researchers from What Works Scotland.

In this first cycle, the PIT has focused its action research on the work of the Community Links project in Insch, Rhynie and Rothienorman in rural Aberdeenshire (2013-15) – a project supported by Change Fund and Integrated Care Fund monies. The PIT, which includes the project's Community Links worker, has sought to understand:

- what makes for good practice in relation to 'community linking'
- what supports development of 'community linking' and can help its wider use ('spread').

The team researched the Insch project in some depth through interviews and a study visit, desk research, and policy and practice discussions and reflections – using an action research further informed by some improvement tools and thinking.

The Community Links worker in Insch was understood to be undertaking the following key roles:

- understanding and mapping the community and its assets and needs;
- *linking* community members with existing community-capacity and public services;
- developing relevant community activities to improve local health and wellbeing;
- working in partnership and *linking* with existing community organisations and networks;
- working in partnership and *linking* with health and public services and the wider third sector.

Activities developed across the course of the project included: walking groups, lunch clubs and other social groups; support for volunteering; and informal partnership-working across the local community sector, health services, other public services and the wider third sector.

Key learning points

Headline figures for the project included:

- Approximately 200 older people a month engaging in community activity initiated by the worker – across Insch Community Hospital catchment area (Insch, Rhynie and Rothienorman).
- Approximately 20 people undertaking volunteering roles related to these activities.
- Wide ranging positive feedback from participants on the value of the activities to their physical, mental and community health.

Good practice in 'community linking' – the work of a community links worker involves:

- *Building a rich, on-going picture of each community:* via relationship-building, developing the project profile and (continuous) listening and learning – don't make assumptions.
- *Linking community members into community networks* in particular through on-going asset-mapping work and supporting peer promotion of activities.
- *Developing community activities that respond to community views and motivations*: being prepared to learn from 'failure' and keeping the community realistic about levels of support.
- *Partnership-working with the local community sector:* using every opportunity for learning and being very flexible and creative about community involvement.
- *Partnership-working with services and wider third sector:* drawing on their knowledge, specialism and resources, and working together to advocate on local inequality and poverty.

Supporting development of good practice in community linking requires:

- *Building from and on existing public and third/community partnerships and initiatives:* collaborative working with partners provides the platform from which diverse community activity can then build – the complex network of partnerships in Insch proved invaluable.
- *Working with one (or more) local community organisation(s):* provides local credibility and knowledge and networks. Likewise, it is valuable to have locally-controlled smaller 'pots' of funding to build creative and locally-responsive solutions.
- *Flexibility and openness to learning:* a community links worker needs to pursue this 'way of working' in order to build their own skills and knowledge. Similarly, partnerships need to be open to such learning and be willing to change public service culture in order to work flexibly with 'community' and the third/community sector.
- *Developing suitable strategies:* both locally and area-wide in order to explore and talk through a change approach to 'risk taking' by public services in their work with the third and community sector; and to match the needs of particular communities to suitable longer-term resourcing that will support the community links worker in building sustainable community activity and capacity.
- *Make links and learning from wider regional and national experiences* about both policy and practice and the issues, challenges and opportunities that inevitably arise.

Recommendations and next steps

The PIT's action research has illustrated community linking as a complex area of policy and practice that needs dialogue across public services and the third/community sector(s) for successful development of good practice relevant to a particular place (context).
In particular, it recommends:

1. Adopting the Community Links model developed in Insch as a 'promising approach' to building community capacity and asset development for improving health and wellbeing in Aberdeenshire.

2. Further action research work to support exploration of:
   - the 'spread' of this model to different types of community of place – remote rural, accessible rural, 'other urban' and deprived;
   - its relevance to thematic areas: preventing poverty and inequality; reducing social isolation; and children, families and early years; and
   - its relevance to improving public service partnership-working and strengthening local third/community sector organisations.

Insch Walking Group – an example of a community links activity

Part 1: Main report

1. Introduction and context

This report gives an overview and detail of cycle 1 of this Partnership Innovation Team's (PIT) Inquiry into the development of community capacity-building that can:

- improve individual and community health and wellbeing, and
- support the process of health and social care integration and its wider role in community planning and public service reform.

Cycle 1 has focused on exploring, understanding and considering the learning from the Community Links project developed in Insch through Change Fund and Integrated Care Fund monies from 2013-16. A cycle 2 is anticipated – see section 3.2 – which would consider how such an Insch 'model' and the learning from the work there could be 'spread' in ways that are relevant to other parts of Aberdeenshire.

Section 1 of this report establishes the background to and focus of the Inquiry: public service reform (1.1); the focus of the Inquiry (1.2); the notion of 'community linking' (1.3); and brief profile of the community of Insch (1.4).

Section 2 details our research process and learning on community linking and the Insch Community Links model. *Section 3* concludes with brief *Recommendations* and the proposed focus for cycle 2 of the Inquiry.

The Appendices in Part 2 provide and/or illustrate the extensive evidence base on which the PIT's learning and analysis has been built.

1.1 Background – public service reform, What Works Scotland and Aberdeenshire

With the changing demographics and shift towards an 'ageing' society, stubbornly high levels of social and economic inequality, and the potential for public services funding crises, the 2011 Christie Commission[1] called for significant public service reform in Scotland. In particular, it focused on the development of local partnership working, strengthening communities, improving performance and preventing inequalities – all to be built through an emphasis on collaborative working. As part of its commitment to such reform the Scottish Government, alongside the Economic and Social Research Council, has funded What Works Scotland (WWS) to support, inform and reflect on what happens as community planning partnerships (CPPs) seek to undertake this work.

[1] The Commission was established by the Scottish Government to report on public service reform. View the Christie Commission report at 2011: http://www.gov.scot/resource/doc/352649/0118638.pdf .

Aberdeenshire CPP applied to What Works Scotland to be involved in piloting of an action research approach.[2] It was selected because of its position in the north east of Scotland, its diverse rural nature,[3] and variety of communities across a wide geographic area. The action research seeks to bring together diverse groups of participants to explore key issues and has provided the structure for cycle 1 of this Inquiry (see Appendix 7). The Inquiry has also been informed by the tools and thinking of the improvement science approach developed by Aberdeenshire Council Improvement Team.[4]

1.2 Focus of our Inquiry – good practice and 'spreading' community linking approaches

In early 2015, Aberdeenshire's still-forming Health and Social Care Partnership's (HSCP) Health and Social Care Integration Facilitation Team undertook scoping work into various approaches to 'community linking' developing in Scotland and the role of the third/community sector in health and social care integration (Appendix 4, Annex 1). This initial learning pointed to the opportunity provided by the Community Links Worker approach in Insch to explore good practice in community capacity-building that aims to support health and wellbeing.

The approach had been developed by the Friends of Insch Hospital and Community and its local partners – from the public and third/community sectors – following a proposal generated by the Insch multi-disciplinary Action Learning Set as part of the Aberdeenshire Health and Care Learning Network programme.[5] Funding for the post was provided for the first two years through Aberdeenshire's allocation from the Change Fund (2013-14 and 2014-15) for work with older people; and for a third year (2015-16) through Aberdeenshire's allocation from the Integrated Care Fund, aimed at a broader range of residents. The post has now finished and the person now works as part of the Aberdeenshire Community Health in Partnership Team within Aberdeenshire Voluntary Action.

This model provided the focus for the first cycle of our action research work and aims to inform Aberdeenshire HSCP, Aberdeenshire CPP and the third/community sector as to:

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[2] In this case collaborative action research that seeks to bring together collaborative approaches; research or inquiry process and tools; and practical action, learning and changes.

[3] Aberdeenshire includes remote rural, accessible rural, 'other urban' and suburban (Aberdeen) communities

[4] As a starting point for exploring the relationship between action research and improvement science, improvement methodology tools were drawn into the process – including: a group writing activity that allowed the Team to draw from their participatory analysis to generate this report; project diagram analysis (see Section 2.2); thematic analysis (see Appendix 2); and stakeholder management (see Appendix 8).

[5] The use of action learning sets was identified in the Aberdeenshire Partnership Change Plan 2011/12: *to enhance practice we will establish Aberdeenshire Health and Care Learning Network creating opportunities for GPs, local team managers and practitioners to come together to constructively challenge and improve practice, behaviours and pathways of care for older people, towards a shared outcome of shifting the balance of care.*

- what makes for good practice in relation to 'community linking' and the opportunities that this particular model represents;
- what supports the development of good community linking practice and therefore could help its wider usage or 'spread'.

More generally, the learning here is expected to be of wider relevance across Aberdeenshire to building community capacity to support health and wellbeing. Appendix 7 outlines the initial Research Aims and Objectives of this Inquiry and the What Works Scotland approach to action research as a series of cycles.

This Inquiry is particularly relevant to the current policy and practice context, given:

- it fits with the health and social care integration agenda and its focus on community capacity-building – including Aberdeenshire HSCP's own strategic priorities and plans;
- it complements the transition across Aberdeenshire's CPP that aims to integrate public services and third sector activity in relation to public service provision;
- it fits with current developments in Scottish Government policy-making including the Community Empowerment (Scotland) Act 2015 (Appendix 5).[6]

This PIT includes staff from across public and third/community sectors. The team's diversity has generated synergies, drawing from members' wide range of practice experience, knowledge and skills, and gives a depth of understanding to this Inquiry and its evidence base.

[6] Note: the SNP Government's manifesto for the 2016 Scottish Parliament's elections advocates for community economic and social development (Rural Scotland, Greener Scotland, Empowering Scotland); an 'NHS Community Health Service'; and for recruitment of "at least 250 Community Link Workers to work in GP surgeries and direct people to local services and support" to work in Scotland's most deprived communities.

Community Links worker approach in Insch

The approach used in Insch is one of a number of forms of 'community linking' that are developing across Scotland – see Appendix 6. These aim to make and strengthen links between people/residents; community organisations and networks; and health and public services.

In Insch, this **'way of working'** has sought to:

- engage communities in building capacity;
- empower residents to take greater responsibility for their health and wellbeing;
- support an ethos of prevention; and
- maximise finite public spending through a holistic, innovative approach.

The following five broad areas of practice facilitated by the Links worker are central to the Community Links approach developed in Insch. Therefore these areas are recurring themes across our learning in this report:

1. to understand and map the community and its assets and needs;
2. to *link* community members with existing community capacity and public services;
3. to develop relevant community activities to improve health and wellbeing;
4. to work in partnership and *link* with community organisations, groups and networks;
5. to work in partnership and *link* with health and public services and wider third sector.

Examples of the activities the Community Links worker undertook and developed included:

- *developing activities:* walking groups; lunch club; tea dances; activity (games) group.
- *supporting and promoting activities:* healthy heart group; IT project; stretch & relax class; and local information directory.
- supporting and promoting *local volunteering.*
- *informal partnerships and connections* across GP and health services, community planning and community sector (organisations and groups).
- *advocacy work* with local community planning group and community sector – older people's services, fuel poverty, accessible transport.

The research focused on the activities in *Insch* but recognises, too, activities developed in the small communities of *Rhynie*: weekly weight and walk group (type 2 diabetes) – with links to primary school; *Rothienorman*: lunch club with links to nursing home and sheltered housing.

1.3 More on Insch and surrounding communities

Insch and Insch Hospital Catchment area: Insch is a small rural town in western Aberdeenshire, part of the Council's Garioch Administrative area and on the train line between Aberdeen and Elgin. Its population in 2012 is given as 2320. The hospital catchment area covers two GP practices of Insch and Rhynie. Insch is the largest settlement and there are two more sizeable villages – Rhynie (approximately 500 people) and Rothienorman (1050 people) – and a number of smaller settlements. [7] All three communities were supported by the Community Links worker. However, the main focus of this Inquiry has been the work developed in Insch and surrounding area.

Local inequalities: Geographical access to services is a significant issue for residents of Insch noted as in the bottom 15% of deprived communities in terms of access to services within Aberdeenshire local authority (ScotPHO, 2014)[8]. Although generally income deprivation levels in the area are significantly lower than the Aberdeenshire and Scottish averages, as one interviewee noted, this cannot be taken to mean there aren't significant numbers of people living in poverty; particularly given the higher levels of income needed to cope with increased costs of transport, fuel and food in many rural areas.[9]

Figure 1: Insch Hospital Catchment Area

[7] View Aberdeenshire Council 2012 population reporting (source: National Records Scotland) at: https://www.aberdeenshire.gov.uk/media/4707/aberdeenshiresettlementspopulation2012.pdf. No figure is provided for Rhynie from this source so a very approximate figure is given via several sources.
[8] Scottish Public Health Observatory's Insch, Oyne and Ythanwells Health & Well-being Profile, 2014
[9] See Hircsh et al. (2013) *A minimum income standard for remote rural Scotland*.

2. Learning from cycle 1 of the Inquiry

In this section we set out the Inquiry's process and learning as follows:

- the research activities (2.1)
- summary of key learning (2.2)
- learning and evidence on good practice (2.3)
- learning and evidence on what supports good practice (2.4)

2.1 Action research activity in cycle 1

During cycle 1 of this Inquiry, the PIT has undertaken four broad areas of research activity:

1. Selected interviews and then analysis of prioritised stakeholders in Insch – including with Insch Community Links project participants and local partners (Appendices 1 and 2) – and as part of a study visit that included participation in community activity (participant observation).
2. Practitioner reflections – from the (then) Insch Community Links worker and the Community Health in Partnership (CHiP) team coordinator (Appendices 3 and 4)
3. Desk research into various 'community linking' models or similar approaches elsewhere in Scotland (Appendix 6) and an outline of the national and local policy landscape (Appendix 5)
4. Ongoing discussion or 'participatory analysis' by PIT members of 'policy and practice' across the course of the Inquiry; for instance, to support development of the thematic analysis (Appendix 2) and the drafting of this report. The Appendices 1 – 8 are illustrative of the scope of those ongoing discussions and related reflections.

As noted in 1.1 above, improvement methodology tools and thinking were brought into the action research process to support participation and analysis. The appendices provide a record of the research activity and the evidence generated across this range of research and improvement activity.

