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Agenda Item: 13.

## **Integration Joint Board**

**Date of Meeting: 17 June 2026.**

**Subject: Third Sector Update Report.**

### **1. Purpose**

1.1. To provide an update on the main issues, developments and pressures reported by Third Sector Working Group members in May 2026.

### **2. Recommendations**

The Integration Joint Board is invited to note:

2.1. That third sector organisations are supporting people across Orkney with early help, prevention, mental health, family support, food and fuel poverty, domestic abuse, sexual violence support, bereavement, advocacy, dementia support, youth transitions and other community-based support.

2.2. The highlighted pressures that may need further discussion with partners, including rising demand, short-term funding, waiting lists, staffing pressures, gaps in services, and the impact on statutory services if third sector support is reduced.

2.3. The important role third sector organisations play in supporting health and social care outcomes across Orkney.

2.4. That many organisations are seeing rising demand, more complex need, waiting lists, uncertain funding and pressure on small teams.

2.5. That many third sector services are helping people before they reach crisis, which can reduce pressure on NHS, social work, housing, children's services and other statutory services.

2.6. The positive progress in dementia support, including three-year funding for the post of Admiral Nurse, strong post-diagnostic support, social hubs and wider partnership work.

2.7. The concerns raised regarding funding decisions affecting long-standing third sector services, especially where those services support prevention, early intervention, safeguarding, statutory referral routes and wider community resilience.

2.8. The increasing pressure on independent advocacy, food support, youth transition support, sexual violence support and community-based dementia support.

**It is recommended:**

2.9. That officers are asked to consider how the issues raised in this report can inform planning, commissioning, prevention work, financial planning and risk management across the Orkney Health and Social Care Partnership.

2.10. That the Integration Joint Board supports continued engagement with the Third Sector Interface (Voluntary Action Orkney (VAO)) and the Third Sector Working Group, so there is a clearer shared understanding of demand, capacity, unmet need and opportunities for joint working.

### **3. Background**

3.1. The Third Sector Working Group brings together third sector organisations that provide support across Orkney.

3.2. Members were asked to provide updates on key developments, concerns, positive outcomes, next steps and requests for partnership support.

3.3. Updates were received from:

- Orkney Blide Trust.
- Crossroads Care Orkney and Orkney Young Carers.
- Cruse Scotland Bereavement Support.
- Relationships Scotland Orkney.
- THAW Orkney.
- Women's Aid Orkney.
- Home-Start Orkney.
- Advocacy Orkney.
- Orkney Foodbank.
- Age Scotland Orkney.
- Connect Project (VAO).
- Orkney Rape and Sexual Assault Service (ORSAS).

3.4. The report also reflects key points from the Orkney Dementia Strategy 2020-2025 and the Evaluation of the Orkney Dementia Strategy 2020-2025, attached as Appendix 1 to this report.

### **4. Key Themes for the Integration Joint Board**

4.1. This report summarises the key points for Members, with a focus on health and social care planning, prevention, community resilience, safeguarding, inequalities and the sustainability of local support.

4.2. Demand for community support continues to rise. Relationships Scotland Orkney reported 539 open cases and supported 380 adults and 253 children between April 2025 and March 2026. Counselling and family support are under particular pressure, with longer waits for counselling. Orkney Blide Trust also reported high numbers of new referrals. Its membership has doubled over the last five years, while statutory funding has stayed the same.

4.3. Third sector organisations are supporting people before they reach crisis. This includes:

- Families needing early help.
- Young people needing transition support.
- People experiencing poor mental health.
- Unpaid carers.
- Bereaved people.
- Women and children affected by domestic abuse.
- Survivors of sexual violence.
- People needing independent advocacy.
- Older people and people living with dementia.
- Households affected by poverty, food insecurity and fuel poverty.

4.4. Funding uncertainty is a major concern. Members reported worries about Service Level Agreements, short-term funding, project funding ending in 2026, and the difficulty of maintaining core services. This affects service continuity, staff retention, match funding and the ability to meet demand. Further information is provided in Annex 1.

4.5. Clear communication and better coordination are needed. Several updates point to the need for clearer referral routes, better awareness of services, stronger links between statutory and third sector services, and better partnership forums around mental health, poverty, advocacy, early help, community support, dementia and transitions for young people.

4.6. Despite these pressures, the third sector continues to deliver strong outcomes. Examples include supported employment through Orkney Blide Trust, unpaid carer microgrants through Crossroads Care Orkney, fuel poverty action planning through THAW Orkney, dementia support through Age Scotland Orkney, sexual violence prevention through ORSAS, bereavement support through Cruse Scotland, advocacy helping people navigate complex systems, young people moving into full-time work through the Connect Project, and food support delivered by Orkney Foodbank with the help of volunteers.

## 5. Summary of Third Sector Working Group Member Updates

Theme/Service Area	Summary
Mental health and emotional support	Orkney Blide Trust reports high referral demand, growing membership, and continued delivery 365 days a year. It has secured Distress Brief Intervention and Communities Mental Health and Wellbeing Fund support and plans to produce clearer guidance on services and referral routes.
Relationships, family support and substance misuse	Relationships Scotland Orkney reports high demand for counselling, family support, mediation and drug/alcohol support. It highlights the need for a renewed forum to coordinate mental health support across primary care, secondary care and the third sector.
Carers and young carers	Crossroads Care Orkney and Orkney Young Carers report work around Right to Breaks, support for 71 unpaid carers through Time to Live microgrants, Carers Week activity, and concerns about Service Level Agreement funding and young carer involvement in strategy development.
Older people and dementia support	Age Scotland Orkney reported that three-year Admiral Nurse funding has been agreed through a partnership between Age Scotland Orkney, the Integration Joint Board, Dementia UK and Dementia Friendly Orkney, which is a positive development for people living with dementia and unpaid carers. Its update also highlights expanding social hubs, dementia awareness activity and positive audit findings for post-diagnostic support. Alongside this, the external evaluation of the Orkney Dementia Strategy 2020–2025 shows positive progress in community-based, person-centred dementia support, while also highlighting increasing demand and the need for continued investment in timely diagnosis, post-diagnostic support, support at home, short breaks, social connection, carers support, dementia-friendly communities, respite, peer support and workforce development. These updates also underline the importance of rights-based, person-centred support that enables people living with dementia and unpaid carers to remain at home, participate in community life and access timely diagnosis and support.
Youth transitions and employability	VAO's Connect Project continues to support young people with complex needs who are leaving school or have stopped attending school, with mental health remaining a major factor for many of the young people using the service. The project reports that the complexity of need means some young people require support for longer, which reduces capacity to provide more one-to-one time to others. Despite this, a small

<b>Theme/Service Area</b>	<b>Summary</b>
	number of individuals have moved into full-time jobs this quarter, showing positive outcomes for some young people. The service remains important in providing flexible, relationship-based support for young people moving towards employment, training or further learning, and work is also underway for Connect to become an independent charitable organisation to help protect this bespoke support in future.
Bereavement support	Cruse Scotland continues to support children, young people and adults in Orkney online and by phone. It is seeking an Orkney-based volunteer counsellor to improve access to in-person adult support. It is also promoting training and workplace support after bereavement by suicide.
Poverty and fuel poverty	THAW Orkney reports progress on repair and retrofit work, lived experience interviews, fuel poverty action planning and the cash-first project. Long term funding and capacity for wider poverty leadership and funding coordination remain concerns.
Food insecurity	Orkney Foodbank's updates highlight the growing scale and impact of food insecurity in Orkney. In 2025, it distributed 915 food parcels, the highest annual number since opening in 2013, with 28% going to households with children and a total of 25.7 tonnes of food distributed. The Foodbank supported 320 different households during the year and reports that demand is continuing to rise. Donations are no longer keeping up with need, meaning the Foodbank is now buying in 55% of the food it gives out. It has also identified operational pressures, including last-minute referrals, people not collecting parcels, and the lack of a private, dignified space for conversations with clients. These updates underline the direct equality and health implications of food poverty, particularly for families with children, and reinforce the close links between food insecurity, health, wellbeing, child poverty and wider inequality.
Domestic abuse and community safety	Women's Aid Orkney reports that Scottish Government funding has been renewed for two years, but Housing First and Robertson Trust funding end in September 2026. Refuge remains full, move-on accommodation is a concern, and new referrals are being triaged and placed on a waiting list due to capacity.
Sexual violence support and prevention	ORSAS supported 111 people in 2025/26, including 83 survivors of sexual violence, with 21% of survivors aged 13 to 19. It also delivered 84 sexual violence prevention sessions to 827 pupils across mainland and isles secondary schools, showing the continued importance of early prevention and education. ORSAS reports that there is currently no waiting

Theme/Service Area	Summary
	list for under-18s or advocacy cases, which is a positive position, but it is also seeing increasing numbers of people needing support and growth in criminal justice advocacy work. Alongside this, recruitment and succession planning have been identified as emerging concerns, which may affect the longer-term sustainability of this specialist service if not addressed.
Advocacy and support networks	Advocacy Orkney reports rising demand for independent advocacy, with a 37% increase in cases between 2024 and 2025, growing waiting lists and increased pressure on capacity. The service has reduced from three advocates to two, which is making waiting lists harder to manage and highlights the need to protect staff wellbeing, as any further loss of capacity would have a serious impact on people who rely on the service. Advocacy Orkney also reports communication issues with some statutory services, which can make cases more difficult and increase stress for people using the service, alongside a gap in advocacy support for children who do not meet current eligibility criteria. Its work is important in helping people have their voices heard and engage with complex systems, particularly where individuals may struggle with written information, formal processes or statutory systems. Without advocacy support, there is a risk that people's views are not fully heard in decisions affecting their housing, care, health, finances, education and family life.
Early years and family support	Further information can be found in Annex 1.

