ISLAY COMMUNITY UPDATE 1
21 March 2016

This update is being sent out to all Being Here evaluation participants on Islay. It outlines the findings following the first round of fieldwork in 2015 and concludes with a brief SWOT analysis covering all the pilot areas in the Being Here programme.

Evaluation fieldwork summary

In August 2015 the UHI research team conducted interviews with health and social care professionals, third sector workers and community residents. Four community groups were also visited. A fieldwork summary was presented to the Being Here programme manager in October 2015 and a detailed report given in January 2016.

Service development

Islay medical services operate independently of the Being Here programme and the practices have not received any Being Here funding. The following changes have been introduced independently of the Being Here project. All three practices are now being managed centrally by one GP partnership. Although some opening hours have changed, the GPs cover the same three surgeries in Bowmore, Port Ellen and Port Charlotte. Staff now work within one bigger organisation and can be deployed across the three sites if necessary. It is envisaged that a GP will usually man two of the surgeries to foster and maintain a sense of consistency in care. At the time of interview, work was still on-going to integrate the IT system to enable patients to be seen easily at any of the surgeries. Islay medical services have a full complement of five GPs who also man Islay hospital and undertake all out of hours work on a rota system. In addition to the principal GPs and salaried GPs, another has joined for one year under the Rural Fellowship Scheme. She was also going to be working on Jura to support the two part-time GPs there. A proposal to integrate the community nursing and hospital nursing team was also being planned. At the time of interview Islay had a Health Implementation Board which included health and social care professionals and community residents. Members of the public came from the Community Council health care subgroup and the Public Partnership Forum. The latter is now the Islay and Jura Health and Care Forum.

Evaluation findings

GP service development

On the whole participants were very happy with the high quality of primary care services and the re-organisation of the practice. Attitudes were generally very positive about the standard and quality of primary care particularly because of the increase in the number of doctors. Service safety and sustainability were seen to depend on maintaining the full complement of GPs and ensuring successful future recruitment. In general people were in favour of the perceived practice merger and thought that both the service and continuity had improved. Prior to the integration of the practices, there had been a series of locums which patients did not find very satisfactory. They did not like the lack of continuity
which meant having to repeat their histories and it was also felt to result in frequent changes in medication. Interviewees liked the potential flexibility offered by the practice re-organisation which will allow patients to make an appointment at any of the three surgeries not just the one at which they are registered. There had been fears that one of the surgeries would close but assurances had been given and fears largely allayed. On the whole interviewees were satisfied with the appointment system, the availability of appointments and the access to telephone consultations. A few older residents preferred the former ‘sit and wait’ model. Extended opening times were seen as a benefit for working people. Some interviewees felt it was too early to tell as the changes were very new and needed time to bed in. Amongst the older residents, there were several who were not fully aware of the changes.

**GP practice model**

Amongst some older interviewees there was a feeling that the previous system of single-handed GPs gave greater continuity. However, there was also a general acceptance that the change to a team model was simply moving with the times. On the whole interviewees were happy to see a nurse instead of a GP if appropriate. Some interviewees did not know whether the nurses currently had the level of training and advanced skills to lead specialist clinics.

**Service breadth**

Although many were happy with the breadth of GP services, some thought there were gaps in hospital service provision, mental health, children’s services and addiction services which made trips to the mainland necessary. There was a perception that fewer cases were dealt with locally and more patients had to be flown out now than in previous years. Several interviewees thought the hospital needed to be expanded. There were worries that local hospital beds have been cut. Transport to the hospital and the surgery in Bowmore was also a common concern. Without a public bus people felt it was a long way to walk uphill for older patients especially those with mobility problems. Many interviewees highlighted the issue of pregnant women having to travel to Glasgow for scans, which can take three days and be very expensive. Residents wanted to know why scans could not be provided locally and whether current staff could receive further training to enhance the level of local service. Although the amount of one to one time with a midwife was appreciated, concerns were expressed about the isolation of new mothers, lack of breast feeding support and lack of physiotherapy services. The revised patient transport policy was one of the most frequently raised issues amongst interviewees and was causing widespread anger and confusion. Residents were also worried about the lack of dental services and the potential backlog of patients once a new service was established.