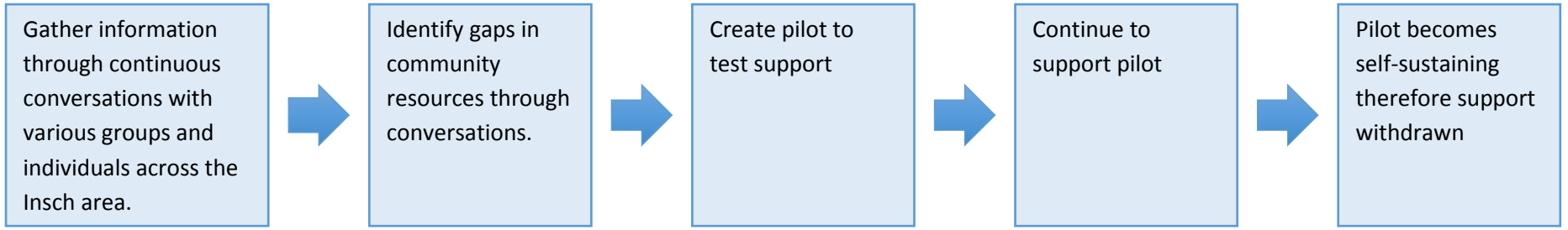
2.2 Learning from the Inquiry: a summary of the role and key outputs of the community links worker

The table below summarises our broad understanding of the Community Links worker role and some of its key impacts in Insch.[10]

[10] (1) the source of the numerical data (numbers) in the table is the Insch Community Links project monitoring records kept by the Community Link worker. The monthly figure of approximately 200 people illustrates an average across the course of a year (2015); both this figure and that for the number of volunteers apply across the full scope of the project – the communities of Insch, Rhynie and Rothienorman. (2) The process identified for 'community linking' and the worker's role draws from an improvement methodology 'Project Diagram' analysis tool. (3) The quotes from the Walking Group are drawn from earlier report recorded in Appendix 4 Annex 2 – sourced by the Community Links worker.

The Community Links Worker model in Insch and its impacts

Purpose of the Insch Community Links Worker: to engage with people aged 65+, within the catchment area of Insch Community Hospital, developing activities, groups and supports which would enhance the health and wellbeing of older people.



Benefits of Community Links Worker project reported Jan 2015

- On average 200 people per month engaged in various activities
- 20+ formally volunteering
- Development of local services directory – improved signposting

A significant number are providing an informal voluntary service: baking, driving, donating tea and coffee. These people have no wish to formalise their role but see it as community-spirited.

Quotes from Walking Group members

- "The group walk is fantastic. My arthritic foot is far less troublesome when I'm walking and talking with others. The social aspect of the walking is so fantastic."
- "Through the group I have become familiar with the area around Incsh which has encouraged me to walk with family members and on my own."
- "Great combination of exercise and socialising."
- "I've made many friends since the formation of the walking group."
- "Enjoyed the walks I've been able to go on… company good, a chance to meet people new to Insch. The group put forward lots of good ideas."
- "Being a member of the group has encouraged me to join others and now feel part of a great community."
- "I wouldn't have lost weight without your help, they're very pleased with me at the medical centre."
- "I hadn't been out for year because of health problems."
- "It's been great. I've met people I haven't seen in ages."

"It was just brilliant, it's made such a difference, just what I was needing."

Person referred through GP, who phoned following first Lunch Club and Activities Group

Anecdotal feedback from participants

Improvement in conditions:

- high blood pressure
- Type 2 diabetes
- weight loss
- reduced social isolation

Infographic about the Insch Walking Group

2.3 Learning from the Inquiry – good practice in 'community linking'

In undertaking its analysis, the PIT has discussed in depth over a number of meetings its evidence base (Appendices 1 – 6). We present this through the following five broad and key areas of practice that we recognise to be central to developing good 'community linking' practice.

2.3.1 Understanding the community and its assets and needs

Raising awareness and building relationships: the worker becoming established in the community through developing links and relationships with existing community networks, groups and key individuals, and local services.

> *For example:* 'Relationship building' by the worker with community groups and networks was the most commonly emphasised theme in the Insch interviews – in particular by community sector colleagues.
>
> (Appendix 2)

Listening and learning: don't make assumptions about what the community needs or wants, rather listen and take into consideration individual and community perspectives. Community-wide discussions, 'action planning' and working with a range of local partners will also support development of detailed local knowledge across the diversity of local people and groups.

> *For example:* "I think she's active with other groups, there's a lot of groups in Insch. An amazing number which I'm not really aware of, but she seems to go to a lot of different committees (for instance) ICAN (Insch Community Association) … she seems to go to these committees and learns from there what's needed"
>
> (interviewee re. Community Links worker – Appendix 2).

2.3.2 Link community members to community assets and services

Developing a depth of local knowledge about services and assets: so that individuals can be linked to relevant community resources and local services.

> *For example:* Linking with the right person/organisation was only possible after the ground work was done in the first few months in establishing networks and contacts. This meant a shared understanding of each other's roles already existed and allowed appropriate connections to specialist skills, experience or knowledge to be levered in when necessary. (Community Links worker, Appendix 3)

Encourage and develop 'peer promotion': local people talking from their own experience and using their local networks is the most effective means of promoting and sustaining local activities and work.

For example: promotion was carried out using all the traditional publicity methods however the most effective tool was word of mouth. Existing participants proved to be the best ambassadors and were more successful in encouraging others.

(Community Links worker, Appendix 3)

2.3.3 Developing community activities that make a difference to health and wellbeing

Responsive and realistic: it is important to be responsive to the community whilst providing a realistic perspective on what is achievable in the current context and with current resources. Appendices 1, 2, 3 and 4 (Annex 2) provide an extensive listing of community activities developed in Insch with the community there and illustrate the 'low cost' nature of most of these e.g. walking, social and support groups, and their range of health and social benefits.

For example: Lost the hotel in Insch which had a function room with music. Folk said they missed their dancing with live music. Set up monthly tea dances with live music, home bakes and a cuppa. Benefits as reported by people who come – dancing is good exercise, social contact, affordable and brings in people from all over the north east.

(discussion notes, Appendix 1)

For example: "… and that's a major factor I think in bringing a lot of people along to the walks because we do find from time to time that when other people come to join the walk there's sometimes an outside factor motivating them to do that, not just health. It may be somebody who's suffered a bereavement recently and they're trying to establish social contact with the outside world and it's ... that's really quite a strong factor I would say for most of us".
(interviewee, Appendix 2)

For example: "Community Links worker was instrumental in encouraging A to do it … had a considerable benefit on (their) outlook on life and (their) own feeling of self-esteem and wellbeing and so on"
(interviewee, Appendix 2).

For example: Getting to know 'Jane' (not her real name) revealed her many years' experience of caring for people with dementia when nursing and the idea of volunteering at the local Day Care service was discussed. Jane has been a regular volunteer at Insch Day Care for more than two years now, making good use of her valuable skills. Through getting to know others in the Walking Group Jane was persuaded to go along to the local Senior Citizens group, 2 years later and she has now taken on the role of Secretary. Regular walking gave Jane and some others from

the village the confidence and fitness required to join a local rambling group. Jane says she now feels very much part of life in the village and would never wish to move. She has a wide circle of friends and has little free time in the week, juggling family commitments and her own busy life. Such is the difference in her wellbeing her family have commented on how happy she is.
(Community Links worker, Appendix 3)

For example: … equally significant are the social benefits recognised by them (participants in Insch): "social interaction", "good company", "part of a great community", "meet new people", "made many friends"

(Community Health in Partnership coordinator, Appendix 4).

2.3.4 Partnership working with the community sector and community

For example: used every opportunity available to speak to people to identify gaps and listen to their views and ideas.
(discussion notes, Appendix 1)

Asset-building: be confident in the potential of communities … and their networks, groups and structures, given suitable resourcing.

For example: it (the role and job description) allowed a degree of freedom to develop services and activities taking the lead from older people defining their own needs and priorities in improving or maintaining their own health and wellbeing. Crucially time was given in the first few months to establish a network of contacts and to become 'a weel kent face' locally, an important factor when working with small communities where trust has to be built in order to foster meaningful engagement.
(Community Links worker, Appendix 3)

Flexibility around levels of involvement and roles of participation: from participants in community activities and volunteers supporting those community activities. This will depend too on the type of activity and levels of ability of participants and so on.

For example: encouraging volunteering and building community capacity was a key aim of the project. Twenty people were registered as volunteers however most people were more willing to be involved if this was on an 'informal helping out' basis which they considered as being 'community spirited' as opposed to a more formal volunteer role (the exception being regulated work). … A noticeboard for advertising local volunteering opportunities was purchased and placed in the centre of the village which other organisations were encouraged to use.
(Community Links worker, Appendix 3)

Managing expectations of long term support: the community links worker will be looking to develop a range of activities and projects across the diversity of their community – and this will be on-going. They will often be seeking to support developing (and existing) groups and activities to become 'sustainable' through self-management – over a realistic period of time – so that they (the worker) can then focus on other parts of the community.

> *For example:* since the project finished in Insch, six months on (and with an exit strategy developed by the 'Friends' and AVA), all activities continue to run and develop further with some attracting new participants. A number of different solutions have made this possible:
>
> - Participants and volunteers attended training giving them the skills and confidence which allowed them to take a more active role in running the group/activity …
> - Support from the sessional worker and volunteers has kept those activities going which require a greater deal of planning and organising, especially behind the scenes.
> - Some activities, where appropriate have been anchored to other organisations such as the local leisure centre, 'Paths for All' and the local Community Association.
> - Other groups continue to be run very successfully by participants with no further input or support required.
>
> (Community Links worker, Appendix 3)

2.3.5 Partnership working with services and wider third sector

> *For example:* Partnerships were crucial to activities being successful and sustainable. Linking with the right person/organisation was only possible after the ground work was done in the first few months in establishing networks and contacts. This meant a shared understanding of each others' roles already existed and allowed appropriate connections to specialist skills, experience or knowledge to be levered in when necessary.
>
> (Community Links worker, Appendix 3)

Risk-taking and openness to innovation: positive risk taking with a willingness to learn from things that didn't work is crucial. Take the time to be creative and explore innovative solutions … 'Creativity before Capital'.

> *For example:* started walking groups as there was demand which hadn't been taken forward. Funding and training through 'Paths for All' (funding source) got this started – now four weekly walking groups for people of different abilities.
> (discussion notes, Appendix 1)

Wider knowledge from the region and nationally: maintain awareness of developments and initiatives in other areas across Scotland. There's a lot to learn from the good practices of

others doing similar work in communities. And, likewise, as to where the current opportunities for funding and support lie as national and local policies continue to change and develop.

> *For example:* keeping abreast of other initiatives nationally and locally enabled shared learning and joint working with contact and visits made to other projects in the north east. This provided ideas and possibilities for what might work locally in addressing some of these gaps as well as important learning in some of the pitfalls to be avoided.
>
> (Community Links worker, Appendix 3)

Infographic of the five areas of practice

2.4 Learning from the Inquiry – supporting development of good practice in 'community linking'

The team's analysis has considered the evidence base – see the appendices – and recognises the following five broad key areas of practice as central to **supporting** the development of good 'community linking' practice and supporting its spread.

2.4.1 Building from existing partnership-working

Collaborative working with partners from all sectors is fundamental, across a range of local community sector organisations and groups; local public services including GP and other health and primary care services; the local third sector more generally including care providers; and relevant private sector services e.g. care homes.

> *For example:* 'The Inside Insch' initiative in 2013 was led by Garioch Local Community Planning Group and developed through a seconded Community Learning and Development worker and the Garioch (Rural) Partnership worker[11]. It involved a range of local partners, both community sector and public service, and this included the Community Links worker who had just started in post. A 'Planning for Real' exercise[12] involving 550 local people proved very valuable in supporting the worker in building local knowledge and working relationships that speed-up the development process.

The initiative led to the development of Insch Community Action Plan, involving the following:

- Local community sector: Friends of Insch Hospital and Community; ICAN (Insch Community Association); Bennachie Community Council; Bennachie Leisure Centre (community-owned); Insch Institute and Bowling Club; Parents' Council at school.
- Services and other CPP structures: Economic Development (Aberdeenshire Council); Police Scotland, Aberdeenshire Council, NHS Grampian; Garioch & North Marr Community Safety Group.

The Community Links worker[13] was then able to participate in a range of wider local partnership-working and advocacy work, including:

- seeking to promote and advocate for the health elements, particularly for older people, of the Community Action Plan with public services;
- work with the local Community Planning Officer, ICAN and the North East Scotland Credit Union on an 'oil club' to reduce fuel costs including for those on low incomes;
- work with 'the Friends', ICAN, AVA and others to improve local public/community transport services – a mix of funding applications and advocacy work.

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[11] The Planning for Real and Community Action Plan and its value to community linking is outlined in Appendices 1 and 3. Further material has been drawn from the Insch Community Action Plan published by Garioch Partnership (Rural Partnership) and from discussion with the Community Links worker.
[12] View 'Planning for Real' at: http://www.planningforreal.org.uk/
[13] In part this was as community links worker but also as a local volunteer/activist for ICAN – interlinking roles.

For example: see also a separate 'co-produced' report on 'Beyond Action Learning' (with WWS) which details an action learning set/improvement methodology initiative. One of the action learning sets involved health and social care staff and local third/community sector staff from the Insch Hospital Catchment and helped to facilitate initial discussions of and support development of this Community Links project.[14]

'Buy-in' from local public services to build trust in 'linking' to community resources: training and learning to support 'culture change' within local public services is important so that the worker can effectively build the links across a diverse community, the local community/third sector, and the local public sector partners. Such a 'culture change' process within the public sector will need a significant investment of resources and time because of the changes in public sector approaches to risk management thinking that are required to support the community links worker in being innovative and taking up challenges (see Appendix 4 and the desk research in Appendix 6).

For example: many voluntary and community-based activities succeed because of their more informal approach. The danger is that placing additional bureaucratic demands on organisations could be a disincentive particularly to those largely dependent on volunteers… It is absolutely right that the needs of vulnerable patients are taken seriously and that evidence of ability to support them provided. But can we 'trust' individuals who have the capacity to assess and take personal responsibility for decisions around engaging in community or voluntary led activities? …During desk research the inquiry team found evidence to suggest that where GPs had direct contact with third sector providers they were more inclined to recommend or endorse their service or activity to patients.

(Community Health in Partnerships team coordinator, Appendix 4)

For example: …(in) traditional health services, it was a case of we'll decide and you've got to go. ...We've got the expertise so we'll make the decisions. (now) I would say, they've been using (the community links worker) and they've been contacting her and referring (informally) people onto her. I think that it has helped and things like (she's) had a big part, she made it happen, and they've now got these cardiac rehab exercise classes in Insch, and that's directly health-related. (interviewee, Appendix 2).