## 6. Pressures and Risks for Health and Social Care Planning

6.1. The updates show a growing gap between community need and sustainable third sector capacity. This matters because many third sector organisations provide early help, crisis prevention, advocacy and support that complements statutory services.

6.2. Key risks for the Integration Joint Board to be aware of include:

- Longer waiting lists and delayed access to support, especially counselling, family support, advocacy and domestic abuse support.
- Loss of preventative services if core, or short-term, funding is reduced or delayed.
- More pressure on NHS, social work, primary care, housing, education, children's services and welfare support if third sector services are reduced.
- Loss of match funding where local commitment is unclear or unstable.

- Pressure on small organisations dealing with high demand, complex need and limited staffing.
- Lack of suitable move-on accommodation for women in refuge, with related safeguarding risks.
- Ongoing fuel poverty, food poverty and financial hardship affecting health and wellbeing.
- Rising demand for food support, with donations no longer meeting need.
- Communication gaps between statutory services and independent advocacy, which can make cases more difficult and increase stress for people using services.
- Gaps in advocacy support for children who do not meet current criteria.
- Increasing need for dementia care, support at home, respite, post-diagnostic support and support for unpaid carers.
- Capacity pressure in youth transition support where young people have complex needs and need long-term, relationship-based support.
- Recruitment and succession planning risks in specialist services such as sexual violence support and prevention.

6.3. Members also identified opportunities to make better use of existing resources. These include clearer referral routes, better use of shared data and insight, joint planning, joined-up funding approaches, and stronger ways to raise cross-sector concerns.

## 7. Areas for Partnership Attention

7.1. **Mental health and emotional wellbeing:** consider how third sector mental health, counselling and emotional support services link with primary care, secondary care and wider community support. Members have raised the absence of an active Orkney Mental Health Strategy Group as a gap.

7.2. **Early intervention and family support:** recognise the role of preventative family support in reducing escalation into statutory services. Consider the risk created by unstable funding for early years and family support.

7.3. **Older people, dementia and unpaid carers:** build on the positive progress in dementia support and ensure future planning keeps focus on diagnosis, post-diagnostic support, short breaks, care at home, social connection, carers support and dementia-friendly communities.

7.4. **Youth transitions:** recognise the need for flexible, relationship-based support for young people with complex needs who are leaving school, not attending school or moving towards employment, training or further learning.

7.5. **Carers:** support the development of short break opportunities. Make sure unpaid carers and young carers are meaningfully involved in the local Young Carer Strategy and planning.

7.6. **Domestic abuse, sexual violence and community safety:** note the pressure on services supporting women, children and survivors. Continue to support prevention, advocacy and safe pathways, including work with schools and young people.

7.7. **Housing:** note the pressure caused by full refuge provision and limited move-on options. This affects individuals seeking safety and creates pressure on wider housing and safeguarding systems.

7.8. **Poverty, food insecurity and fuel poverty:** connect fuel poverty action planning, cash-first learning, food insecurity data and wider poverty leadership into Partnership priorities. Financial insecurity, poor housing, food poverty, health inequalities and wellbeing are closely linked.

7.9. **Commissioning and funding:** consider how Service Level Agreements and funding decisions are communicated, reviewed and risk assessed, especially where changes may affect statutory pathways, match funding, staffing and service continuity.

7.10. **Partnership governance:** consider how decisions affecting third sector services are shared through relevant partnership groups, especially where services contribute to prevention, early intervention, child poverty, The Promise, family wellbeing, community-led support and reducing demand on statutory services.

7.11. **Independent advocacy:** consider how statutory partners communicate and work with independent advocacy. This includes clarity around roles, boundaries, referral expectations and response times. Advocacy Orkney has also highlighted a possible gap in advocacy support for children who are not looked after, are not in the care system, and do not have social work involvement.

7.12. **Referral practice and practical access:** consider how referral routes can better support services such as Orkney Foodbank. This includes reducing last-minute referrals where possible, supporting appropriate collection arrangements, and recognising the need for private, dignified spaces for conversations with people experiencing food insecurity.

## 8. Contribution to quality

Please indicate which of the Orkney Community Plan 2025 to 2030 values are supported in this report adding Yes or No to the relevant area(s):

<b>Resilience:</b> To support and promote our strong communities.	Yes.
<b>Enterprise:</b> To tackle crosscutting issues such as digital connectivity, transport, housing and fuel poverty.	Yes.
<b>Equality:</b> To encourage services to provide equal opportunities for everyone.	Yes.
<b>Fairness:</b> To make sure socio-economic and social factors are balanced.	Yes.

<b>Innovation:</b> To overcome issues more effectively through partnership working.	Yes.
<b>Leadership:</b> To involve partners such as community councils, community groups, voluntary groups and individuals in the process.	Yes.
<b>Sustainability:</b> To make sure economic and environmental factors are balanced.	Yes.

## 9. Resource and financial implications

9.1. There are no direct financial implications from this report. However, the updates show wider financial and resource risks for the Partnership if preventative third sector services cannot maintain current levels of support.

9.2. Several organisations report funding uncertainty, project funding ending, increased demand and reliance on reserves or short-term funding. This may affect service continuity, staff retention and the ability of third sector partners to support people in the community.

9.3. Funding decisions can have a wider impact than the value of the funding itself. Local authority or partnership funding can help organisations secure match funding, show local commitment to national funders and maintain core staffing. If this funding is removed or delayed without transition planning, there is a risk of losing wider external funding and creating more pressure elsewhere in the system.

## 10. Risk, equality and climate change implications

10.1. This report highlights risks linked to health inequalities, poverty, safeguarding, domestic abuse, sexual violence, mental health, unpaid carers, children and families, bereavement, food poverty, fuel poverty, independent advocacy, dementia support and early support.

10.2. The issues raised affect people who may already face barriers to support. This includes children and young people, unpaid carers, women and children experiencing domestic abuse, survivors of sexual violence, people affected by poverty, people with poor mental health, disabled people, people with communication barriers, people living in island communities, older people, people living with dementia and people who need early help before crisis.

10.3. Climate change implications are not directly identified in this report. However, fuel poverty, housing condition, retrofit, repair, household energy resilience and food insecurity are linked to both climate and equality outcomes.

10.4. There is an equality and prevention risk where short-notice funding decisions affect services supporting vulnerable families, children, carers and people experiencing crisis or hardship. Any reduction in preventative third sector support may have a bigger impact on people who already face barriers to statutory services or who rely on trusted community-based support.

10.5. Under Section 50A(4) of the Local Government (Scotland) Act 1973, the public should be excluded from the meeting in respect of any discussion relating to Annex 1. Annex 1 contains exempt information as defined in paragraphs 4 and 6 of Part 1 of Schedule 7A of the Act.

## 11. Direction required

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

NHS Orkney.	No.
Orkney Islands Council.	No.

## 12. Escalation required

Please indicate if this report requires escalated to:

NHS Orkney.	No.
Orkney Islands Council.	No.

## 13. Authors and contact information

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## 14. Supporting documents

14.1. Appendix 1: Dementia Evaluation 2020 – 2025.

14.2. Annex 1: Additional Exempt Information.



# Evaluation of the Orkney Dementia Strategy 2020-2025



**“Old people like me are well  
treated in Orkney.”**

Gentleman living with dementia

To cite this report: Thompson-Bradley, O. (2025) An Evaluation of the Orkney Dementia Strategy 2020-2025. Age Scotland Orkney.

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# Executive summary

This evaluation reflects on progress made in delivering the Orkney Dementia Strategy 2020–2025, exploring the extent to which the strategy’s eleven commitments have been met, and identifying opportunities and key priorities for future planning.

## Key achievements

- Successful rollout of a GP with special interest (GPSI) diagnostic pathway, significantly reducing waiting times and increasing diagnosis rates.
- Integration of specialist nursing roles (Alzheimer Scotland Clinical Nurse Specialist, Admiral Nurse), enhancing post diagnostic support and local expertise.
- Delivery of flexible, coordinated and open ended post diagnostic support, rooted in communities and aligned with the 5 Pillars, 8 Pillars and advanced models of care.
- Expanded allied health involvement in post diagnostic support, helping people maintain independence and supporting them to remain at home longer.
- Introduction of a proactive care home liaison model, helping reduce crises and reliance on hospital services.
- Investment in workforce development, resulting in a more knowledgeable, skilled and confident workforce.
- Notable progress towards a more dementia friendly Orkney, with inclusive hubs, social activities and awareness raising fostering visibility and connection.

## Impact on people’s lives

- Valued peer support and social connection, through hubs, singing groups and memory cafés, which have helped reduce isolation and stigma for people living with dementia.
- More timely access to assessment and diagnosis through an improved diagnostic pathway.
- Greater opportunity to remain at home, enabled by cross sector and multidisciplinary working, upskilling of staff and community support.
- A growing culture of inclusion, with dementia becoming more visible, talked about and understood within the wider community.
- Increased awareness of dementia and its modifiable risks, laying important foundations for earlier diagnosis and prevention.

## Future priorities

While strong progress has been made, several areas require continued focus to ensure sustainability and equity of support.

- Make respite a strategic priority: co-design sustainable, flexible respite options with carers to safeguard wellbeing and long-term community resilience. Align with the Orkney Unpaid Carers Strategy 2024–2026, to accelerate progress, ensure coordinated efforts and avoid duplication.
- Address delays in home care, which place strain on carers, risk care breakdown or carer burnout, and impact timely hospital discharge.
- Develop a remote specialist pathway to close gaps in support, particularly for complex dementia, and reduce the need for people to be supported outwith Orkney.
- Strengthen assessment and diagnostic capacity locally, reducing reliance on single practitioners and expanding the breadth of local expertise.
- Rebuild formal peer support structures with and for carers, acknowledging their expertise and role.
- Ensure dementia is explicitly named in all local strategies and work plans, embedding a rights based approach throughout culture and practice.
- Increase awareness of dementia risk factors and support for risk reduction.
- Maintain and deepen co-production: service development must continue to be shaped by the voices of people living with dementia and carers to remain responsive and relevant.
- Stay informed on emerging evidence and best practice in diagnostic pathways and pharmacological treatment, ensuring local approaches remain current, effective and person centred.

As the Orkney Dementia Strategy 2020–2025 comes to a close, Orkney can reflect on significant achievements built on strong foundations of partnership, community and connection. The next strategy will need sustained investment, strategic collaboration and an intensified focus on equity and sustainability, so that every person with dementia and every carer receives timely, person centred support that meets their needs, while also maximising opportunities to prevent dementia, enable timely diagnosis and provide treatment in line with best practice.

# About this report

This report presents an evaluation of the Orkney Dementia Strategy 2020-2025 undertaken by Oonagh Thompson-Bradley on behalf of Age Scotland Orkney. The author would like to thank all those who shared their time and experience to contribute to this evaluation. This includes care and support teams, volunteers and members of the local community. In particular, thank you to all those people who have been impacted by dementia who so kindly shared their lived experiences.

# Orkney Dementia Strategy 2020-2025

The Orkney Dementia Strategy 2020-2025 articulates a vision for dementia care and support in Orkney. It draws on national and local policy, including Scotland's Third National Dementia Strategy. Crucially, it also incorporates the lived experiences of people with dementia, care partners and others impacted by dementia in Orkney.

The Orkney Dementia Strategy 2020-2025 emphasises the importance of risk reduction, timely diagnosis and continued access to high quality, strengths based and person centred post diagnostic support. The strategy commits to partnership working, recognising the vital contributions of unpaid carers, and endorses a community led, rights based model of support based on systems and services working together. This is a strategy developed with and for people living with dementia and unpaid carers.

## Strategy commitments

1. We will engage with communities, voluntary and statutory services to increase awareness of modifiable risks associated with dementia and will support people to make positive changes to reduce risks.
2. We will work collaboratively to improve awareness of the benefit of diagnosis, the process and rate of diagnosis in Orkney. This will involve a multi-agency approach between community groups, voluntary and statutory services and a full review of current assessment and diagnostic service provision.
3. We will support a trial of an integrated care pathway for every person newly diagnosed with dementia. We will also review current support and services to facilitate provision of grass roots informed, multi-agency post diagnostic support beyond the minimum period of one year by realigning resources.
4. We will fully involve people living with dementia and carers in the delivery and evaluation of this strategy, recognising their vital role as valued experts and equal partners in care, whilst recognising and supporting their individual needs and wellbeing.
5. We will work collaboratively across all sectors to explore options to deliver innovative and flexible respite solutions which are designed with and for people with dementia and unpaid carers.
6. We will continue to support people to live in their own homes wherever possible by continuing to build resilience and capacity in line with demand on current cross sector community based services, as well as exploring new and innovative solutions, including assistive technology.
7. We will review support and services to explore options to safely reduce provision outwith Orkney and, where possible and appropriate, hospital admission will be avoided or reduced. Where hospital is the optimal location for care – adverse effects of admission will be reduced.
8. We will undertake a robust cross sector training needs analysis in line with the Promoting Excellence Framework. We will support training in line with results to ensure support for people with dementia is provided by a knowledgeable and skilled workforce.

9. We will embed accessible, preventative and reactive allied health support into post diagnostic support to promote independence, optimise strengths, build resilience and prevent unnecessary crises.
10. We will ensure that every person diagnosed with dementia will experience Rights Based support and services throughout their dementia journey. This will include recognition of dementia as a priority in every relevant work stream, initiative and procedure.
11. We will support Orkney to become a dementia friendly, inclusive place where people with dementia are valued and welcomed as part of their own community by their own community.

# The evaluation

This evaluation aimed to assess if the Orkney Dementia Strategy 2020-2025 leads to meaningful improvements in the lives of people living with dementia and unpaid carers, by assessing progress across the eleven commitments identified in the strategy. The evaluation assessed progress against the commitments and outcomes set out in the strategy, both in terms of measuring actual progress (where data supported this) and stakeholders' perspectives on progress. The evaluation also aimed to identify key themes to be considered in a subsequent strategy.

## Key evaluation questions

- To what extent does the Orkney Dementia Strategy 2020-2025 meet its stated commitments?
- What key themes/actions should be prioritised in a future strategy?

## Methodology

The evaluation employed a mixed methods approach and the following activities:

- Analysis of existing service data, specifically assessment wait times, new diagnoses, post diagnostic support referrals and home care packages<sup>1</sup>.
- Interviews with a range of stakeholders, including people living with dementia, unpaid carers, volunteers and health and social care professionals.
- A digital questionnaire focused on the experiences of people living with dementia and unpaid carers. Participants were supported to give feedback verbally or in other forms where this supported their contribution, including discussion during support sessions or other activities.
- An online survey of Orkney residents, shared via the local library and community groups, to gauge public understanding around dementia, brain health and local support.
- Participation in community activities to engage directly with stakeholders and understand their perspectives.

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<sup>1</sup> Service and audit data were provided by Age Scotland Orkney and NHS Orkney.

# Findings

This section summarises progress made against each of the eleven commitments during the five-year strategy, with an important note on the context for delivery.

## Pandemic legacy

Implementation of the Orkney Dementia Strategy 2020-2025 was significantly impacted by the COVID-19 pandemic. Time to implement the strategy was curtailed, assessment, diagnosis and routine services were disrupted, and vital supports like day centres and community groups were forced to close their doors. Despite these challenges, like many communities, Orkney demonstrated remarkable resilience, with services pivoting to remote support wherever possible. These changes laid important groundwork for a more responsive, community led approach. The pandemic highlighted the need to invest in locally delivered assessment and diagnosis, and acted as a catalyst for positive change, encouraging a solutions focus.

## Pressures on health and social care

Scotland's health and social care system is under substantial pressure on multiple fronts. People are living longer but not always healthier lives, and often require support for complex physical and mental health needs. Funding cuts, difficulties in recruiting and retaining staff and increasing costs compound things further. Workforce shortages are especially acute, with many providers reporting a high number of vacancies, high staff turnover and competition for labour<sup>2</sup>.

In Orkney, these national pressures are compounded by local challenges. The islands have a higher than average older population; nearly half of residents are aged 50 or over, rising to around 60% on ferry-linked isles. Projections suggest that the number of people with dementia in Orkney could nearly double between 2016 and 2041, increasing demand on services. Orkney is also facing social care workforce issues; difficulty recruiting and retaining permanent staff, rising reliance on agency workers with increased cost, and the need for a more sustainable workforce. Collectively, these issues contribute to more care and support falling on families and informal support networks.

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<sup>2</sup> Nikolova, M., Cunningham, I., & Baluch, A. (2025). *Benchmarking Report: Not-for-Profit Social Care 2023-2024*. Coalition of Care and Support Providers in Scotland.