2.4.2 Working with a credible local community organisation(s)

A credible local organisation and locally-controlled 'pots' of funding: ideally 'anchoring' the post to an established local group or organisation that holds: similar values and ways of

[14] Available from WWS website at: http://whatworksscotland.ac.uk/

working; strong local knowledge and relationships; and a positive reputation across the diversity of people, groups and networks in that community. In this case the worker was supported by a local organisation that had experience and applied to a multitude of sources to build local funding options.[15]

> *For example:* At a local level the Friends of Insch Hospital and Community identified the potential for further development in supporting people aged 65… As a group of volunteers they felt they did not have the capacity to develop this potential into something more tangible but were best placed to support a Community Link Worker post.
> (Appendices 1 and 3, and also a key theme in desk research in Appendix 6)

2.4.3 The Links Worker skills, attributes and openness to learning

Abilities and approach of the worker: the worker needs to be open to and supported in developing the necessary skills and attributes for doing the job. Self-motivation will be fundamental and a concern for a community approach or 'way of working'.

> *For example:* Community Links worker skills and competencies were strongly emphasised by community sector colleagues in the Insch interviews analysis.
>
> (from interviews, Appendix 2).

Flexibility and support for flexibility: as highlighted above the worker must have the freedom to 'try things', not being constrained by precise plans, 'hard and fast rules' or always needing to use the official routes – such as a formal referral system. The worker needs to be open to such a flexible approach, but will need support from all partners and sectors – including public services – if they are to pursue this way of working effectively.

> *For example:* additional funding had to be sourced to cover start up and activity costs - £15,000 from 11 different sources. Funding was not difficult to acquire although it was time consuming completing applications and writing associated reports. Other Community Links models report having access to a small budget allowing for a quicker response in progressing ideas.[16]
> (Community Links worker, Appendix 3)

Space and support to learn from experience and 'failure':

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[15] See Appendix 6: the research report from Inspiring Scotland identifies the provision of suitable 'local pots of funding' as crucial to the development of a flexible approach by a local worker.
[16] In Appendix 6, the Inspiring Scotland recent research report (2016) on the qualities of a 'links worker' is pointed to as a valuable resource for further research in cycle 2 of this Inquiry.

Example: (In Rhynie) … These discussions formed the basis of planning a community event which would cover a number of key topics, for example: information about services, supports and activities; what was working well, what connected people now; and individual conversations re gaps and potential solutions.

The venue was booked and event promoted by local minister with posters distributed. On the day only five people attended – the lack of response was very disappointing. People were aware of event but the Community Links worker was largely unknown in the village. In hindsight, we should have probably done more work linking into existing groups and getting to know a larger number of people … progress in Rhynie came through linking with the Health Improvement Officer – attached to Public Health Team – who already had links with the local GP Practice and Primary School. She organised a 'Healthy Helping' course (NHS) to be delivered in the village which the GP practice supported by contacting patients by letter they thought would benefit. From those attending this, work was done around setting up a Health Walk group and the support of the local Paths for All Co-ordinator was sought.

(Community Links worker, Appendix 3)

2.4.4 Developing suitable strategies locally and area-wide

Culture change requires learning and dialogue on risk-taking: in changing the complex working relationships between public sector, 'community' and third/community sectors, there is a need for those involved in this change to learn from 'failure' – as illustrated in 2.4.3 above – and talk about how to manage the changing nature of risk and related responsibilities in this service reform:

For example: There are many examples of cross sector collaborative practice working well. However, the question of 'trust' comes up repeatedly in discussions with HSC professionals. 'How can the third sector be trusted to effectively deliver what they say?' ...Many voluntary and community-based activities succeed because of their more informal approach. The danger is that placing additional bureaucratic demands on organisations could be a disincentive, particularly to those largely dependent on volunteers. …During desk research the inquiry team found evidence to suggest that where G.P.s had direct contact with third sector providers they were more inclined to recommend or endorse those services or activities to patients.
(Community Health in Partnership team coordinator, Appendix 4)

Scoping a manageable community: the size and diversity of a community of place, and likewise the scale of financial and other support needed, must be considered when placing a Community Links worker. It is important that their workload is realistic, and likewise the

scale of the particular challenges generated by each community, if the worker is to successfully establish community priorities and work to make progress.

> *For example:* covering a very rural area posed difficulties in reaching potentially isolated people who live outwith the main communities. Connecting with those harder to reach remained one of the greatest challenges.
> (Community Links worker, Appendix 3)

Suitable longer-term funding: a minimum of two years of appropriate levels of funding would seem to be necessary to develop a significant range of activities and projects to improve health and well-being. This is so that the worker can build links with community networks and organisations and with local public services, and then developing relevant community-based activities. The PIT's analysis has concluded this because of:

- the experiences in Insch where it took time, skill and patience to build relationships with residents and then develop community-based activities that could then be sustained with less or without worker support (Appendix 3 and Appendix 4 Annex); and
- the desk research that illustrated across various forms of 'community linking' in Scotland the need for investment in a worker over a longer term. (Appendix 6)

There are further factors here that likely influence the time needed to generate impact – as outlined above – including the levels of development of the existing local community sector and the scale of existing partnership-working across public and third/community sectors. These are beyond the scope of this Inquiry, thus far.

2.4.5 Learning from wider regional and national experiences

Drawing on national and area-wide networks and support: linking to national networks and forums, for example the Health & Social Care Alliance Scotland, which can share learning, good practice and opportunities; and support understanding and discussion of national outcomes and policies. Likewise, links to regional and area-wide bodies – for instance in this case Aberdeen Voluntary Action and the Rural Partnerships (see 2.4.1 above).

> *For example:* at the 2016 Scotland Policy Conference 'Integrating Health and Social Care in Scotland'[17] Dr John Montgomery (GP & Lead Clinician, Govan SHIP project) spoke of the importance of communication between all parties involved in the care of a patient within the multi-disciplinary team (MDT) being the crucial element to this. This Practice has Community Links Practitioners (CLPs) (a Scottish Government funded programme) as part of the General Practice team with the aim of supporting

[17] Conference organised by Scottish Policy Conferences in March 2016. Material referring to particular presenters here is drawn from participation at the conference and reporting notes provided by the organisers to conference attendees but shouldn't be understood as a verbatim account of their views.

people to live well in their local community by building links between the practice and local community resources… There is ongoing debate in Aberdeenshire regarding the appositeness of third sector presence at MDT (multi-disciplinary team) meetings where patient details are discussed. Some health and social care (HSC) professionals recognise the benefits of a wider contribution to the discussion. Others consider it inappropriate due to client confidentiality and data protection.
(Community Health in Partnership team coordinator, Appendix 4)

Relevant area-wide and national policy-making to support dialogue across all sectors: to establish the necessary resources and culture change that can support and learn from community linking. This theme is clearly illustrated within the desk research (Appendix 6).

For example: At the conference several speakers spoke of the need to work with the community and voluntary sector. The expectation that communities will be able to develop initiatives in response to unmet need is growing. However, many communities are unaware of this and instead are exposed to the largely negative media stories: 'NHS crisis', 'GP shortage', 'Underfunding of NHS' creating a sense of 'helplessness'. …In order to stimulate community capacity building then a national message (from government) would help individuals and communities to become more engaged with the integration agenda and encourage ideas around prevention and self-management.

(Community Health in Partnership team coordinator, Appendix 4)

For example: "I think because of the work that's been done to date now that there's this whole focus on health and social care, and the whole thing about community and looking after older members of the community and supporting them, it's even more vital that the community as a whole become aware of it and understand that as a community ...with the various community partners that there are that this is a vital link into it because she (community links worker) works across various services and it's not just part of the community alone or the health board and things that it links into the whole support network".
(interviewee, Appendix 2)

3. Recommendations and next steps

3.1 Recommendations

For Aberdeenshire HSCP, Aberdeenshire CPP, Aberdeenshire's Third Sector Interface (TSI) and other strategic and representative bodies in Aberdeenshire to consider:

(1) adopting the Community Links approach (Insch) as one 'promising approach' to building community capacity and assets for improving community health and wellbeing in Aberdeenshire;

(2) in the light of considerations of (1), through further collaborative action inquiry develop an understanding of issues of 'spread and sustainability' and related issues in relation to this Community Links approach to support its relevant use in Aberdeenshire (see 3.2 below).

(3) in the light of considerations of (2), to consider:

- the role of this Partnership Innovation Team or PIT in this process (see 3.2 below).
- the relevance of What Works Scotland's 'Spread and Sustainability' framework in supporting the further development of this approach in Aberdeenshire (see Appendix 9).

3.2 Proposed next steps for the Partnership Innovation Team – cycle 2 of the Inquiry work

Following discussions of the initial recommendations above with the HSCP, CPP, TSI and other key strategic and representative bodies, the Inquiry *can* develop an action research cycle 2 aimed at:

(1) Considering issues of transferability or 'spread and sustainability': while this approach has been illustrated to be productive in developing and supporting community capacity-building in Insch, further Inquiry work is needed to support understanding of how the model – or the learning from the model – can be appropriately 'spread' to other communities.

For instance, in considering its relevance to other communities in Aberdeenshire, the following types of community and inequality should be recognised and their implications for this approach explored:

- remote rural communities where there are likely to be fewer and less accessible services;
- accessible rural and suburban communities where there are often newly-arrived and growing populations – including older, retired people;
- towns with neighbourhoods with significant levels of urban deprivation and inequality;
- hidden 'pockets' of poverty and inequality that occur in all communities in Aberdeenshire.

(2) Scoping links to other HSCP, CPP and third sector strategies, priorities and ways of working: in recognising that to transfer or 'spread' this model, and the learning from it, to other communities will need careful consideration, the PIT recognises the connections that

need to be made to policy, strategies and other areas of practice. For example, and as highlighted by the Christie Commission 2011, in relation to:

- mental health and social isolation for older people and other inequality 'groupings';
- children, families and early years;
- culture change within health/public services that supports third/community sector roles;
- other forms of community capacity-building and local community sector approaches;
- complex, multi-layered partnership-working aiming to prevent poverty and inequality;
- the role of the third/community sector in advocacy, accountability and 'independent community action'.

(3) Building further links between the Inquiry work and key bodies within the HSCP, CPP, TSI and other strategic and representative bodies: this would include discussion with these bodies as to further members of this PIT for cycle 2.

Part 2: Appendices 1 - 9

Note: These Appendices evidence and illustrate the range of different types of evidence collected by the PIT members, as researchers; and likewise the in-depth discussions of 'policy and practice' generated as different team members have brought their own areas of knowledge, practice and expertise into the developing team thinking and analysis.

Appendix 1: Initial mapping work with the Insch Community Link Worker

By **Sharon Van de Ruit**, Senior Improvement Officer, Aberdeenshire Council, and **Alison McPherson**, previously Community Links Worker in Insch with Friends of Insch Hospital and Community; now Community Health in Partnership Team Officer, Aberdeenshire Voluntary Action.

An initial discussion between the (then) Insch Community Link Worker, who is also a PIT member, and a fellow team member provided early material for:

- the initial mapping work on the role and the work – as below
- a Project Diagram analysis – giving an outline of the development process in Insch – see Main Report section 2.2
- 'participatory analysis' and discussion by the PIT of the issues raised, and these informed the development of an interview guide and thematic interview analysis – see Appendix 2

Initial mapping work record

(1) How did this Community Links Worker post come about?

The need/idea for the post came as a result of an action learning set[18] which included a local GP. The Friends of Insch Hospital and Community, a group of volunteers now constituted as a SCIO[19], identified there was potential to increase supports and services locally especially to older people. The Friends were a well-established group in the area (26 years) and held a wealth of knowledge between them of the local area and useful contacts.

The primary aim of post is to provide supports which have a positive impact on people's health and wellbeing whilst promoting independent living, reducing or delaying the need for

[18] Note: an action learning set – improvement programme 2011-13 initiated by the then Aberdeenshire Community Health Partnership supported discussions between health and social care services and the local third/community sector on community capacity-building that led to the development of the Community Links worker project.

[19] Scottish Charitable Incorporated Organisation – view: http://www.oscr.org.uk/charities/becoming-a-charity/scio

involvement from statutory services. Also increasing opportunities for volunteering and building community capacity.

(2) Key tasks of the Community Links worker in the first two years

- Getting to know the area and its older people
- Baseline data
- Research
- Setting up pilot scheme(s)
- Running the pilot scheme(s)
- Data collection and future funding

(3) How did you achieve this?

Used every opportunity available to speak to people to identify gaps and listen to their views and ideas.

> *Example:* Started walking groups as there was demand which hadn't been taken forward. Funding and training through 'Paths for All' (funding source) got this started - now four weekly walking groups for people of different abilities.
> There is no social meeting place in Insch since they lost the café, particularly for men. Three month pilot of a lunch club, targeted on an activity e.g. domino's, cards with a cup of tea – social thing. This part is open to all. A man made a stand for a person who had a stroke in order for him to be able to play……now everyone has one!

Have just had further funding for another (third) year. 4-6 volunteers help each month.

> *Example:* Lost the hotel in Insch which had a function room with music. Folk said they missed their dancing with live music. Set up monthly tea dances with live music, home bakes and a cuppa. Benefits as reported by people who come - dancing is good exercise, social contact, affordable and brings in people from all over the north east.

(4) Why do you think it was successful?

- Not linked to the NHS or the local authority. Freedom to 'just do'.
- Nobody said you 'can't do this' – no restrictions
- Reported to a steering group
- Very flat management systems and structure
- Ways of working – established links with health professionals
- Used knowledge of what already exists to match needs with resources
- Using the tool 'Planning for real' – opened up access to lots of contacts. Provided evidence of what's needed to make life better in Insch.

- Creates opportunities for people to be involved through volunteering - sharing what they're good at.
- Learned from others
- Lead came from what folk said they wanted, so not manufactured in anyway.

Appendix 2: Thematic analysis of Insch interview data

Analysis by **Jane Warrander**, Senior Improvement Officer, Aberdeenshire Council, with contributions from **Alison Davidson**, Strategic Development Officer, Aberdeenshire Council and **James Henderson**, What Works Scotland.

The project team undertook five interviews with stakeholders from the Insch Links worker project to gain their understanding of the key elements of the project. Interviewees were identified by the Insch Links worker and included four people who were participants and/or volunteers within a walking group and wider body of community activities organised by the worker (interviews 1 and 2); two people working within the community sector in Insch (interviews 3 and 4); and one person within a local public service (interview 5).