**Commitment 1. We will engage with communities, voluntary and statutory services to increase awareness of modifiable risks associated with dementia and will support people to make positive changes to reduce risks.**

Age Scotland Orkney has completed numerous engagement actions around dementia awareness, brain health and risk reduction. This includes, for example:

- Delivering the STARS: My Amazing Brain programme, developed by Brain Health Scotland, to primary school children. The STARS programme teaches children about brain health through fun, interactive lessons aligned with the Scottish Curriculum for Excellence.
- Hosting dementia research talks led by Dr Tom Russ, a leading old age psychiatrist from the University of Edinburgh, as part of a Neuroprogressive and Dementia Network (NDN) visit to Orkney in June 2025. The NDN team delivered sessions for clinicians and health professionals, carers and members of the public.
- Outreach activities, including information sessions hosted in different community spaces, as part of Dementia Awareness Week each year.

A survey to assess public understanding of dementia, brain health and local support was completed as part of the evaluation. Twenty-two members of the public completed the survey<sup>3</sup>. Although limited in number and diversity, findings indicated a good level of understanding of dementia, risk factors and the importance of brain health among respondents. The majority of respondents:

- Had a good understanding of dementia and common symptoms.
- Placed high importance (95%) on brain health for maintaining wellbeing.
- Had a good understanding of practices to maintain or improve brain health.
- Were aware of common risk factors for dementia. Less well understood risk factors were: quality of education (identified by 5% of respondents), hearing loss (41%), type 2 diabetes (50%), high blood pressure (50%) and poor diet (55%).

In terms of local support, more than half of respondents (59%) were either unsure or not aware of local services or support for people with dementia and carers. Where respondents were aware of local supports, those specified were Age Scotland Orkney, Crossroads, Dementia Friendly Orkney, Orkney Blide Trust, NHS, day centres and care homes. Narrative comments indicated that several respondents felt more care and support was needed to meet current demand. Respondents indicated that they would approach their GP (41%), Age Scotland Orkney (36%) or do an internet search (23%) in the first instance if they needed information or support about dementia.

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<sup>3</sup> Respondent demographics: Age 30-44 (23%), 45-59 (23%), 60-74 (50%), prefer not to say (5%); mainland resident (95%), ferry-linked isles resident (5%).

**Commitment 2. We will work collaboratively to improve awareness of the benefit of diagnosis, the process and rate of diagnosis in Orkney. This will involve a multi-agency approach between community groups, voluntary and statutory services and a full review of current assessment and diagnostic service provision.**

Assessment and diagnosis is perhaps the area that has seen the greatest change during the strategy implementation period. Prior to the pandemic, diagnosis of dementia in Orkney lacked a consistent approach, relied on visiting psychiatrists and meant people did not have timely access to local diagnostic support and expertise. During the pandemic, diagnosis all but stopped, with a waiting list of over 160 people forming; there was an urgent need to innovate to develop a sustainable solution based on local resources. As a result, a GP with special interest (GPSI) model was established in June 2023. This model leverages the expertise of a GP who has undertaken further education on dementia.

**A GP with special interest (GPSI) model in dementia care enables specially trained GPs to assess, diagnose and manage dementia within primary care settings. The model aims to improve timely access to diagnosis, particularly in rural and remote areas, supporting earlier intervention and more personalised, community based and cost effective care.**

In Orkney, the model adopts a collaborative approach whereby the GPSI is supported by the Community Mental Health Team (CMHT) and operates a weekly memory clinic from Age Scotland Orkney's Kirkwall base. Complex cases, accounting for less than 10% of all diagnoses, can be referred for support to neuropsychology (Orkney based, part-time) or neurology (Aberdeen based). For people who are unable to attend a memory clinic, a remote consultation or visit can be supported. If visiting remote or rural areas, the team aims to complete multiple assessments to maximise time/resource efficiency.

***“A cannae mind on.”***

Great strides have been made in developing a diagnostic pathway that aims to simplify and personalise the experience of assessment and diagnosis for people in Orkney. The evaluation found that some people experienced a straightforward route to diagnosis, while others experienced challenges, specifically delays for and between appointments, and a lack of local specialism to support complex symptoms or less common dementias.

In the initial stages of implementation of the GPSI model, additional clinics were held to reduce the considerable backlog of people who were awaiting assessment. Audit data indicates a reduction in average waiting time between March 2023 and March 2025 of 14 months to 3 months. The total number of dementia diagnoses made has increased, from 56 in 2023/24 to 94 in 2024/25 (Fig.1). Diagnoses of mild cognitive impairment have also increased during this time, from 7 in 2023/24 to 21 in 2024/25. These data

indicate that progress has been made in terms of both reducing waiting times and the rate of diagnosis.

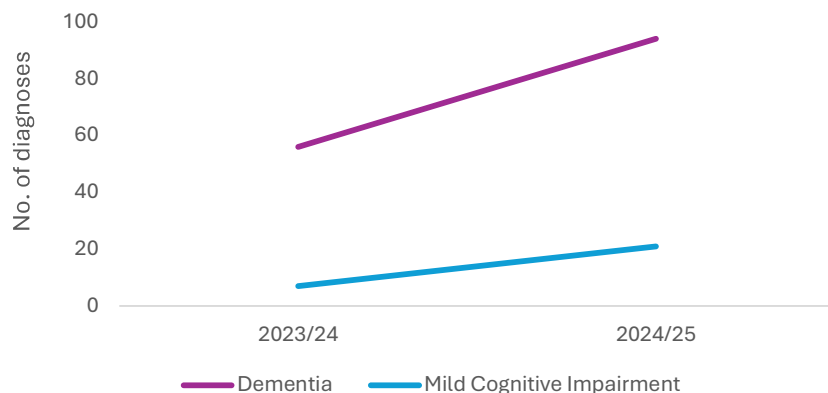


Figure 1. Number of new dementia and mild cognitive impairment diagnoses.

**Commitment 3. We will support a trial of an integrated care pathway for every person newly diagnosed with dementia. We will also review current support and services to facilitate provision of grass roots informed, multi-agency post diagnostic support beyond the minimum period of one year by realigning resources.**

### Key roles

An **Alzheimer Scotland Clinical Nurse Specialist**, employed by NHS Orkney, plays a central role in delivering the dementia strategy and providing community based support. This specialist works collaboratively with the GP with special interest and organisations including Orkney Islands Council, Age Scotland Orkney and other third sector partners, to ensure that people diagnosed with dementia have access to the right support and can engage with local services.

In September 2024, Orkney became the first region in Scotland to introduce an **Admiral Nurse**, a dementia specialist nurse, from Dementia UK. Funded jointly by Dementia UK, Orkney Health and Care and Dementia Friendly Orkney, and managed by Age Scotland Orkney, the Admiral Nurse works alongside the Alzheimer Scotland Clinical Nurse Specialist to deliver community based, person centred support. This new role, rooted in the strategy, aims to offer timely, compassionate care that supports people with dementia to remain at home for longer.<sup>4</sup>

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<sup>4</sup> The Admiral Nurse post had become vacant, pending recruitment, at the point of evaluation.

A **Post Diagnostic Support Worker**, based at Age Scotland Orkney, collaborates closely with the Alzheimer Scotland Clinical Nurse Specialist and Admiral Nurse to deliver support to individuals and families throughout Orkney.

### What is post diagnostic support?

A diagnosis of dementia initiates access to post diagnostic support, aligned with the 5 Pillars Model. The vision for post diagnostic support in Orkney is flexible, relationship based support, with a single, trusted point of access. Post diagnostic support aspires to be open ended, gained through connection, engagement and everyday activities, and not prescriptive or fixed. Emotional support for carers is a key focus.

Age Scotland Orkney is the entry point for post diagnostic support, acting as a single point of access. Located in the heart of Kirkwall's busy high street, it is the home of dedicated hubs for older people, including peer support for people living with dementia. The hubs provide a warm, non clinical environment where people can enjoy a cup of tea and conversation. Services, such as foot and hearing care, are provided within the same building. This colocation of community support alongside health services for all older people, makes Age Scotland Orkney an inclusive, non stigmatising space for everyone.

The number of people referred for post diagnostic support more than doubled between 2023/24 and 2024/25, from 26 to 58 people. In response to this rising demand for support, Age Scotland Orkney increased the capacity of its social hubs from 1,250 in 2023/24 to 1,550 in 2024/25. Age Scotland Orkney has also sourced funding from national and local organisations, alongside donations from individuals, to develop a dementia friendly sensory garden that provides a community space for people with dementia and carers to meet and enjoy activities outdoors.

In 2024, Age Scotland Orkney piloted and evaluated a blended model of Cognitive Stimulation Therapy (CST), delivered both face-to-face and virtually, for 82 participants. Evaluation outcomes demonstrated:

- An average improvement of 3.6 points on the Mini Mental State Examination (MMSE) post intervention<sup>5</sup>;
- A reported quality of life uplift for 75% of participants, reflecting increased wellbeing and engagement<sup>6</sup>.

These results highlight the value of early intervention and support, particularly when offered flexibly to meet individual needs and geographical challenges.

Orkney has a platform on the Right Decision Service website and mobile app; Orkney - Living Well with Dementia<sup>7</sup>. This digital resource provides information on dementia,

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<sup>5</sup> The MMSE ranges from 0 – 30.