A set of questions was developed by the Project team to give meaning and consistency to the interviews. The team adopted a well-thought-out interview style, ensuring interviewees were fully aware of giving their consent and the purpose of the interview. The following questions were used to structure the interview:

1. What is your experience of the Community Links service?
2. How does this service 'impact' on local people and the community?
3. How does this service connect to other services and resources in the area?
4. How has/is the service influenced/ influencing local health and social care provision?
5. What has helped/is helping this service to develop?

Analysis of the interviews was undertaken by three members of the project team by matching the interview dialogue to the emerging themes from the ongoing work of the project team.

	Themes	Detail
1	Benefits from contributing to local group	An individual benefits from their involvement in supporting a group but they are not an active participant in the group activity but see the benefit to themselves And/or They participate in the group activity but are also volunteers within that same group, and may have had some training in their supporting role. Where the supporter or volunteer doesn't directly express their role as beneficial to themselves, we cannot be confident in the benefit to them as evidential.
2	Key role of existing community group, org or Anchor	The role of an existing body as fundamental support, local understanding and resource for the community links worker. Gives the community links worker post credibility
3	Underlying support structure	Often unseen public sector structure which gives strategic direction and infrastructure.
4	Making & sustaining relationships with services	Managing positive connections with the local public sector services and their commissioned service providers
5	Having the "space" by not being directly managed by public sector	A sense of space to be creative and responsive to communities.
6	Making relationships with communities	Building positive and relevant relationships with community groups, networks, individuals, organisations, activists, volunteers, residents etc.
7	Mapping of local communities	Taking active steps in discovering and knowing what assets exist and also identifying gaps in provision
8	Fostering local ownership	Being able to support the building of capacity but crucial the ownership is handed to the community so the community links worker can move on to other projects.
9	Inclusive ethos	Everybody counts
10	Link worker skills and competencies	PIT needs to identify these. – Inspiring Scotland is producing a report on this for their linkup workers
11	Local, Regional, National context and history	Understand the area and what's driving local change and the impact of such

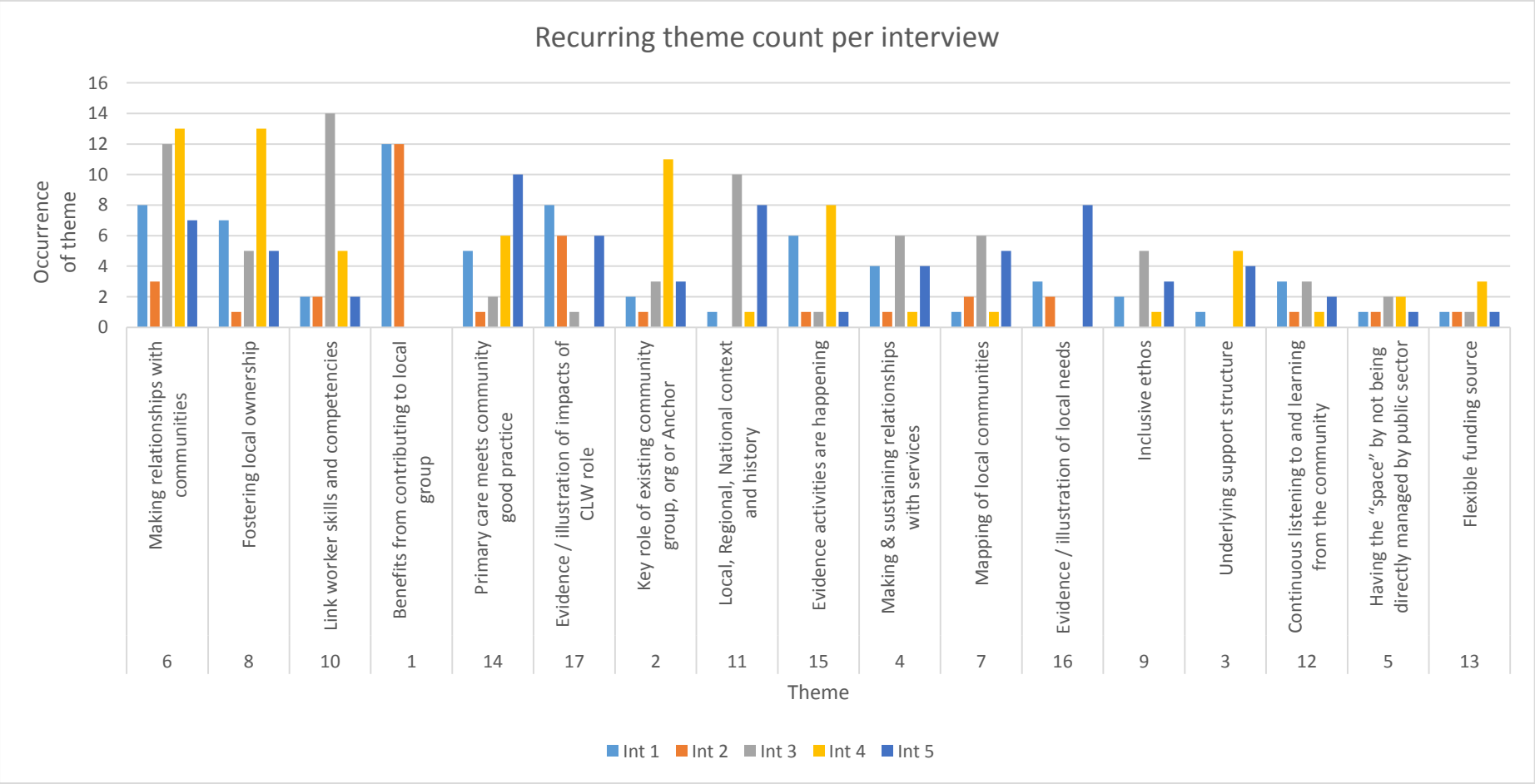
12	Continuous listening to and learning from the community	Hearing the needs and aspirations of the community and feeding that into community links worker planning cycle
13	Flexible funding source	Variety of funding options and some scope to make decisions locally
14	Primary care meets community good practice	Fostering good, positive, relevant relationships with health services and other public services
15	Evidence activities are happening	Tangible evidence from the interviews
16	Evidence / illustration of local needs	
17	Evidence / illustration of impacts of community links worker role	

Once the interview material was matched to themes the following graphs identified the most common themes from the interviews

Graph 1

Interview colour codes for graph 1:

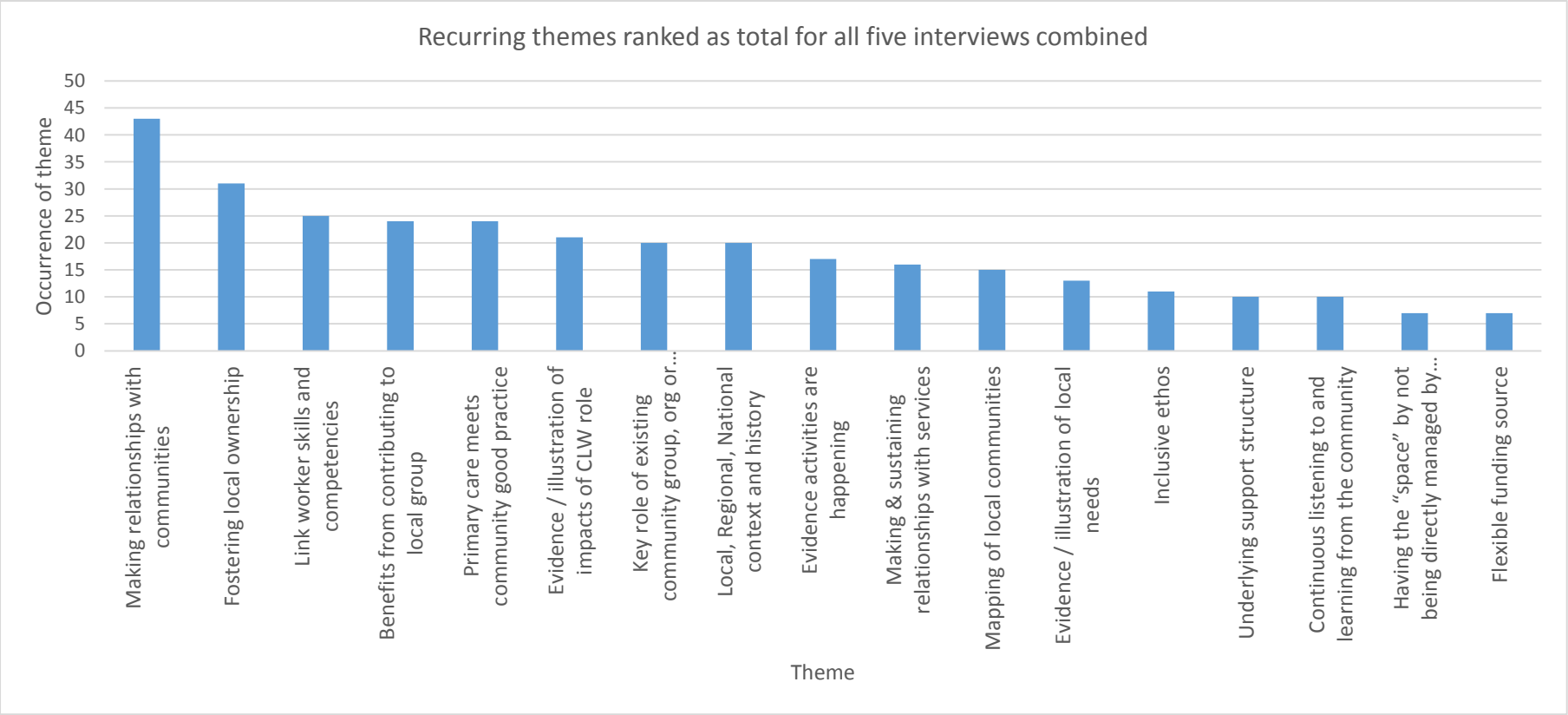
Interview 1	(light blue)	two participants in community activities
Interview 2	(orange)	two participants in community activities
Interview 3	(grey)	person from local community sector
Interview 4	(yellow)	person from local community sector
Interview 5	(dark blue)	person from local public service



Graph 2 [20]

[20] Graph 1 illustrates the 'significance' of each particular theme to each particular interview e.g. how often it arose. The interviews were qualitative in nature, 'conversations with a purpose', rather than a quantitative survey so the graphs illustrate the extent to which discussions between interviewee(s) and interviewer(s) raised and talked about particular themes. They suggest the depth and extent of discussions rather than the number of people who expressed a particular view.

Graph 2



Graph 2 [21]

[21] Graph 2 illustrates the significance of each particular theme across all five interviews.

The most frequently repeated themes were:

1. Making relationships with communities (theme 6)
2. Fostering local ownership (theme 8)
3. Link worker skills and competencies (theme 10)
4. Benefits from contributing to local groups (theme 1)

The following comments from the interviews enrich the numeric data given above - Examples of interview narrative

1. Making relationships with communities

"I think she's active with other groups, there's a lot of groups in Insch. An amazing number which I'm not really aware of, but she seems to go to a lot of different committees [for instance] ICAN [Insch Community Association] … she seems to go to these committees and learns from there what's needed"

"I think because of the work that's been done to date now that there's this whole focus on health and social care, and the whole thing about community and looking after older members of the community and supporting them, it's even more vital that the community as a whole become aware of it and understand that as a community ... with the various community partners that there are that this is a vital link into it because she works across various services and it's not just part of the community alone or the health board and things that it links into the whole support network"

"I mean, I think it's just generally because community links worker been involved with these...the meetings for us towards planning for the new development at Insch building and services. Community links worker's been involved with that. That's been really valuable. I suppose it hasn't really happened yet but we're hoping that that's just all part of the process that's going to help take things forward for the next while."

“Our experience is usually identifying these problems to start with and then we give them the community links worker’s contact details and she contacts them, goes through all the groups and things that she’s got on board at the minute and invites them.”

2. Fostering local ownership

“Yes, so it’s been driven by the participants, what services develop.”

“Go along and help set out the tables, help…I don’t really bake, so I’ll occasionally buy something, help set out the tea things, collect the dirty dishes, and tidy up and hoover…sell the raffle tickets, give cheek to the people who come. At the Walking Group, I’m a walk leader, and just done the refresher training.”

“That’s right. I mean, we have...we have become one of the talking points of the issue in walking around the town. People become aware of it and people will say to me, oh, I saw you out with the Walking Group and I say why don’t you come along?”

“Yes. So, from that ongoing it was like her information was good because it was looking at the village itself and also those that use the village for services and things. It’s good to get that information because otherwise we would have spent a lot of time going into the smaller communities and trying to engage with them whereas the engagement had already been done.”

“I have to say one of the GPs locally had been speaking to us just as I say informally over the years before this happened so it just seemed like that it was the idea of a person who could coordinate things and really tie in the community with health and social care things would seem to be the way forward. And also to try and get back a bit of the old community type spirit that used to be really obvious in communities, in villages, long ago.”

3. Link worker skills and competencies

“…because we just can’t really see how it is... without some input how the groups are going to be totally self-sufficient.”

"…unless there was somebody just dedicated to doing just that, specifically, it wasn't going to happen or else we would have made it happen before it did."

"She's just sort of got in there quietly. She's not really up front. She's not organising big meetings asking people to come and listen and hear. It's just about quietly going in, setting things up, and then it just spreads out from that rather than actually going flat out with some big huge... idea."

"…[in] traditional health services, it was a case of we'll decide and you've got to go. ... We've got the expertise so we'll make the decisions. [now] I would say, they've been using [the community links worker] and they've been contacting her and referring [informally] people onto her. I think that it has helped and things like [she's] had a big part, she made it happen, and they've now got these cardiac rehab exercise classes in Insch, and that's directly health related."

4. Benefits from contributing to local groups

"… and that's a major factor I think in bringing a lot of people along to the walks because we do find from time to time that when other people come to join the walk there's sometimes an outside factor motivating them to do that, not just health. It may be somebody who's suffered a bereavement recently and they're trying to establish social contact with the outside world and it's...that's really quite a strong factor I would say for most of us."

"But, well, I've met new people doing this. I find it easy to walk with a group more so than walking myself. As B was speaking about all the different places...a lot of the walks that we've done I would never have gone..."

"So, it makes a specific commitment as far as we're concerned to actually going around taking a bit of exercise and it's probably cheaper than having a dog."

"Yes. Yes. X is a very extrovert person and she will naturally go out and meet people whereas I've got an introvert personality so this has been a tremendous help to me especially being in a retired situation because if you look at your life, the relationships that you form with

other people evolve naturally out of your work. Once that work situation goes you can become quite isolated especially if you move to a new community so it's been a great help to me in getting me out and meeting people and I'm meeting people from very broad terms that I've got something in common with and that we're generally of a certain age. We have obviously younger people like Y but you have that underlying attachment to other people although they've had very different experiences in life and because of that sense of being part of a social group people are a bit more willing to talk about their lives in perhaps more frank terms than they might have otherwise."

"Community Links worker was instrumental in encouraging A to do it … had a tremendous...tremendous is perhaps an exaggeration but a considerable benefit on [their] outlook on life and [their] own feeling of self-esteem and wellbeing and so on."

Appendix 3: Case study and practitioner reflections on Community Links, Insch

Report by **Alison McPherson**, previously Community Links Worker in Insch and now Community Health in Partnership Officer with Aberdeenshire Voluntary Action

Here she reflects on her three years of experience working in Insch and explains:

- how and why the project began (1)
- the actual developments, outputs and areas of good practice developed there (2, 3)
- the evaluation and learning from this project (4)
- and then what's happened since the project finished (5).

1. Getting started...

The context: it has been well documented and recognised that increasing numbers of people can now expect to live longer, but that these extra years are not necessarily spent in good health, with many people requiring interventions from statutory services in living with long term conditions and multiple morbidity. The Change Fund allowed new ways of working to be tested using a different approach; one which recognised that individuals were often best placed to determine what worked best for them in maintaining and supporting good health and wellbeing and that the resources to enable this could often be found within communities themselves.

A local initiative: At a local level the 'Friends of Insch Hospital & Community' (FOIH&C), identified the potential for further development in supporting people aged 65 and over derived from the group's existing knowledge of the community built up over 25 years from its close association with the Insch Medical Practice, Insch Community Hospital and the local population. As a group of volunteers they felt they did not have the capacity to develop this potential into something more tangible but were best placed to support a Community Link Worker post.

An early Change Fund investment in Aberdeenshire involved the setting up of multi-agency, cross-sector 'Action Learning Sets' (ALS) in various localities across the Shire. Discussions at the Insch ALS led to the 'community anchor' – FOIH&C – bidding successfully for further Change Fund money that enabled the local TSI (third sector interface, now Aberdeenshire Voluntary Action) to employ a full-time Community Link Worker to work with the Friends to promote volunteering and build community capacity across the Insch Hospital Catchment Area. This partnership project got under way in January 2013 and ran until the end of the Change Fund on 31st March 2015. Further funding from Integration monies supported development of the project during 2015-2016, with a specific focus on supporting the national outcomes linked to the Integration process.

The drivers supporting the project: were identified through national initiatives such as the Reshaping Care for Older People agenda, co-production as a way of working, and findings from the Christie Report – specifically around prevention and participation and using a Community Asset Based Approach to build community capacity.

2. Developments in Insch over the three years (2013-16)…

The community: the Community Link Worker post covered the catchment area of Insch Community Hospital encompassing the two GP practices of Insch and Rhynie. The main settlements within this rural locality included the villages of Insch, Rhynie and Rothienorman as well as a number of smaller hamlets. Patients aged 65 and over registered with the GP practices in 2013 were as follows, Insch – 1044 and Rhynie – 237.

The role and main responsibilities: of the Community Link Worker were broadly outlined in the job description, whilst not being restrictive or prescriptive, it allowed a degree of freedom to develop services and activities taking the lead from older people defining their own needs and priorities in improving or maintaining their own health and wellbeing. Crucially time was given in the first few months to establish a network of contacts and to become 'a weel kent face' locally, an important factor when working with small communities where trust has to be built in order to foster meaningful engagement.

Identifying needs, priorities & strengths of this community: The focus during the first year included mapping and understanding local networks and resources. Using the existing knowledge and extensive contacts of the Friends, links were made with organisations, groups and key individuals throughout the area. 'Having the conversation' many times over as well as listening was crucial in gaining an overview of what was already happening, what was not, what was working well and what could be improved. This provided a baseline for future developments.

Insch has seen rapid growth over recent years with a large number of people choosing to move to the area near or just after retirement. During the first few months of the post a community engagement process 'Planning for Real' took place in Insch. Over 550 people of all ages contributed some 2,000 comments in their feedback on what would make Insch a better place to live and work in. Being involved in this consultation process provided contact with all sections of the community and provided a strong sense of what mattered to people. Priorities from this consultation formed the basis for the Insch Community Plan with associated actions, including a section on health.

It was clear early on, that each community, although not geographical dispersed, had different needs. This was largely influenced by what existing resources, facilities and infrastructures were in place, however some common themes emerged such as transport

issues, activities for men, opportunities to socialise and lack of clarity where to access information. These were all were identified as common gaps across the area.

Capacity-building: encouraging volunteering and building community capacity was a key aim of the project. Twenty people were registered as volunteers however most people were more willing to be involved if this was on an 'informal helping out' basis which they considered as being 'community-spirited' as opposed to a more formal volunteer role (the exception being regulated work).

A noticeboard for advertising local volunteering opportunities was purchased and placed in the centre of the village which other organisations were encouraged to use. This successfully linked several people to local volunteering opportunities. Support was also forthcoming from local businesses and groups with many donating goods or making small financial contributions, this helped raise the profile and aims of the project. People were generally keen to undertake training to enable them to take a more active role in supporting and delivering activities, however most preferred to take a lead only when the Link Worker was not present.

The outputs: during the initial three years of the Community Link Worker project resulted in approximately 200 retired people engaging in activities each month. These were all activities which did not exist prior to the establishment of the post.

In addition to the setting up of regular activities and groups, partnership working with another local voluntary organisation resulted in the development of a volunteer driver patient transport service. An Information Directory for Insch was created in response to an identified need for an accessible source of information covering a wide range of topics. The Directory is available in key places throughout the village and is also available online. Information is regularly updated and used by health/social care professionals and local people alike. Other activities saw retired people contributing to a Café Conversation in Insch as well as being involved in an Outside the Box research project which informed a guide to safer drinking for older people.

Some groups were time limited with several sessions delivered on specific themes such as IT or healthy eating. For these, the Community Link Workers' role was largely as facilitator in sourcing the expertise, funding, suitable venue etc. This enabled activities and supports to be delivered locally. Negotiating and highlighting levels of local need encouraged organisations to deliver services and activities in more rural locations.

3. Other areas of good practice

Learning more widely: keeping abreast of other initiatives nationally and locally enabled shared learning and joint working with contact and visits made to other projects in the

North East. This provided ideas and possibilities for what might work locally in addressing some of these gaps as well as important learning in some of the pitfalls to be avoided.

Partnership working: Fostering connections between individuals and services was only one element of the Community Link Worker role, connecting existing groups and organisations to each other, where there was the potential for mutual benefit was another aspect. Partnerships were crucial to activities being successful and sustainable. Linking with the right person/organisation was only possible after the groundwork was done in the first few months in establishing networks and contacts. This meant a shared understanding of each other's roles already existed and allowed appropriate connections to specialist skills, experience or knowledge to be levered in when necessary.

An informal approach: No formal referral pathway was used, individuals were encouraged to contact the Link Worker directly for more information or just come along and try activities. Community Link Worker leaflets with contact details were distributed throughout the area and actively promoted by health professionals. Direct enquiries from individuals however were infrequent with community nurses, occupational therapists (OTs), GPs and occasionally families getting in touch for more information.

Promoting activities: was carried out using all the traditional publicity methods however the most effective tool was word of mouth. Existing participants proved to be the best ambassadors and were more successful in encouraging others. Regular updates were provided to health professionals in person and by email. A Friends noticeboard in the GP waiting room was also used to promote activities and groups.

4. Ongoing learning and evaluation by the worker

Evaluation: on the benefits gained was usually through discussion and feedback, with individuals reporting on any notable difference in terms of their own health and wellbeing. Participants generally had an awareness that they had some responsibility in maintaining their own health and wellbeing and the impact lifestyle choices have in keeping them well. For some, an existing health issue was the main reason for participating whilst others sought benefit from increased companionship and a greater sense of belonging in the community. Creating the opportunities which bring people together will generate numerous additional benefits far beyond the aims of the original activity. Acquaintances became friends and informal circles of support were developed. Peer support and encouragement led to people trying new activities, information was shared and confidence was increased.

One participant's story... 'Jane' (not her real name) gave up life in the city when she retired after many years nursing and decided a move to the country was in order. She had no prior connections to the area but looked forward to starting this new chapter in her life, moving into one of the many new build houses in the village. She chose the area as it was within

travelling distance to her family who lived throughout the North East. Jane initially made enquiries at the local Leisure Centre about the availability of a local walking group as this was an activity she previously enjoyed. Jane was one of a small number of people who shared a common interest and desire to see a local walking group established. Being involved in the very early planning stages she readily agreed to undertake training which would give her the skills to become a Walk Leader for the group.

Getting to know Jane revealed her many years' experience of caring for people with dementia when nursing and the idea of volunteering at the local day care service was discussed. Jane has been a regular volunteer at Insch Day Care for more than two years now, making good use of her valuable skills. Through getting to know others in the Walking Group Jane was persuaded to go along to the local senior citizens group; two years later and she has now taken on the role of secretary. Regular walking gave Jane and some others from the village the confidence and fitness required to join a local rambling group. Jane says she now feels very much part of life in the village and would never wish to move. She has a wide circle of friends and has little free time in the week, juggling family commitments and her own busy life. Such is the difference in her wellbeing her family have commented on how happy she is.

Other benefits reported by participants include

- "I am much more supple and my lower back problems have lessened."
- "Feel much better, balance is good amongst other things."
- "More relaxed, happier."
- "I would not have lost weight had it not been for the support given, the doctor is really pleased with me."
- "The Lunch Club was just what I needed – it was great." Resident in sheltered housing.

Significant challenges faced in developing this project:

- Covering a very rural area posed difficulties in reaching potentially isolated people who live outwith the main communities. Connecting with those harder to reach remained one of the greatest challenges.
- It takes time to establish a relationship with people and for them to become familiar and engage with the project. Some people are fairly resistant to change and can have preconceived ideas about what is right and appropriate for them. This can sometimes cause a barrier and prevent engagement. A joint approach with the community nurses sometimes overcame this with a small number of people.

Other key learning points

- Only a small number of people are required when starting a new activity.

- Investing time in getting to know people and place as well as researching what is happening further afield are essential in the initial phase.
- Be creative with limited resources, fully utilise all areas of support.
- Be willing to take the risk and try something different.
- Creating circumstances which bring people together will generate numerous additional benefits far beyond the aims of the original activity.
- Successful activities in one area may not work in another. Ideas tested on this basis failed to progress beyond the initial stage – didn't match or fit with local need.
- Additional funding had to be sourced to cover start-up and activity costs – £15,000 from 11 different sources. Funding was not difficult to acquire although it was time-consuming completing applications and writing associated reports. Other Community Links models report having access to small budgets allowing for a quick response in progressing ideas.

5. What's happened in Insch as the project finishes up?

In November 2015, the Community Link Worker accepted a new post as Community Health in Partnership Officer with Aberdeenshire Voluntary Action (AVA). Initially beneficiaries expressed disappointment, however, after a relatively short period the mindset appeared to shift and people started discussing and planning for the future.

The Friends of Insch Hospital & Community, with support from AVA, put forward a proposition which would see them employing someone on a sessional basis using the 'underspend' of funding allocated to the Community Link Worker post. This support would be targeted to those activities which needed it and would allow more time for planning an exit strategy which would ensure sustainability.

Six months on, with this now in place, all activities continue to run and develop further with some attracting new participants.

A number of different solutions have made this possible:

- Participants and volunteers attended training giving them the skills and confidence which allowed them to take a more active role in running the group/activity. There would appear to be a greater feeling of ownership and determination by group members to continue, with greater clarity expressed around the benefits to be gained.
- Support from the sessional worker and volunteers has kept those activities going which require a greater deal of planning and organising, especially behind the scenes.
- Some activities, where appropriate have been anchored to other organisations such as the local leisure centre, Paths for All and the local Community Association.

- Other groups continue to be run very successfully by participants with no further input or support required.
- Where activities have been delivered by an external organisation or person, these continue as part of their core work and are now established groups requiring no further input.

6. Work in Rhynie

During the first year (2013) contact was made with the following to build a local picture of Rhynie: local minister; organiser of local volunteer car aid scheme supporting access to health appointments; and manager of supported housing complex (run by Castlehill) to get a better understanding of the community – what was already happening, views on gaps, local needs.

These discussions formed the basis of planning a community event which would cover a number of key topics, for example:

- information about services, supports and activities
- what was working well, what connected people now
- individual conversations re gaps and potential solutions

In planning the event, the worker linked with Community Learning and Development worker in Huntly (known contact) who was keen to do some work in more rural areas. Also the worker contacted voluntary organisations for information about their services, collated a wide range of leaflets and promotional materials and invited reps from more locally-based organisations to come along on the day so they could personally answer any queries/questions about services.

The venue was booked and event promoted by local minister with posters distributed. On the day only five people attended – the lack of response was very disappointing. People were aware of event but the Links Worker was largely unknown in the village. In hindsight we should have probably done more work linking into existing groups and getting to know a larger number of people – more time and effort in raising the profile and local knowledge of what the Links Worker was trying to achieve might have seen a different outcome.

Progress in Rhynie came through linking with the Health Improvement Officer (attached to Public Health Team) who already had links with the local GP practice and primary school. She organised a 'Healthy Helping' course (NHS) to be delivered in the village which the GP practice supported by contacting patients by letter they thought would benefit. From those attending this, work was done around setting up a Health Walk group and the support of the local 'Paths for All' Co-ordinator was sought. Both the Health Improvement Officer and Community Links Worker supported these weekly health walks by going along most weeks, promoting and encouraging. Weekly weigh-in sessions were included as well as dietary advice.

The Health Improvement Officer used links with the primary school to involve them in the walks as well as sessions around healthy eating. This developed into doing monthly community social events which revolved around lunches, afternoon teas and entertainments or 'Big Breakfasts'. Members of the walking group undertook food hygiene training and became very much a part of the organising and running of this type of event which benefitted not just the community of Rhynie but also the surrounding areas and made links to other groups in Huntly and Lumsden. Monies raised from these meant the walking group was self-sustaining financially and covered costs of venue hire to allow future events. Any extra funds were donated to the school, car aid scheme, Macmillan services in the North East and Charlie House in Aberdeen.