<sup>6</sup> Using the Quality of Life in Alzheimer's Disease (QOL-AD) scale.

<sup>7</sup> <https://rightdecisions.scot.nhs.uk/orkney-living-well-with-dementia/>

local services, legal and financial matters, and much more. People with dementia and carers are signposted to the service as part of post diagnostic support.

The evaluation highlighted a range of experiences and perspectives on support. Many people spoke positively about the people providing support, recognising their dedication, kindness and the impact they made. Where support had been accessed, it was often described as meaningful and beneficial. Peer support, such as that offered through the hubs and singing groups, was particularly appreciated. There was a sense that, once engaged, the support available was of a high standard.

For some people, finding support had proved more difficult, suggesting that ensuring equitable access to services remains a challenge. The primary access point for post diagnostic support being Age Scotland Orkney delivers strengths including flexibility, inclusivity and a non stigmatising approach. However, locating post diagnostic support within the third sector rather than alongside statutory services led to confusion for some about where and how to seek support. In addition, a few individuals expressed concern about delays in accessing CST in the early stages of post diagnostic support, when they felt it could offer the most benefit. In recognition of this, a more robust process is now in place to ensure that everyone diagnosed with dementia is offered an introduction to post diagnostic support at the point of diagnosis.

Orkney's approach to post diagnostic support demonstrates leadership, innovation and collaboration. The introduction of new specialist roles and a single point of access, alongside growing capacity, has laid a solid foundation for a responsive, coordinated and community centred model of post diagnostic support.

**Commitment 4. We will fully involve people living with dementia and carers in the delivery and evaluation of this strategy, recognising their vital role as valued experts and equal partners in care, whilst recognising and supporting their individual needs and wellbeing.**

People living with dementia and carers contributed directly to this evaluation, ensuring that their voices, experiences and perspectives are helping to shape the future direction of dementia strategy and services in Orkney. This input has informed both the findings and opportunities, in keeping with the commitment to treat individuals as equal partners in care and decision making.

Prior to the pandemic, formal carers' support groups had been in place but have not yet re-established. Current support is offered on a more targeted, one-to-one basis. Carers who participated in the evaluation consistently identified the need for improved access to home care, respite and emotional and peer support. In the absence of formal support structures, many carers gain only informal moments of peer connection, such as conversations during drop-offs at social groups, and seek emotional support through family, social circles or the workplace. These informal networks are vital but cannot fully replace dedicated peer support and respite.

The evaluation found that carers continue to experience considerable pressure in their caring responsibilities, and enabling them to sustain their caring role requires more robust and accessible support. Going forward, rebuilding or reimagining formal peer support for carers will be an essential component of upholding this commitment and recognising carers not just as support providers, but as individuals with needs, rights and expertise of their own.

**Commitment 5. We will work collaboratively across all sectors to explore options to deliver innovative and flexible respite solutions which are designed with and for people with dementia and unpaid carers.**

Access to respite continues to be a priority raised by carers supporting people with dementia, in Orkney, but also across Scotland<sup>8</sup>. While post diagnostic support should typically provide up to six weeks per year of respite for carers, many services ceased during the pandemic and have not yet been reinstated.

Carers consistently identified respite as critical to their wellbeing and vital to sustaining their ability to care. Current limitations in formal respite place considerable strain on carers, many of whom are providing support on a full-time basis, without adequate opportunities to rest or recharge.

Day centre provision was described as a ‘lifeline’, offering both structured support for the person with dementia and essential time out for carers. However, capacity constraints mean that access to day centre placements is limited and not available to everyone who might benefit.

Some carers are currently supported by Crossroads Orkney, which provides up to four hours of home based support each week and brief rest for carers. Otherwise, carer respite is primarily informal. For example, carers may get an hour or two to themselves while the person they support attends a social group, such as Dementia Friendly Orkney’s singing group or an Age Scotland Orkney hub. While these informal options are valued and appreciated, they are not sufficient to meet the long-term needs of carers, particularly as dementia progresses and care needs increase. Carers expressed that more structured, reliable and flexible forms of respite are needed to enable them to continue in their roles without burnout or poor health.

**Commitment 6. We will continue to support people to live in their own homes wherever possible by continuing to build resilience and capacity in**

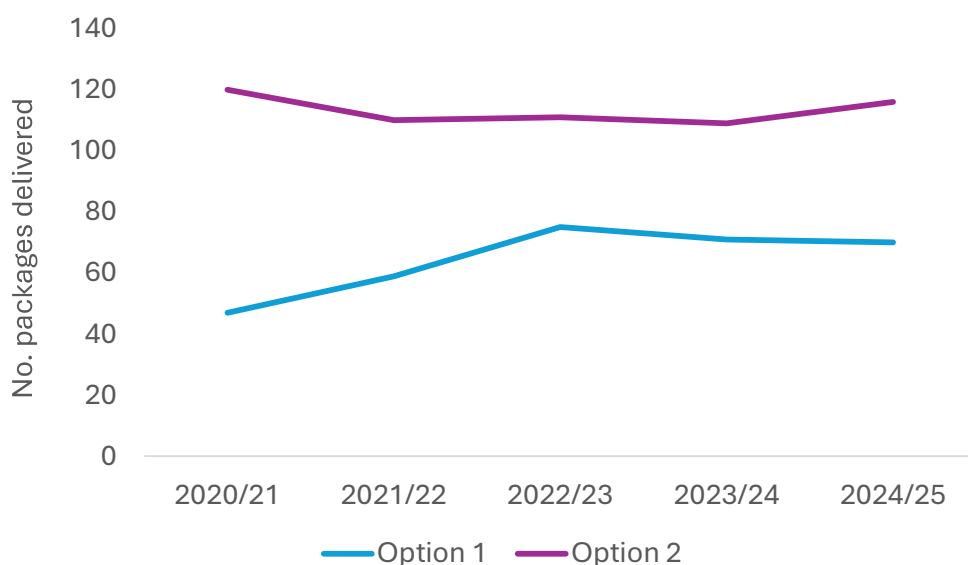
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<sup>8</sup> Scottish Government. (2025). *Day and respite services survey 2024: Results*. Scottish Government. <https://www.gov.scot/publications/day-and-respite-services-survey-2024-results/>

**line with demand on current cross sector community based services, as well as exploring new and innovative solutions, including assistive technology.**

Across the strategy implementation period, progress has been made in building resilience and capacity within community based services.

Figure 2 illustrates trends in Self-Directed Support for older people (aged 65+) across the five-year period. Option 2, where the person arranges their own care but does not manage the funding, is the more commonly used approach and has seen a relatively stable pattern over the years. Option 1, where the person manages their own care and budget via a direct payment, has shown a steady increase, particularly between 2020/21 and 2022/23. These data might suggest greater awareness and willingness among service users to take an active role in managing their care, exercising autonomy and choice. Consistent use of Option 2, however, reflects the importance of maintaining flexibility and choice in the delivery of support.



**Figure 2. Self-Directed Support (SDS) home care packages, 2020–2025<sup>9</sup>.**

Several other services, working individually and in partnership, support people at home, including:

- **Occupational Therapy:** Embedding allied health input into the early stages of post diagnostic support ensures that people receive timely advice on personalised home adaptations and equipment, helping to support

<sup>9</sup> Data relates to support for all people aged 65+. Some people receive more than one package (e.g., social care and personal care); figures relate to packages delivered, not the number of people in receipt of support.

independence and safety at home from as early as possible. Home based memory rehabilitation supports people living with dementia to achieve goals and maintain meaningful daily routines.

- **Here2Care, Age Scotland Orkney:** This service delivers care within the person's home, including personal care and support with meal preparation and daily living tasks. The service aims to promote dignity, companionship and autonomy.
- **Here2Help, Age Scotland Orkney:** This service provides clients with help in day-to-day domestic tasks such as cleaning, laundry, shopping and meal preparation. The service is flexible and tailored to ensure people receive support that matches their specific needs, preferences and routines.
- **NHS Orkney Ageing Well Service:** This service supports people who are at higher risk of falls or have experienced a fall, providing assessment, aids, adaptations and strategies to support independence and wellbeing.
- **Orkney Care and Repair:** This service provides financial, technical and practical support to older people, for example, to fit grab rails or ramps in the home, complete minor maintenance works, assess for safety and security, or assist with adaptations to support hospital discharge.
- **Crossroads Orkney:** Offering up to 4 hours per week of support for carers, this service provides vital respite, contributing to the sustainability of home based care.
- **THAW Orkney:** THAW Orkney helps to ensure that older people are supported to live in affordably warm homes, reducing the risk of ill health due to cold and promoting wellbeing.

These combined efforts reflect a continued commitment to building community based support in the face of rising demand. The range of services demonstrates a robust approach to supporting people at home, contributing to individual and community resilience.