Following the departure of the Health Improvement Officer, the Community Links Worker continued to support activities in Rhynie. Additional funding secured from a local wind farm trust meant we were able to introduce a number of free taster sessions of Stretch & Relax, a short programme of IT classes all delivered in the village using contacts with other sector providers – introducing new activities not previously available (public transport being a big issue). These were offered on the basis of feedback we had received from people attending the community events.

Since the end of the Links Worker's involvement in the area, the group 'The Tap O' North Trampers' have gone from strength to strength, expanding what they do to include a fortnightly rambling group, book club and community social events. As a group they have been recognised locally and asked to help out with other events. The group said as a team they have gelled and work very well together and their confidence has increased by their continued success and knowing 'yes, they can do it'. What you can't capture on paper is their enthusiasm, teamwork, good humour and community spirit …this they continually demonstrate by the bucketful.

The group received advice from Aberdeenshire Voluntary Action's (AVA) Development Officer and set up their own bank account and manage their own finances ensuring they have funding to continue all their activities in the village in the future as well as support other good causes. Contact is maintained with Rhynie through the work of the AVA Community Health in Partnership Team and the representatives from the group have attended a recent Community Health Exchange[22] event and have become members of AVA.

[22] See CHEX at: http://www.chex.org.uk/

Appendix 4: Discussion Paper: Issues arising when seeking to develop Community Linking approaches to community capacity-building that can support health and social care integration

By **Alison Knight**, Community Health in Partnership Co-ordinator, Aberdeenshire Voluntary Action. (June 2016)

There are many models of Community Linking including the examples considered by the Inquiry Teams in their Desk Research (see Appendix 6). The key to all models is making the link between traditional health and social care services (statutory) and the third sector in its widest sense. In this Discussion Paper I look at a range of issues arising from my own practice over the last two years, firstly as Third Sector Organisational Development Facilitator (ODF) in Health and Social Care Integration (HSCI) and latterly as Co-ordinator of the Community Health in Partnership Team with Aberdeenshire Voluntary Action, the Third Sector Interface (TSI) for Aberdeenshire.

Third/community sector and working closely with a general practice team

At the 2016 Scotland Policy Conference 'Integrating Health and Social Care in Scotland'[23] Dr John Montgomery (GP & Lead Clinician, Govan SHIP project) spoke of the importance of communication between all parties involved in the care of a patient with the Multi-Disciplinary Team (MDT) being the crucial element to this. This Practice has **Community Links Practitioners** (CLPs) (Scottish Government/Health and Social Care Alliance Scotland funded programme)[24] as part of the general practice team with the aim of supporting people to live well in their local community by building links between the practice and local community resources.

The Govan CLPs "practically link into the voluntary and third sectors". There is ongoing debate in Aberdeenshire regarding the appositeness of third sector presence at MDT meetings where patient details are discussed. Some HSC professionals recognise the benefits of a wider contribution to the discussion. Others consider it inappropriate due to client confidentiality and data protection. It is unclear if the CLPs are present at MDT meetings in the Govan practice. HSC staff may *suggest* meeting the CLP or patients can self-refer. The literature advertising this service suggests a fairly formal approach with patients supported to identify individual goals and assistance offered to access local resources that will help patients to reach their goals.

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[23] Conference organised by Scottish Policy Conferences in March 2016. Material referring to particular presenters here is drawn from participation at the conference and reporting notes provided by the organisers to conference attendees but shouldn't be understood as a verbatim account of their views.

[24] View at: http://www.alliance-scotland.org.uk/what-we-do/our-work/primary-care/national-links-worker-programme/

An organic, informal approach to community linking in Insch

The **Insch Community Links** project had no formal referral pathway. Some health staff would *recommend* the service to patients with the onus on the patient/service user to contact the Community Links Worker. Many leaflets about the service were given out to patients but most people engaging in the Community Links Worker activities made the connection through local knowledge or knowing someone participating in the groups. This was an effective model that took time to become established and had a 'light-touch' approach to engaging participants. Activities were user-identified with the community links worker exploring the practicalities and facilitating the establishment of particular groups. Lunch Clubs, Tea Dances, Games Afternoons and Walking Groups are all successful examples. There was a focus on encouraging volunteers from within the groups to take more ownership of activities e.g. training as walk leaders; identifying and risk assessing walks. The flexibility and variety of roles allows people to move seamlessly from participant to volunteer to group organiser. All activities were strengthened by encouraging individuals to share their strengths and skills for the benefit of participants (see Appendix 3, and Appendix 4: Annex 2).

Loneliness, social isolation and improving mental health

A Local Government Information Unit report (March 2016)[25] indicates that:

Loneliness:

- can increase the risk of premature death by 30 per cent.
- can be as harmful for our health as smoking 15 cigarettes a day.

Lonely individuals are more likely to:

- visit their GP
- have higher use of medication
- higher incidence of falls and
- increased risk factors for long term care.

Participants in the Insch Community Links Worker activities reported improvements to physical health conditions such as arthritis, Type 2 diabetes and high blood pressure also improved diet and weight loss. However, equally significant are the social benefits recognised by them – "social interaction", "good company", "part of a great community", "meet new people", "made many friends" – are some of the quotes from interviewees (see Appendices 2 and 3, and Appendix 4: Annex 2). Benefits for patients (and HSC staff) were recognised. Patients have something they can go on to and are less likely to ask for call-backs from community nursing team.

[25] Report no longer available (free of charge) from LGIU. See Scottish Parliament report on social isolation from 2015: http://www.parliament.scot/S4_EqualOpportunitiesCommittee/Reports/FINAL_Report.pdf

Billy Watson, Chief Executive, Scottish Association for Mental Health (SAMH), spoke at the 2016 Conference[26] of the correlation between social deprivation and poor mental health. His view is that mental health is currently still addressed by services "through a diagnosis driven medical model". He also suggested sport and physical activity might be "one of the most important things to invest in for the mental wellbeing of our nation." SAMH believes the key to future success will be investing in local mental health models e.g. peer support, social prescribing, community development assets and greater self-management.

Working at a wider, macro level to support 'community linking' – the need to build trust between public services and the third/community sector.

Whereas the Insch Community Links and other Link Worker models looked at by the research team could be considered to operate at a micro level, the **Community Health in Partnership (CHiP) Project** in Aberdeenshire is concerned with linking on a macro level. The CHiP team is working to:

- Support the third sector to recognise where they currently and potentially could contribute to health and wellbeing particularly around prevention and early intervention.
- Support the establishment of strong and sustainable links between health and social care services and the third/voluntary/community sector.
- Create a 'vehicle' to facilitate the direct exchange of views and information between sectors.
- Help the third sector to achieve parity of esteem and ensure the potential of voluntary and community group assets is fully realised in collaborative and co-production activities.

Ensure that project learning "best practice" around third sector activities is captured to inform future delivery and design of health and social care services.

There are many examples of cross-sector collaborative practice working well. However, the question of 'trust' comes up repeatedly in discussions with HSC professionals. 'How can the third sector be trusted to effectively deliver what they say?' Standards of voluntary sector providers and levels of training are also concerns. Unfortunately, it is examples where things have not gone well that tend to stick in people's minds and create barriers to future collaboration.

Many voluntary and community-based activities succeed because of their more informal approach. The danger is that placing additional bureaucratic demands on organisations could be a disincentive, particularly to those largely dependent on volunteers.

[26] Conference organised by Scottish Policy Conferences in March 2016. Material referring to particular presenters here is drawn from participation at the conference and reporting notes provided by the organisers to conference attendees but shouldn't be understood as a verbatim account of their views.

Interestingly, during a series of workshops last year on the theme of integration, some voluntary organisation staff said that they felt undervalued by HSC professionals. They felt that one of the reasons for this was around perceptions of volunteers not being 'qualified'.

It is absolutely right that the needs of vulnerable patients are taken seriously and that evidence of ability to support them provided. But can we 'trust' individuals who have the capacity to assess and take personal responsibility for decisions around engaging in community or voluntary led activities? This would then remove the responsibility from the GP or other HSC professionals. During desk research the inquiry team found evidence to suggest that where G.P.s had direct contact with third sector providers they were more inclined to recommend or endorse those services or activities to patients (see Improving Links in Primary Care report – listed in Appendix 6: Annex 1).

Needing a national message and greater public awareness on community capacity-building

At the 2016 conference several speakers spoke of the need to work with the community and voluntary sector. The expectation that communities will be able to develop initiatives in response to unmet need is growing. However, many communities are unaware of this and instead are exposed to the largely negative media stories: 'NHS crisis', 'GP shortage', and 'underfunding of NHS' creating a sense of 'helplessness'. There is no doubting that we are facing increasing health inequalities and changing demographics and that our ability to carry on providing services at current levels unsustainable. Health and social care integration is transformational change and for that to succeed all partners need to be fully aware and engaged. In order to stimulate community capacity-building then a national message (from government) would help individuals and communities to become more involved with the integration agenda and encourage ideas and discussion around prevention and self-management.

In conclusion

As far as the participants are concerned the informal approach of the Insch Community Links Worker model worked for them. Hosting the project within an established local organisation – in this case The Friends of Insch Hospital – and having the support of a Voluntary Service Support organisation (CVS Central & South Aberdeenshire which then became Aberdeenshire Voluntary Action) provided 'back office' assistance when needed. 'Buy-in' from HSC professionals in the early days was also a key element. The activities in this model centred around social and physical needs.

In other areas different approaches will be required. For instance, the Govan CLP project functions in an area of high deprivation with increased premature multi-morbidity and social difficulties. A more structured and holistic approach to community linking is required to tackle the many barriers to achieving and maintaining wellbeing. Speaking at the 2016 Conference, Dr Andrew Fraser, Director of Public Health Science, NHS Scotland, said:

> "it is one thing to be free of disease but it is quite another to be free from worry about having your housing tenure in a good place, having enough money to heat your house, enough food including some fresh food in the fridge… That's all part of what health and social care in a holistic sense is all about."

There is much expectation of communities' capacity to tackle health issues such as social isolation and poor mental health. Building trust and meaningful relationships between the public sector (including GPs) and third/community sector and indeed, within the third sector itself, and will take time but is essential to progress.

Community Linking is a complex area of practice that is generating a range of issues and dilemmas that will need to be discussed and worked out over time by public services and third/community sector in Aberdeenshire. Part of the focus of the CHiP team's practice is around the need for a culture change and the subtle emphasis of this ethos to all stakeholders. Establishing a sustainable and meaningful way to enable information and views to be exchanged and respected is a key piece of work going forward.

Note: All quotes above are from the reporting of the speakers at the 2016 Scotland Policy Conference: Integrating Health and Social Care in Scotland held in Edinburgh.

Appendix 4 – Annex 1: Early scoping work on potential third/community sector roles within health and social care integration

By **Alison Knight,** then Third Sector Organisational Development Facilitator in Health and Social Care Integration.

Representing/linking with the third sector

All six areas in Aberdeenshire have started the process of deciding where the 'integrated' teams (now known as Health and Social Care Teams) should be based and who will be part of the teams. There is cognisance that third sector organisations (TSOs) are essential partners in the delivery of health and social care services. The challenge lies in how the links can be established/enhanced and sustained.

- **Link Worker model** as in Nairn Community Health Partnership as detailed in the following report:
  http://www.alliance-scotland.org.uk/news-and-events/news/2014/09/improving-links-in-primary-care-report-launched/#.VEZy7ef7CvE
  In this model the Link Worker is an adviser from the Citizens Advice Bureau with a room in the practice three days per week. The service is used when a patient presents at or contacts the GP practice.

  *The Link Worker model in **Insch** operates more from a preventative viewpoint and is largely accessed through word of mouth but also engages with people who have been signposted by health professionals – mainly occupational therapists (OTs), physiotherapists and community nurses.

- **Aberdeenshire Signposting Service:** originally established to sit within GP practices but redesigned as few referrals were being made.
- **TSO representative** representing all TSOs in area – agreement/buy-in required (use agreement similar to Aberdeen Council of Voluntary Organsiations). Forums/Networks have been suggested with rotating reps.
- **TSI representative**
- **Social Prescribing Team** – Kings Fund report featured Tower Hamlets example: http://www.kingsfund.org.uk/reports/thefutureisnow– contacted to ask for further information:
- http://www.bbbc.org.uk/-social-prescribing-seminars--201

Note: Information from the Public Health Coordinator at Buchan Area Manager's meeting that Signposting service has applied for funding to provide a dedicated signposter in Peterhead Health Centre. Also application for funding for a Link worker across the 'Shire has been made.

Appendix 4 – Annex 2: Extracts from *Report on Community Link Worker, Insch Hospital Catchment area (2015)*

By **Alison Knight**, then Third Sector Organisational Development Facilitator in Health and Social Care Integration

1. Activities in Insch

Walking groups: need was partially identified by the local leisure centre staff who had been asked about walking groups. Funding and training provided by 'Paths for All' enabled two weekly walking groups to be set up in Insch and one in Rhynie. These weekly low-level health walks are promoted as part of a person's recommended weekly exercise target of 150 minutes. Several members of the group have also attended the walk leader training and other courses offered by 'Paths for All' strengthening the sustainability of the group. Motivation for joining the group varied from people wishing to get to know others as they were new to the village to others who had health issues such as: high blood pressure, diabetes and weight management. When improvements were made people acknowledged that the social benefits of the group activities were equally beneficial to their health and wellbeing.

Links have been established with other walking groups locally and this has led to a number of joint walks. During the 'Big Fit Walk' initiative in June 2014 three groups walked together and were joined by children from a local primary school. A large number of people taking part in the walking groups now volunteer with other groups in the village e.g. Day care, RVS, Friends committee, Lunch Club, an activities group, tea dances and the local charity shop.

Healthy Heart: contact was made with the Garioch Community Kitchen in Inverurie and their worker ran an eight-week Healthy Heart programme using the kitchen at the local leisure centre (with whom a reasonable rent was negotiated, funded by the 'Friends') funding was obtained from the Change fund to cover the cost of delivering the course. The majority of people taking part in this activity have reported making positive changes to their diets: smaller portions, weight loss, less salt, increased awareness and consumption of different food groups.

Tea dances: established as a way of encouraging exercise and increased social contact, this was set up partially in response to the loss of regular dances held locally in a former hotel. Advice was sought from other successful tea dance initiatives who also gave contact details for a musician, one of the key components in the success of the dances. Attendance is averaging 35-40 per dance with some people travelling from other areas to attend.

Lunch Club: a monthly lunch club has been established following a successful pilot mainly targeting people living alone, perhaps not cooking for themselves or largely reliant on ready/frozen meals. A target of 20 participants (identified by health staff, sheltered housing officers, and local knowledge) were invited to take part in a pilot. A health worker provides highly nutritious two-course meals including the recommended five portions of fresh fruit and

vegetables. Clients also enjoy tea/coffee after the meal which has a reasonable cost of £4.50. Any leftovers are available to participants for a donation and are appropriately packaged and labelled with instructions on re-heating the food safely. Funding has been secured to allow the continuation of this service for the next 12 months during which time, options for sustaining this popular activity will be sought.

Activities Group: Insch is lacking a café and a natural meeting place. Funding from the Garioch Charity Shop allowed a room to be hired and some board games to be purchased. This fortnightly activity provides a meeting place, bringing people together for an informal social session where they can play scrabble, dominoes and cards. Despite the variety of activities happening in the village it was often commented on that there was a lack of groups offering something which appealed to men. Both the Lunch Club and the Activity Group have been successful in seeing more men than women come along.

Friends and IT: funding was obtained from 'Awards for All' to establish an IT project after informal discussions with people living in sheltered housing and nursing homes revealed many people had family dispersed widely across the world. The local library has some IT facilities but limited resources to provide individual support. Using the 'Moose in the Hoose' model, an established service in Edinburgh, the project uses volunteers to support people in nursing homes and sheltered housing to connect with computers and discover the benefits. This project has proved difficult to get off the ground due to a lack of volunteers.

Stretch & Relax Classes: these classes were established again in response to people asking for an age appropriate activity as they did not feel there was anything suitable available at the local leisure centre. The yoga-type movements and exercises are suitable for people of all abilities and can be adapted for people who require to sit to take part. This group is attended by around 12 people each week and during their first year they have made a financial donation to local good causes from any profits generated from the class. The group has also produced a CD with the help of a local musician. Monies raised from this are donated to the Friends.

Information Directories: joint working with another local voluntary organisation led to the production of a local directory for retired people in Insch. This resource is available in key places throughout the village, health centre, library, post office and the sheltered housing complex etc. Extra copies have been produced due to demand from health professions so they can pass on information to patients requiring social care type support.

Activities in Rhynie: people affected by Type 2 diabetes were invited by the local GP practice to attend a 'Healthy Helpings' course run by health worker. Through this, a newly established weekly health walk was promoted which has grown into an established weekly weigh & walk group. Strong links have been made with the local primary school. The children have joined in the walks, provided entertainment at a monthly activities group and helped with preparing healthy snacks for participants. One participant aged 70+ was recommended to attend Healthy Helpings by his GP to address weight and other issues. He lost weight appropriately

with the support of coming along to the groups and health checks show a positive improvement in blood sugar levels and weight loss. He has become more involved with the group – growing vegetables and donating to the group to provide healthy ingredients for meals and has been encouraged to help in the preparation of meals.

Activities in Rothienorman: lunch club established and running well. People attending include some residents from the local nursing home and sheltered housing complex as well as retired people of Rothie living in their own homes. The Lunch Club meet once a month taking advantage of a 'pensioners meal deal' at a local restaurant. Numbers attending vary between 15-22 people. This has now been running for 18 months and provides an opportunity for people to meet and socialise with folks they may not otherwise have contact with.

2. Feedback from local participants

Feedback from the Insch walking group, Rhynie walk & weigh and Insch Lunch Club and Activities Group:

> "The group walk is fantastic. My arthritic foot is far less troublesome when I'm walking & talking with others. The social aspect of the walking is so fantastic."
>
> "Through the group I have become familiar with area around Insch which has encouraged me to walk with family members and on my own."
>
> "Great combination of exercise and socialising."
>
> "I've made many friends since the formation of the walking group."
>
> "Enjoyed the walks I have been able to go on…. company good, a chance to meet people new to Insch. The group put forward lots of good ideas."
>
> "Being a member of the group has encouraged me to join others and now feel part of great community."
>
> "I wouldn't have lost weight without your help, they're very pleased with me at the medical centre."
>
> "I haven't been out for a year because of health problems."
>
> It's been great I've met people I haven't seen in ages.
>
> Person referred through GP phoned following first Lunch Club and Activities Group – "it was just brilliant, it's made such a difference, just what I was needing."

Source: Quotes passed by participants to Community Links Worker and then passed to researcher.

Appendix 5: Considering the national and local policy context and its implications for 'community linking'

By **Sophie Humphries**, Strategic Development Officer (Community Planning); Policy, Performance and Improvement, Aberdeenshire Council.

Introduction: The work examining the critical success factors for the Insch Community Links Worker project has implications across a broad range of thematic partnerships, not solely partners involved in Health and Social Care Integration. A number of other localities within Aberdeenshire are conducting or considering similar projects, given the evidence bank surrounding the use of the Community Links Worker model nationally.

Health and social care integration and policy development: Health and social care integration is subject to a great deal of national and local scrutiny and the March 2016 Audit Scotland report (*Changing models of Health and Social Care*) is clear that a lack of leadership and clear planning is preventing the significant change required to successfully implement the Government's intentions (the 2020 Vision). NHS boards and councils are encouraged to do more to facilitate change by focusing funding on community-based models of care, workforce planning, understanding the needs of local communities, evaluating new models and sharing learning across the Health and Social Care Partnerships.

The work within the Health and Social Care PIT (Partnership Innovation Team) examines our approach to these issues, particularly in gaining experience of using Collaborative Action Research to evaluate and share best practice. The action research is also generating clear opportunities to integrate the thinking of the PIT with strategic developments within *Aberdeenshire HSCP Strategy (2016-19)*. In particular Outcomes 1, 2 and 6 – although potentially all of the 15 Outcomes within the Strategy – and Programmes/Priorities concerned for 'Involving and engaging with communities' as well as concerns and actions in relation to tackling health inequalities, community asset-building and community empowerment.

Community Planning Partnership (CPP) reform and community empowerment: The Scottish Government has made clear, through the publication of the Community Empowerment (Scotland) Act 2015 and other proclamations (i.e. Statement of Ambition 2012[27]), that a significant focus on prevention and inequalities by CPPs is critical. In examining the Insch Links Worker we have a deeper understanding of the requirements that need to be in place for success and how similar models of building community capacity could be used in areas of inequality/deprivation and the key benefits of shifting resources to preventative action/early intervention (from the perspectives of community organisations, the third sector, NHS, individuals, communities and staff).

[27] Access Statement of Ambition on Scottish Government website http://www.gov.scot/Topics/Government/local-government/CP/soa

Aberdeenshire Local Outcomes Improvement Plan: Aberdeenshire CPP is currently in the process of drafting their first Local Outcomes Improvement Plan (as required by the 2015 Act), with a specific focus on the underpinning principles of community involvement, prevention, joint resourcing and tackling inequalities within Aberdeenshire. As at September 2016, two priorities have been endorsed by the CPP Board (i) Reducing alcohol consumption and (ii) Reducing child poverty. A third priority is currently in development, which will focus on supporting and delivering Locality Planning and supporting community capacity-building. The final version of the Local Outcomes Improvement Plan will be signed off by the CPP Board during Spring 2017. We have built a strong evidence base to identify and support these priorities and our understanding our local need and aspirations through use of quantitative and qualitative data, producing an Evidential Narrative and Life Stages Outcome document to identify key priorities for Aberdeenshire. We will shift partners' resources on a larger scale than we have previously to these priorities and have an enhanced focus on improving services to deliver key priority outcomes. The learning from this PIT is assisting us in assessing how we design and deliver services, target resources and deliver on our ambitions.

Developing relevant partnership working: the learning from this PIT can provide opportunities to support creative discussions – where shared in suitable forms (see Appendix 8 for early thinking on communicating learning to a range of stakeholders) – for all levels of partnership working, for example:

Third sector organisations

- Building the relationship with health and social care providers and key partners, including an understanding of values and perspectives.
- The type of individual required to successfully deliver similar projects.
- Contributing to the development and role of the Community Health in Partnership (CHiP) Officers across Aberdeenshire.

The community

- Where their role in health and social care integration is and how they can influence change.
- How they can input into assessing public services (key requirement of Audit Scotland Report on Community Planning[28], March 2016).

Community Planning Partnerships

- Understanding how Collaborative Action Research can be used to improve outcomes.
- Improving understanding of methods/interventions to support community capacity building and sustainability post withdrawal.

[28] Access Community Planning report on the Audit Scotland website http://www.audit-scotland.gov.uk/report/community-planning-an-update

- Understanding at a local level where similar interventions could support aspirations (across all thematic areas, not just health).
- Improving our understanding of the implementation of health and social care integration and the role of respective partners within that process.
- Evaluation of performance and small tests of change.

Integrated Joint Board

- Test of model of change within the Partnership – sharing learning and the impact of this model on the whole system.
- Contributing to service planning, design and delivery and achievement of key outcomes.

Appendix 6: Initial desk research on 'community linking' – summary of learning and other relevant resources

By **Sharon Van de Ruit**, Senior Improvement Officer, Aberdeenshire Council; and **James Henderson**, What Works Scotland.

The PIT undertook initial desk research through reading and then discussion of five research reports relevant to 'community linking' (see Appendix 6: Annex 1 for list of reports). The resulting themes helped form development of our thinking on the Community Links Worker role and our interviewing in Insch, as per Appendix 2. A summary of our initial learning is given below, and an indication of further research reports from which a cycle 2 of this Inquiry work or the HSCP more generally can draw upon is given in Appendix 6: Annex 2.

1. The relationships between 'people' and worker

Generally, all of the five research reports illustrated workers seeking to do similar work: improving wellbeing by involving people at a local level; giving people choice and options; connecting people or signposting them to services in their community and/or community networks and groups. In particular, the reports highlighted:

- **The personal touch is important:** simply making people aware of the resources/services that are available is not enough i.e. not enough to simply *tell* patients about local support. Interaction at a human level is key.
- **Importance of supporting people to make choices:** in all examples workers either work with or alongside people.
- **Model 2 – Social Prescribing (see below)**
    - Is resource intensive in most, if not all, cases – the worker needed to make a great effort to keep people involved and participating. This is a big investment in time and would need to be targeted at those people who really required it.
    - In some cases the intervention is prescribed (social prescribing) therefore requiring GPs to have a holistic approach requiring a change to traditional methods of treatment and working culture – time-intensive but there is evidence that it works.
    - The urban/rural dimension is relevant, as is the willingness of GPs to refer people.
- **Model 1 – Community building (see below):**
    - In this model, local people decide what happens and how with support from link workers through ongoing discussions and community consultations.
- **Diversity of people and place:** the reports covered different geographic areas, deprived and affluent, different age groups with mixed results. What works with one group can/could be rolled out to another but may not have same results.

2. What does 'community linking' involve?

The initial desk research identified two broad models – or uses of the term – active in Scotland currently.

Model 1: a community-building approach

- The worker to be based in a local community organisation(s).
- Likely drawing on community development tools (or similar) to explore with people and communities – or particular target groups e.g. people with disabilities and their families – what is needed and what resources from community and services can be accessed, advocated for, or developed.
- Can involve building new capacity or using existing community capacity and services – or mix of these – and also advocacy-type activity.
- A particular ethos, way of working or philosophy is likely to be in use – but used flexibly – e.g. 'community asset building' or 'ordinary living' (for disabled citizens).
- Outcomes will point towards individuals, communities and services – across a community or network of communities.

Model 2: Social prescribing

- Workers based in GP practice – playing an advisory/signposting role e.g. like a CAB worker perhaps, and potentially offering a significant level of more complex support e.g. person-centred support.
- They will seek to network and map locally to understand full range of assets and services; this likely recorded in a relevant database e.g. ALISS[29], and perhaps using community development tools. But they are unlikely to be seeking to actively develop local capacities or assets; more to link individuals and services into community networks and groups.
- Relationship-building and associated culture change with GPs and other health professionals are also a high priority to support the development of 'social prescribing'.

3. What makes for good practice in 'community linking' – and so can improve community capacity-building and support self-management?

The desk research on Models 1 and 2:

- Both illustrate the value of building in evaluation – as funding allows – and of drawing from a growing evidence base, or even seeking to sustain an on-going research and learning process; but also that a certain caution is needed here in interpreting the data/information generated e.g. what happens to people who don't take up the offer

[29] ALISS is a search and collaboration tool for health and wellbeing resources in Scotland https://www.aliss.org/

of an intervention or drop out early; are there other potential interventions that might be yet more effective?

- Both point towards 'seeing the whole' and the relationship between people, communities, community orgs and groups, services – of a changing people and context.

Model 1 only:

- Would seem to illustrate the value of a widely-used (across Scotland, for instance) and flexible ethos or philosophy (theory and practice) and potentially a 'central', 'regional' or 'area-wide' organisation or community of practice that sustains discussions of a 'good practice' culture and helps locate resources.
- Role of key local community organisations to support the worker in their community-building practices – perhaps key local public services too – in generating credibility and networks
- Useful creative and common areas of practice:
    - local funding pots
    - in-depth listening, participatory processes
    - space to take risks

Model 2 only:

- Here the emphasis is on culture change – how to shift GPs and health professionals towards social prescribing – a holistic/bio-social model – and understand the range of community assets and resources available.
- Intensive person-centred support potentially on offer here to support more vulnerable people.
- Concern to establish 'credibility' through – professionals, local history, policy initiatives.
- Potential to tackle stigma through access to advice/info/support at a 'universal' access point at the GP's surgery or health centre, and so not separate from the wider community.

4. What supports the development of effective 'community linking?'

Both Model 1 and Model 2 illustrate the value of the following as supporting and sustaining good practice:

- Role of 'central' 'regional', or 'area-wide' coordinating body to work with policy/policy networks and build 'community of practice' – particularly Model 1, but also Model 2.
- Credible, flexible ethos – a theory and practice – to support diverse discussion and local development – again in particular Model 1, but also Model 2.
- Need for relevant resourcing and funding – in both cases, but Model 2 in particular seems to point to the need for suitable funding to provide more intensive support

- Value of opportunities for learning and on-going development research to continue the learning within the project.
- Establishing credibility across a range of different stakeholders including local organisations and professionals is a common theme. Also relevant to credibility is previous local experience and knowledge of such types of working and relevance of such working to national policy context.

Model 2 only:

- Culture change – in relation to GPs/health services is emphasized. Although this is likely of relevance to Model 1 too. One key aspect of this is bringing together health services with communities/the community sector.
- Community capacity is assumed by the model, but may not necessarily actually be there 'on the ground' within a particular community in sufficient 'depth' or 'relevance'; and there is no commitment to develop it within Model 2*.