The evaluation found that, where support has been provided, people consistently reported a high standard of care, and valued the services available. Feedback from individuals and families highlighted the importance and positive impact of being supported to remain at home. However, significant challenges remain. Conversations with families and survey responses reported long waits for home care, with delays ranging from four months to over a year. There was a strong view that timely access to adequate home care is essential to sustaining the caring role, and delays in accessing this care increased stress for carers.

It should be noted that this is not due to a lack of effort or commitment; substantial effort has been made to address these issues, including incentivised recruitment, collaboration and flexibility in delivery. Despite these efforts, demand continues to outpace capacity, and timely access to home care remains a key area for improvement. Addressing this will be critical to ensuring that the progress made so far is sustained, and that more people can benefit from high quality, community based support when they need it most.

**Commitment 7. We will review support and services to explore options to safely reduce provision outwith Orkney and, where possible and appropriate, hospital admission will be avoided or reduced. Where hospital is the optimal location for care – adverse effects of admission will be reduced.**

There has been meaningful effort to reduce the need for hospital admissions through the development of preventative and responsive supports within the dementia care pathway. Allied health support, particularly occupational therapy, has played a vital role in supporting risk enabled care at home. These services have supported people to maintain independence and day-to-day activities.

A key development has been the introduction of proactive care home liaison, led by the Alzheimer Scotland Clinical Nurse Specialist and Admiral Nurse. This approach provides care home staff with timely expertise, early intervention and problem solving. The proactive model seeks to reduce the likelihood of hospital admissions, particularly transfers outwith Orkney, which are both distressing for individuals and families, and place substantial financial<sup>10</sup> and logistical pressures on services.

Within the hospital setting, inpatient ward staff are building knowledge and capacity through participation in a national training programme designed to reduce stress and distress in patients with dementia. This strengthens the ability of the team to respond effectively to changes in behaviour, helping to reduce the adverse effects of hospital admission and stays.

An audit of service data indicated a reduction in hospital admission outwith Orkney following implementation of the strategy, from nine patients between 2015 and 2020 to four patients between 2020 and 2025<sup>11</sup>.

The evaluation highlighted vulnerabilities that affect both the ability to consistently avoid hospital admission and care outwith Orkney, and to support timely discharge. Carers experience a lack of access to regular, planned respite, which puts them at greater risk of burnout, care breakdown and crisis. Additionally, delays in accessing regular home care may increase pressure on families and the risk of a crisis situation leading to an avoidable hospital admission.

Timely hospital discharge often requires a period of intensive and flexible home care support. The Home First approach in Orkney has previously demonstrated success in facilitating timely hospital discharges and promoting independence, particularly among older people. By offering up to six weeks of reablement support, this model enables the person to return home safely and receive care in a familiar environment. Home care, including Home First, is an area of provision in huge demand. Bolstering this provision

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<sup>10</sup> Scotland averages for hospital services, 2023-24: Geriatric long stay, £3,297 per inpatient week; geriatric psychiatry, £4,730 per inpatient week; geriatric inpatient assessment, £6,483 per case; Air Patient Transport Service, £7,342 per mission. Scottish health service costs, Public Health Scotland.

<sup>11</sup> Admissions to the Royal Cornhill Hospital in Aberdeen, where dementia was the reason for admission. Data generated from Trak, where the patient was over 65, had an Orkney address at point of admission, and the ICD-10 admission code was a form of dementia.

may help ensure that a person can return home safely and earlier, with the right support in place to maintain stability at home and prevent readmission.

Timely access to old age psychiatry also remains a critical gap in supporting people with complex symptoms. Enhancing specialist input, for example through telepsychiatry support for the GP with special interest, Alzheimer Scotland Clinical Nurse Specialist and Admiral Nurse, would build resilience across the system and provide an essential layer of support for both staff and families.

The actions to date demonstrate a strong commitment to reducing reliance on hospital and outwith Orkney care through early intervention, professional development and multidisciplinary working. Addressing the identified gaps in respite, home care provision and specialist input will help sustain progress and improve outcomes for people with dementia and carers.

**Commitment 8. We will undertake a robust cross sector training needs analysis in line with the Promoting Excellence Framework. We will support training in line with results to ensure support for people with dementia is provided by a knowledgeable and skilled workforce.**

Considerable progress has been made in aligning workforce development with the Promoting Excellence Framework. Staff delivering care to people with dementia are trained in accordance with the framework, with mandatory dementia training embedded within personal development plans. This is supported by a combination of on-the-job learning, refresher sessions and access to formal education resources.

An audit of the 10 Dementia Care Actions in Hospitals was completed at The Balfour, identifying both areas of strong practice and opportunities for improvement. The findings reinforced the need for a comprehensive training needs analysis to ensure knowledge and skills across all roles are aligned with the Promoting Excellence Framework. In response, a training and education plan has been developed, with delivery supported through Turas Learn, Scotland's digital learning platform for health and social care.

An inpatient ward at The Balfour is currently engaged in a national programme to reduce stress and distress, delivered in partnership with Healthcare Improvement Scotland and the Care Inspectorate. This initiative aims to build staff capacity in understanding and responding to changing behaviours related to dementia.

Within social care, a pilot of skilled level training has been delivered and positively received. Plans are underway to expand this as a face-to-face training programme, shaped by participant feedback and learning. For services equipped to support digital learning, skilled level training is also available via the Turas Learn platform, increasing accessibility and flexibility.

This multi-pronged approach demonstrates a strong commitment to ensuring that all staff who support people with dementia have the knowledge, skills and confidence to provide high quality, person centred care and support.

**Commitment 9. We will embed accessible, preventative and reactive allied health support into post diagnostic support to promote independence, optimise strengths, build resilience and prevent unnecessary crises.**

There has been meaningful progress in embedding allied health support within the dementia care pathway, both as preventative and reactive support. Occupational therapy input is highly valued, with positive feedback from evaluation participants reflecting its key role in promoting independence and supporting people to maintain autonomy and daily activities. A home based memory rehabilitation programme, led by occupational therapists, has enabled individuals to achieve personal goals, maintain independence and continue engaging in meaningful daily routines. While service capacity has been reduced, this remains an area of promise that can be strengthened and developed further.

In the hospital setting, multidisciplinary staff on an inpatient ward are currently upskilling as part of a national training programme aimed at reducing stress and distress in people with dementia. This initiative strengthens staff capacity to respond to people experiencing changes in behaviour in a way that is both person centred and evidence based.

The recent development of proactive care home liaison leverages the expertise of the Alzheimer Scotland Clinical Nurse Specialist and Admiral Nurse. The aim of this work is to provide tailored support, including:

- Timely advice, support with problem solving and access to information;
- Targeted, person centred learning for care home staff;
- Prevention of escalation to crisis through early support.

Post diagnostic support will also be enhanced through this liaison work, contributing to more responsive support and greater continuity of care.

While the integration of allied health support, development of Admiral Nursing and the new care home liaison approach represent significant progress, feedback indicates that further enhancement is needed to ensure sustainability and capacity. In particular, timely access to old age psychiatry remains critical in the prevention of crises and the support of complex symptoms.

The actions to date reflect a strong commitment to embedding a multidisciplinary, strengths focused and crisis prevention approach within dementia care in Orkney. Strengthening specialist input, for example, via telepsychiatry support, will further build resilience across services and improve outcomes for people with dementia and carers.

**Commitment 10. We will ensure that every person diagnosed with dementia will experience Rights Based support and services throughout their dementia journey. This will include recognition of dementia as a priority in every relevant work stream, initiative and procedure.**

The existence of the Orkney Dementia Strategy 2020-2025 itself represents progress in strengthening rights based support for people living with dementia in Orkney. Planning is underway to develop a refreshed dementia strategy to continue this momentum.

While there is limited evidence of dementia being fully embedded across all local strategies and work plans, there are some positive signs of integration.

- The NHS Orkney Clinical Strategy 2022-2027 includes dementia as a priority.
- Dementia is referenced in the Orkney Local Housing Strategy 2024–2029.
- The Orkney Community Planning Partnership’s Community Plan 2025–2030 acknowledges dementia within the context of demographic change.
- The Orkney Unpaid Carers Strategy 2024–2026 includes implicit recognition of the needs of carers supporting people with dementia.
- The Council Plan 2023–2028 highlights older people as a key focus.

The evaluation found that staff across both statutory and third sector services work in a way that upholds the principles of a rights based approach, including respect for dignity, autonomy and inclusion. There is clear evidence of collaborative working across organisations, with a shared objective of delivering high quality, person centred support to individuals and carers impacted by dementia.

Services in Orkney strive to be personalised, flexible and responsive, however, capacity is a challenge. For some people, this means delays getting support, with implications for how effectively rights such as timely access to care, independence and support for carers are upheld in practice. While the ethos of rights based support is evident in service delivery and some strategic planning, further work would be beneficial to embed dementia as a named priority across all relevant local workstreams, and to strengthen the systematic application of a rights based approach.

**Commitment 11. We will support Orkney to become a dementia friendly, inclusive place where people with dementia are valued and welcomed as part of their own community by their own community.**

Significant progress has been made towards making Orkney a more dementia friendly and inclusive place. People with dementia and carers reported feeling connected within their communities and highlighted a multitude of social activities and groups that they take part in, enjoy and value. A few of these are highlighted below.

- **Age Scotland Orkney hubs:** These welcoming gatherings are particularly valued by people living with dementia, who enjoy friendship and connection in a cheerful environment.
- **Dementia Friendly Orkney singing group:** This well established weekly group attracts 20-30 participants and places an emphasis on fun, connection and engagement. Craft sessions, summer outings and an annual Christmas party are also hosted by Dementia Friendly Orkney.
- **Dial-a-Bus:** Many people referred to this service as their means of getting around, with one man highlighting not just the value of getting to his weekly engagements, but enjoyment of the journey itself.
- **Orkney Rocks Choir:** An inclusive and relaxed choir, with a focus on fun and connection through singing.
- **Young at Heart Memory Café:** A twice monthly memory café offering support and friendship for people with dementia and carers.

Orkney is age friendly by nature, perhaps because of its higher proportion of older residents. As one evaluation participant noted, *“Up here you can lay eyes on people”* – there is a strong culture of looking out for one another. It was felt that there is a growing openness around talking about dementia. A notable example of this being supported locally is Orkney International Science Festival hosting “The Power of Music for People Living with Dementia”. This talk explored how music remains a powerful source of connection and joy for people with dementia.

*“Dementia feels less hidden.”*

These activities and actions reflect progress towards inclusion, visibility and reduced stigma. Continuing to build on this will support dementia to be recognised, not only as a health condition, but as part of the community’s collective experience.

## Limitations of the evaluation

While this evaluation was subject to the following limitations, it nevertheless provides a meaningful and credible account of progress made by the Orkney Dementia Strategy 2020–2025.

- **Geographical bias:** The majority of feedback was gathered from people living on mainland Orkney. As such, the perspectives of those in smaller island communities may be underrepresented, potentially limiting insight into variation in access and experience across geographies.
- **Depth and breadth of engagement:** Although qualitative data was gathered through interviews and questionnaires, engagement was limited in scale and depth.
- **Limited quantitative data:** Robust quantitative data, particularly around service use, was limited. This constrained the ability to fully measure progress against

certain commitments, or to draw conclusions around the scale and consistency of impact.

- Time and resource constraints: The evaluation was completed within a short timeframe and by a single evaluator. This shaped the scope of data collection and depth of analysis.

Despite these constraints, the evaluation draws on a consistent set of themes and experiences from across professional and lived experience perspectives. It provides a valuable snapshot of local progress and identifies clear areas for consolidation and improvement. This will be further supported and informed by a series of local events with a broader group of professionals and carers. Future evaluations would benefit from enhanced access to data, wider geographical engagement, and more sustained input from people with lived experience.

## Progress summary table

The table below provides an at-a-glance summary of progress against the eleven strategy commitments, using a traffic light system to indicate progress.

●	Green	Embedded	The commitment is well established, integrated into practice and culture, with evidence of sustained impact.
●	Amber	Developing	Clear progress is evident, with positive initiatives underway. Some gaps remain to be addressed.
●	Red	Emerging	Initial steps or intentions are in place, but significant work is needed to implement and embed the commitment.

Commitment	Key achievements	Future priorities
1 Raising awareness of dementia risk and brain health	● A range of activities have been delivered through schools, community events and professional engagement, with survey responses indicating good understanding of brain health and dementia risk reduction among members of the public.	Leverage partnerships to promote awareness of dementia risk factors, signs and symptoms, and benefits of diagnosis. Consider ways to target those at greatest risk.
2 Improving dementia diagnosis and access to assessment	● A new GP with special interest model has transformed access to local diagnosis, reducing average waiting times from 14 to 3 months and increasing diagnosis rates. Collaborative delivery with community and clinical teams has improved consistency and accessibility.	Strengthen pathways for complex cases and enhance specialist support for less common dementias. Sustain improvements through ongoing collaboration and resourcing.
3 Strengthening post diagnostic support and care pathways	● Orkney has developed a flexible, community based post diagnostic support model featuring key roles of Clinical Nurse Specialist, Admiral Nurse and Post Diagnostic Support Worker. Referrals have more than doubled and interventions like Cognitive Stimulation Therapy have shown promising outcomes. Development of dementia friendly community spaces.	Improve equitable and timely access to post diagnostic support, e.g., CST. Ensure clarity of pathway to access. Continue expanding capacity of social hubs and community support. Monitor and evaluate ongoing impact and outcomes.
4 Involving people with dementia and	● People with lived experience contributed directly to the strategy's evaluation, helping shape service development. Carers' voices have	Rebuild or reimagine formal peer support for carers. Embed co-production in strategy delivery.

carers in planning		highlighted critical gaps and priorities, reinforcing their role as key partners in care.
5 Developing flexible and responsive respite solutions	●	Carers' need for respite is well recognised, and some activities, e.g., Crossroads Orkney, day centres, social groups, provide valued support.
6 Supporting people to live at home through community based support	●	A range of community based services are providing valued, flexible support, with growing use of Self-Directed Support Option 1 reflecting increased choice and autonomy.
7 Reducing hospital admissions and care provision outwith Orkney	●	The introduction of proactive care home liaison, participation of hospital staff in behaviour support training and the Home First reablement model have potential to reduce admissions and support timely discharge.
8 Building a skilled and informed workforce	●	Mandatory dementia training is embedded. Audits have identified strengths and areas for improvement. Skilled level training and digital learning increase accessibility.
9 Embedding allied health support in dementia care and reducing crisis	●	Occupational therapy and proactive care home liaison have improved tailored, person centred support and crisis prevention. Inpatient ward staff upskilling on behaviour support improves the hospital experience.
10 Embedding rights based support throughout the experience of dementia	●	Dementia is referenced in local strategies. Staff demonstrate a rights based ethos. There is evidence of strong collaborative working.
11 Creating dementia friendly and inclusive communities	●	A wide range of social activities and support groups. Orkney has strong community connection, with an increasing openness about dementia. Cultural events featuring dementia promote understanding, inclusion and reduce stigma.
		Co-design reliable respite options with carers. Explore innovative models that can respond to different needs. Address gaps left by services not yet re-established post pandemic.
		Address ongoing delays in accessing home care by enhancing capacity. Explore new innovations including technologies to meet rising demand and sustain care at home.
		Expand access to regular respite and reliable home care to reduce avoidable crisis admissions. Increase old specialist input, e.g., via telepsychiatry.
		Continue expanding skilled level and specialist training. Monitor and update training plans to respond to evolving workforce needs and feedback.
		Enhance access to old age psychiatry, e.g., via telepsychiatry. Increase capacity to ensure sustainability of allied health and specialist support. Continue strengthening multidisciplinary collaboration.
		Embed dementia explicitly and systematically in all relevant local strategies and work plans. Address capacity challenges to improve timely access to care and uphold rights in practice. Strengthen the understanding and consistent application of rights based approaches.

# Opportunities

Drawing on learning from the evaluation, this section sets out broader opportunities to inform the development of the next dementia strategy. These may be considered alongside the specific future priorities outlined in the conclusion.

## Support for carers

- Prioritise respite as a core component of any future dementia strategy, recognising its critical role in sustaining carers and enabling people living with dementia to remain at home.
- Explore new respite models for planned and unplanned respite, co-designed with carers and people with dementia.
- Pilot innovative respite formats, particularly those tailored to rural and island communities, e.g., a care farm model that builds on Orkney's farming heritage to support identity, belonging and connection.
- Integrate respite into open ended post diagnostic support, ensuring carers are aware of all supports available to them.
- Re-establish a formal support network with and for carers.
- Align with the Orkney Unpaid Carers Strategy 2024–2026, to accelerate progress, ensure coordinated efforts and avoid duplication.

## Community based support

- Continue to seek solutions to address delays in accessing essential home care, which increases strain on carers and contributes to burnout and care breakdown, crisis escalation and avoidable hospital admissions.
- Continue to seek solutions to support timely hospital discharge and stabilisation at home, e.g., bolstering the Home First service.
- Ensure equity of access to care and support across the mainland and isles, leveraging local assets, e.g., through the Island Wellbeing Project, to build a hub and spoke model of support that enhances local capacity and resilience in the most remote areas.
- Explore low resource approaches to maintaining contact with those awaiting assessment or services, e.g., regular check-ins by phone. This may help people to feel supported, to increase connection and prevent a sense of feeling 'lost in the system'.

## Supporting complexity

- Explore opportunities to enhance psychiatry input, e.g., through the use of telepsychiatry, to improve access to timely, specialist care and reduce the need for people to be cared for outwith Orkney.
- Develop additional diagnostic capacity, reducing dependence on a single GPSI, by training more GPs or nurses in dementia assessment and diagnosis.

- Build sustainability into the care home liaison model, ensuring it becomes a consistent part of the wider post diagnostic and crisis prevention pathways.
- Consider how the care home liaison model may be adapted for unpaid carers or home care workers, to support home based carers in understanding and responding to changing behaviours.