*whereas Model 1 aims to help develop or advocate for development of community capacity. There is of course potential for hybrid approaches drawing from both models.

5. In what ways is our learning relevant more widely? For example, to be transferred or 'spread' to other contexts

Both Models 1 and 2

- The need to bring together a flexible way of working – perhaps through developing a community of practice – and relevant local investment with a focus on 'local listening'.
- Evidence tends to be constrained to particular targets; deprived communities; women; 'success stories'; people with disabilities or mental health problems; older people … *so it's unclear if the evidence is relevant to all communities and with all groups in a community**.
- Local context and knowledge and what is credible and or relevant is highlighted as important to understand through community development tools. Similarly, understanding existing local community capacity and risks of people facing discrimination or stigma in relation to service-use.

* One example is given of Model 2 being less successful in one particular 'more affluent' community, but this shouldn't be assumed to mean it is not relevant to other more affluent communities.

Appendix 6: Annex 1: Documents used in the desk research

The five reports drawn from are as follows:

1. *Evaluation of the Link Up Programme (2011-14) – Inspiring Scotland* (2014) by ODS Consulting: http://www.inspiringscotland.org.uk/media/37341/Link-Up-Phase-1-Evaluation-by-ODS_FINAL_Oct-2014.pdf
2. *Improving Links in Primary Care Project Report*. A research report studying four GP practices using a Links Worker system… a partnership project between the Health & Social Care Alliance (the ALLIANCE) and the Royal College of General Practitioner (Scotland) (RCGP Scotland) (2014). http://www.rcgp.org.uk/rcgp-nations/~/media/Files/RCGP-Faculties-and-Devolved-Nations/Scotland/RCGP-Scotland/RCGP_Scotland_Improving_Links_in_Primary_Care_report_September_2014.ashx
3. *Social prescribing in Maryfield, Dundee.* Lynne Friedli (2012). Link Work project in deprived Dundee community and based in GP practice. (Also included in 2 but in more depth here). http://www.dundeepartnership.co.uk/sites/default/files/Social%20prescribing%20evaluation%20report.pdf
4. *Engaging Community Assets.* Royal College of General Practitioners (Scotland) (2014*)* http://www.rcgp.org.uk/rcgp-nations/~/media/Files/Do-Not-Use-RCGP-near-you/RCGP%20Scotland/RCGP%20Scotland%20Engaging%20Community%20Assets%20Project%20-%20Final%20Report%20May%202014%20Brand%20Guidance%20changes.ashx
5. *Values into Practice: A framework for Local Area Coordination in Scotland.* Consultation report – across wide range of relevant stakeholders – that provides a practice framework.Produced by the Scottish Consortium for Learning Disability (with the Scottish Government) (2015). http://www.scld.org.uk/wp-content/uploads/2015/08/SCLD-LAC-Framework-FINAL.pdf

Appendix 6: Annex 2: Additional potentially useful research

In carrying out this research we note further research that could valuably be considered by HSCP and CPP and in any further cycles of this Inquiry work:

- Social Prescribing report and Community Café reports – Carolyn Lamb, Public Health Coordinator, Garioch, NHS Grampian
- Building Community Capacity report – 2012 (provides a consideration of the evidence as to the value of tackling isolation)
- Local Area Coordination briefing – 2011
- Social Isolation reports: Scottish Parliament report (2015) and Local Government Information Unit report (2016)
- Inspiring Scotland report on qualities of a Link-up Worker (2016)
- Volunteer Action Angus – Third Way report (2016) on role of social enterprise in health and social care

Note: At the time of publication **What Works Scotland** was also working with the Rural Policy Centre to produce an evidence review on rural community capacity-building for health and

wellbeing to support the informed development of health and social care integration in Aberdeenshire.

Appendix 7: Research Aims and Objectives for Cycle 1

1. Initial Research Aims, Objectives and Questions: 'Building Community Capacity' (June 2015)

(Initial) Project Aims:

- Understand what contributes to building community capacity and self-management for older people and those with long term conditions.
- Transfer this learning to the Belhelvie Parish.
- Roll out across appropriate areas across Aberdeenshire.

What does success look like (initial visioning)?

- We will know how the Health and Social Care Partnership can support self-management and contribute to building community capacity.
- Future projects will be more effective at supporting self-management and communities to build capacity.
- Self-management and independence is evident through more people participating in community.

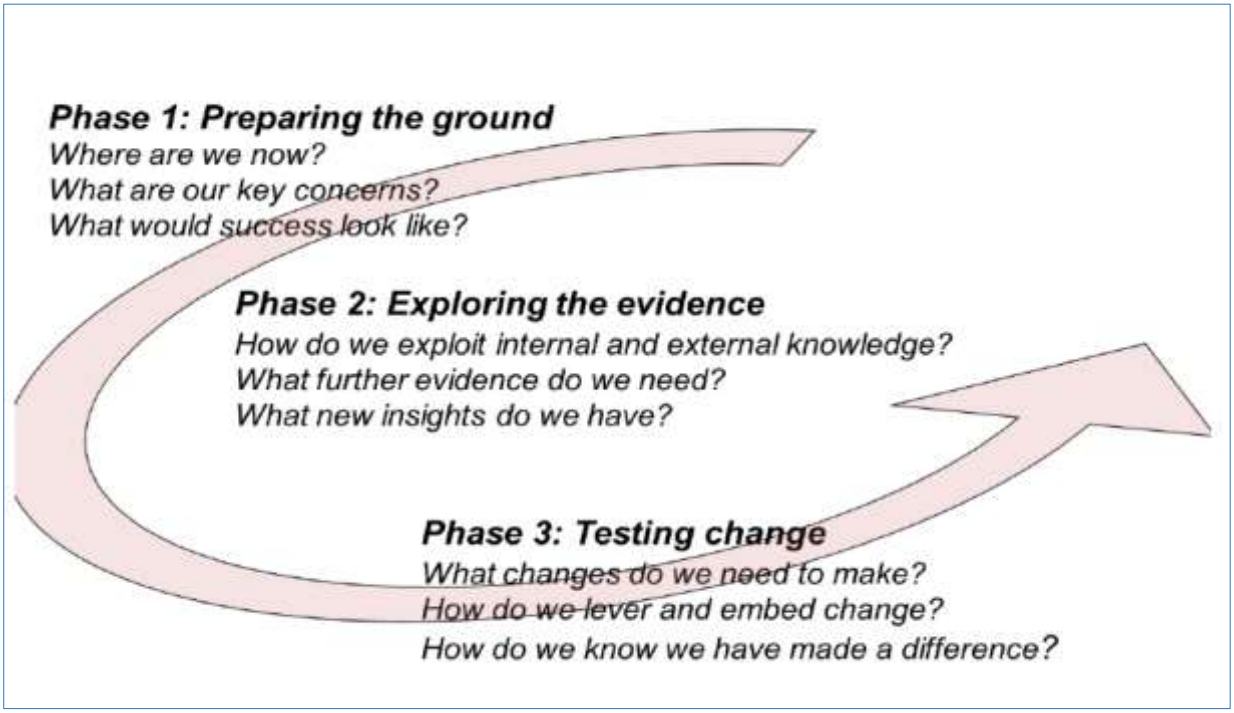
(Initial) Research Questions – Cycle 1

1. Who are the partners and what has been their involvement in the Community Links Worker Project?
2. What has been the nature and extent of activity within the Community Links Worker Project?
3. What has and hasn't worked well from different partners' perspectives?
4. What factors influenced the success of the project?
5. How can the learning from this project be embedded within the work of the HSC Partnership e.g. the development of Belhelvie Parish?
6. Explore the area-specific factors that will contribute to success.

2. Summary of Cycle 1 Research Questions (above) as four Research 'Foci' (January 2016)

- What is community linking?
- What makes for good community linking practice?
- What supports community linking?
- What would support the spread of community linking?

3. The Collaborative Action Inquiry and Research Cycle and its three Phases



Appendix 8: Exploring relevant stakeholder communications on 'community linking' and action research: a draft Communication Plan

Jane Warrander, Senior Improvement Officer, Aberdeenshire Council.

The PIT considered a range of potential stakeholder groups which might be interested in learning more about 'community linking' and/or action research processes. The following draft Communication Plan was generated from these discussions and can support further planning work.

What message	Who	Purpose	How	Who leads	By when
What we are learning from a community linking model and how it supports building community capacity	Strategic Planning Group	To inform allocation of resources Informing their thinking on options Evidence to assure local spend on best practice Evidence to assure some change on strategic direction Consideration of the Strategic Planning Group Audience and Potential future application	Interactive session to understand the Report and evidence trail Executive Summary and appendices Video?		
What we are learning from a community linking model and how it supports building community capacity	Community Planning Group	To report on progress Report on initial findings Inform their strategic direction Put community links worker model into the context of HSC Integration and beyond e.g. role of community sectors	Full Report including Executive Summary and appendices		

What message	Who	Purpose	How	Who leads	By when
What is community linking about and how it can help community capacity-building and self-management	Health and Social Care Teams	Where does the model fit in relation to building community capacity Understanding what building capacity entails Raise awareness of community linking models What are the benefits of a community linking model. What's in your area Contributor to changing culture	Video? Article in newsletter		
What CAR can do for you? Collaborative working in practice	Community Planning Officers	Make them aware of the model used to investigate community links worker	How to use a collaborative approach – talk to CPO to see if this is necessary or beneficial		
	Public Health Officers				
What we are learning from a community linking model and how it supports building community capacity	CHiP Team Advisory Group	To report on progress Report on initial findings To inform CHIP deployment Deepening understanding of the issues involved Inform the challenges around sustaining community capacity	Full Report including Executive Summary and appendices		
This is useful to your work	CHiP Team	To give them a real example to help them deliver the understanding of some of the	Training resource for them and/or others in their sphere		

What message	Who	Purpose	How	Who leads	By when
		key elements for building community capacity	How to guide to pass on		
How to add value to collaboration	An improvement and CAR audience	To demonstrate added value and explore the challenges of blending two approaches	Paper Research as evidence for improvement		
What community link working is about	Public	Engage the public in community capacity building Provide a picture of what's been happening in Insch and give people a sense of what's possible in the scope of community links worker An information hand-out for public	Leaflet, internet article, newsletter AVA		
How to make this model work in your area	Areas of inequality	What to consider when rolling out this model to areas of high deprivation What are good ways of tackling inequality	This needs more work – part of the PIT		
A potential model for public service reform	WWS	To inform What Works Scotland research Describe Community Linking as a model Describe CAR as a model	All material provides evidence for the enquiry in public service reform Blogs, Case Studies etc.		

Appendix 9: What Works Scotland: Spreading 'what works' in public service delivery – a draft framework

By **Nick Bland**, co-Director, What Works Scotland

Note: At time of publication this Framework was still in development.

How to spread 'what works': a framework for planning and organisation
What do we mean by 'spread'? "*A deliberate effort to increase the impact of innovations/interventions with demonstrated effectiveness on a small-scale to benefit more people*." (From Simmons and Shiffman, 2007) "*The essence of scaling up an educational practice is the ability to implement a practice across a large number of classrooms, schools, or districts*." For example - a planned programme to spread a classroom-based educational practice with children with a mild developmental disability for which there was good evidence of effectiveness at improving learning outcomes - peer tutoring- to five schools across four U.S. states. (Buzhardt et al 2007).

How are we going to spread?
Are we trying to spread 'across'- from one setting to another? e.g. from one classroom or one school to another classroom or another school from one hospital ward to another hospital ward **or are we trying to spread 'out' (i.e. scale up)?** e.g. from one school to many schools from one hospital to many hospitals from one part of a council to the whole council.

How do we know 'it works'? **Do we have credible evidence that shows the intervention we want to spread is effective?**
Describe the kinds of evidence we have on the effectiveness of the intervention we want to spread. Do we have evidence from a formal evaluation? Or some performance information, key performance indicators? Is there information from self-assessment, local knowledge about context and mechanism? Is there any evidence that questions the effectiveness of this approach?

Effectiveness: How does it work? **With what kinds of people? Are there features of the local setting that are important?**
Describe the evidence for the effectiveness of the intervention to be spread: 1. **What works**: what are the core elements of the intervention that are critical to its effectiveness? What are the specific outcomes it delivers? 2. **For whom**: what are the characteristics of the client group with whom the intervention is effective (e.g. what age and gender; specific needs) 3. **In what context**: are there key elements of the context (the circumstances, environment in which it was delivered) which supported the effectiveness of the intervention Together, this provides the basis of a clear description of the 'model' intervention that will be spread.

How will we know we have been successful? What will it look like? **What is our 'vision' for spread?**
A description of success- how will we know when the model intervention has been successfully spread? How will we know that the change has been sustained? Describe the information that will be collected routinely to monitor the success of the spread plan and of the delivery of the intervention at scale, and plans to evaluate to ensure sustained success of the intervention over time.

Have we got the leadership and management support we need?
Identifying the necessary leadership and management involvement and support required for successful spread, and sustainability, and plans to achieve that involvement and support (e.g. specific leadership activity, roles, any 'champions') Have the resources we need for spread been agreed and committed by the leaders who hold them?

Knowledge exchange: how do we make sure everyone knows what they need to know?
A description of how the knowledge and understanding of how and why the intervention is effective (the model) is to be communicated and shared to ensure a consistent level of understanding at strategic and operational levels.

Who are the leaders and operational staff key to the successful spread of the intervention? **Who needs to be involved and engaged from the beginning?**
Description of plans to develop active support, ownership and buy-in to the spread process, the implementation of the intervention, and its sustainability, with all the necessary operational staff and leaders key to the success of the intervention. This should involve discussion about whether and how the model should be adapted to ensure its successful implementation in the new site.

Who are the key partners? Are they committed to working together to achieve successful spread?

Have we got the necessary connections and commitment from partner organisations to support, implement and sustain the intervention?.

What resources will we need to spread the intervention?
Have we got a detailed assessment of the financial and human resources needed to spread and sustain the intervention? i.e.the money, the people and the infrastructure- estate, equipment etc.

Are we ready to spread?
Have we assessed the readiness of the new sites to receive the new intervention? Are they ready to begin to deliver it according to the model (ensuring 'fidelity') and sustain it? Have we identified plans to remedy any outstanding areas of weakness?

How are we actually going to do the spread? **What are our plans for 'roll-out'/implementation?**
What are the practical requirements, logistics and timings necessary to implement the spread of the intervention?