### **Brain health and dementia prevention**

- Continue to leverage partnerships to promote awareness of modifiable dementia risk factors, the signs and symptoms of dementia and the benefits of timely diagnosis.
- Review GP training around dementia prevention, particularly how dementia risk could be more routinely discussed during consultations with patients who present with multiple risk factors.

### **Co-production and co-design**

- Adopt co-production approaches in the design of new and emerging services, ensuring the lived experience of people with dementia and carers shapes priorities and delivery models.
- Build on existing feedback mechanisms to ensure that service development remains person centred and locally relevant.

### **Workforce development**

- Continue rolling out skilled level training across sectors, ensuring consistent understanding and practice.
- Consider training for home based carers, both paid and unpaid, on understanding and responding to changing behaviours. This would aim to build community resilience and reduce crisis escalation and avoidable hospital admission.
- Monitor training uptake and impact, and use training needs analysis to inform workforce planning and development.
- Evaluate allied health contributions in the post diagnostic support pathway, to help identify gaps or opportunities.
- Consider professional development focused on rights based approaches, to help embed this into the culture and practice of dementia care and support.

# Learning from other areas

This section draws on innovative approaches and successful models from other regions. These examples may offer valuable insights or transferable lessons for enhancing dementia support in Orkney. Each example demonstrates how services can be adapted to meet the unique needs of local communities, particularly those in rural or island settings, through creative use of resources, collaborative working and a strong focus on person centred care.

## Dementia Assessment Service, Shetland

The Dementia Assessment Service in Shetland offers an example of how an innovative, nurse led approach can deliver effective dementia care within the unique challenges of an islands setting. By integrating advanced practice nurses at the forefront of diagnosis and support, and utilising telepsychiatry for specialist input, the model ensures timely, community based care without the need for extensive travel. This holistic service is enhanced by partnerships with organisations dedicated to dementia support, creating a seamless pathway for people with dementia and families to access clinical, social and emotional resources. The collaborative nature of the service, which brings together statutory and third sector partners and offers a single point of referral, ensures continuity and adaptability, meeting the needs of both people living with dementia and carers. Recognition for excellence in leadership underscores the quality and adaptability of this model. For other island based communities, key lessons include the value of empowering advanced clinical roles, leveraging technology to overcome geographical barriers, fostering multi-agency collaboration, and prioritising person centred, integrated support that addresses the complexities of dementia care in remote settings.

## Meeting Centres

The Meeting Centre model provides community based support for people with dementia and carers, offering social, emotional and practical support in a non clinical and accessible environment. The centres are embedded in local communities and offer adaptable support to respond to local needs. Meeting Centres can leverage existing local roles (e.g. wellbeing leads), volunteer power and community spaces like village halls, reducing costs and boosting local engagement. Meeting Centres empower people with dementia and carers, build community resilience and contribute to a sustainable, dementia friendly community that wraps around the person and carer. A hub and spoke model could support a Meeting Centre (spoke) to connect to a central organisation (hub) for additional support such as clinical input, training, care planning and support. This may work well for rural and remote communities, helping people to access timely, personalised support in familiar surroundings.

## **Tapestry Day Club, West Sussex & Surrey**

Tapestry Day Club is a self funded model of social engagement and carer respite, where trained hosts open their own homes to small groups of people with early stage dementia, offering a homely, social setting with home cooked meals, activities and transport. Designed to feel safe and familiar, the clubs provide meaningful engagement for guests and regular respite for carers. With minimal infrastructure and reliance on volunteer hosts, the clubs are an ideal solution for remote or resource stretched communities, using what already exists to create strong, localised dementia support.

## **Brain Health Campaign, Public Health Dorset**

Public Health Dorset developed a local poster campaign using the tagline "What's good for the heart is also good for the head" to highlight modifiable lifestyle factors, such as exercise and a balanced diet, that help reduce dementia risk, while also aiming to increase uptake of NHS Health Checks<sup>12</sup>. The initiative included surveys of local residents' awareness and discussions with GPs, which revealed that most patients had not addressed dementia risk in consultations. In response, GP training was introduced to integrate dementia prevention into Health Checks, and the posters were redesigned to be more eye catching with help from local design students.

## **CLEAR Dementia Care App**

The CLEAR Dementia Care app is a free, accessible tool designed to help family carers understand and respond effectively to changed behaviours experienced by a person living with dementia. It provides clear, bitesize information on types of dementia, symptoms and behaviours, with illustrations and real life examples that help carers view the world from the perspective of the person they support. The app includes a feature to log and chart behaviours over time, enabling carers to identify patterns, better understand triggers and tailor their responses to reduce distress. The app aims to support compassionate, responsive care and improve quality of life for both the person with dementia and carer.

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<sup>12</sup> NHS Health Checks are for adults in England aged 40 to 74.

# Conclusion

## Key achievements

The Orkney Dementia Strategy 2020–2025 has brought about meaningful and measurable progress in embedding a person centred, community based approach to dementia care. Key achievements include:

- Successful rollout of a GP with special interest (GPSI) diagnostic pathway, significantly reducing waiting times and increasing diagnosis rates.
- Integration of specialist nursing roles (Alzheimer Scotland Clinical Nurse Specialist, Admiral Nurse), enhancing post diagnostic support and local expertise.
- Delivery of flexible and coordinated post diagnostic support, rooted in communities and aligned with the 5 Pillars Model.
- Expanded allied health involvement in post diagnostic support, helping people maintain independence and supporting them to remain at home longer.
- Introduction of a proactive care home liaison model, helping reduce crises and reliance on hospital services.
- Investment in workforce development, resulting in a more knowledgeable, skilled and confident workforce.
- Notable progress towards a more dementia friendly Orkney, with inclusive hubs, social activities and awareness raising fostering visibility and connection.

These successes reflect the value of cross sector collaboration and Orkney's commitment to delivering care that is responsive, centred in community and strengths based.

## Impact on people's lives

The strategy has had a meaningful and positive impact on the lives of many people living with dementia and carers in Orkney. Evaluation feedback frequently emphasised the compassion and dedication of professionals and volunteers delivering care and support. Positive outcomes include:

- Valued peer support and social connection, through hubs, singing groups and memory cafés, which have helped reduce isolation and stigma for people living with dementia.
- More timely access to assessment and diagnosis through an improved diagnostic pathway.
- Greater opportunity to remain at home, enabled by cross sector and multidisciplinary working, upskilling of staff and community support.
- A growing culture of inclusion, with dementia becoming more visible, talked about and understood within the wider community.

- Increased awareness of dementia and its modifiable risks, laying important foundations for earlier diagnosis and prevention.

Despite these gains, challenges remain in ensuring consistent and equitable access to support. Delays in accessing home care, a lack of respite and specialist psychiatry support will affect the quality, continuity and timeliness of care. This is particularly true for people experiencing complex symptoms of dementia.

## Future priorities

While the strategy has delivered important gains, a number of priorities remain critical to sustaining momentum and addressing persistent challenges:

- Make respite a strategic priority: co-design sustainable, flexible respite options with carers to safeguard wellbeing and long-term community resilience. Align with the Orkney Unpaid Carers Strategy 2024–2026, to accelerate progress, ensure coordinated efforts and avoid duplication.
- Address delays in home care, which place strain on carers, risk care breakdown or carer burnout, and impact timely hospital discharge.
- Develop a remote specialist pathway to close gaps in support, particularly for complex dementia, and reduce the need for people to be supported outwith Orkney.
- Strengthen assessment and diagnostic capacity locally, reducing reliance on single practitioners and expanding the breadth of local expertise.
- Rebuild formal peer support structures with and for carers, acknowledging their expertise and role.
- Ensure dementia is explicitly named in all local strategies and work plans, embedding a rights based approach throughout culture and practice.
- Increase awareness of dementia risk factors and support for risk reduction.
- Maintain and deepen co-production: service development must continue to be shaped by the voices of people living with dementia and carers to remain responsive and relevant.
- Stay informed on emerging evidence and best practice in diagnostic pathways and pharmacological treatment, ensuring local approaches remain current, effective and person centred.

By addressing these areas, Orkney can continue to lead the way in delivering community centred dementia care and support.

# Appendices

## Summary of evaluation participants

<b>Stakeholder</b>	<b>Number</b>	<b>Method of engagement</b>
Person Living with Dementia	9	In person interview (3) Questionnaire (6)
Carer	7	In person interview (2) Video interview (1) Questionnaire (4)
Hub Participants (female group)	4	Participation in hub
Age Scotland Orkney CEO	1	In person interview
Alzheimer Scotland Clinical Nurse Specialist	1	In person interview
Post Diagnostic Support Worker	1	In person interview
GP with Special Interest	1	In person interview
Social Worker	1	In person interview
Care Home Manager	1	In person interview
Dementia Friendly Orkney Co-Lead	2	In person interview
Community Member	23	In person interview (1) Questionnaire (22)