**Technology**

Many people were open to using Video Conferencing (VC) links for medical consultations especially if it meant avoiding travel to the mainland. At the time of interview VC was not used with patients. It was not felt that telehealthcare was being expanded and a lack of telecare responders was also reported. Comments were made on the incompatibility of IT systems in the light of the integration of health and social care services. Although patient notes were not accessible in all the surgeries at the time of interview, people were positive about the potential of this development.
**Communication**

Lack of communication with patients was a key concern and interviewees generally called for more information about changes to services. Many older residents did not have access to the internet and wanted information conveyed in different ways. Suggestions for improvement included making information in the local paper more prominent, informing local community groups directly, putting fliers in prescriptions and placing public notices in shops and Post Offices in outlying communities. Community and housing organisations would like more direct communication so they can distribute relevant information to their members and housing residents. The majority of interviewees found that it can be very difficult to get the wider community involved in service planning and consultation. Lack of communication and transport were given as key factors in the perceived lack of participation and community feedback. The practice had tried to set up a Patient Participation Group, but no one came forward to join.

**Community resilience**

A range of different views were expressed on the impact of service changes on community resilience. For some the changes have strengthened resilience while others think either it was too early to tell or that the community was already resilient with existing strong informal support networks. Lack of transport was widely seen to undermine community resilience.

**Professional Isolation**

Professional Isolation can be a problem because of the small number of staff in certain roles. Staff members may be the only professional in that particular type of post so they do not have equivalent colleagues on hand. Professionals are also living in the communities which they serve. The importance of team-working and good communication was stressed.

**Home care**

Although a high level of satisfaction was reported with the quality of home care, zero hours contracts were criticised; as was a recent reduction in the level of home carers on duty at night. A possible lack of home care in the future was highlighted with potential workers attracted to the tourist industry. This could have an impact on the level of service sustainable for outlying areas.

In summary, interviewees were generally satisfied with the quality, breadth and safety of primary care services particularly now there is a full complement of GPs. A sense of continuity was being restored after a long time of locum cover. Patients could see the advantages of the new team based practice and re-organisation although a few thought the former single-handed GP model offered more continuity. On the whole people were willing to give the new system time to bed in. The main concerns were the perceived lack of communication with patients, lack of public transport, the revised travel policy and dental services. The revised travel policy was commonly raised and criticised because of the lack of prior consultation and the new restrictions on the type of transport and escort arrangements for patients.
Next steps

Evaluation findings have been reported back to NHS management. The second round of fieldwork on Islay is due to take place in April 2016.

The Being Here project takes an action research approach. This means that as project activities take place, they are monitored and assessed by researchers. The researchers’ findings are fed back to the project's operational team. The findings are used to develop ongoing project activities and to respond to the needs of health and care staff and local communities.

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## Being Here Programme SWOT Analysis 1

A SWOT analysis is a study undertaken to identify a programme’s internal **Strengths** and **Weaknesses**, as well as its external **Opportunities** and **Threats**.

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<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
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<tbody>
<tr>
<td>• Healthcare professionals working well together.</td>
<td>• Instances of GP training not being tailored to the remote and rural context.</td>
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<td>• Staff are connected into support and training networks.</td>
<td>• Recruitment process can be lengthy.</td>
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<td>• Technology is used by staff for meetings and training, e.g. video and</td>
<td>• Technology used less frequently to communicate with patients than between staff.</td>
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<td>teleconference.</td>
<td>• Some staff feel they lack IT literacy, software training and confidence in using technology.</td>
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<td>• Staff feel primary health care services are safe for patients?</td>
<td>• Instances of community members not feeling adequately listened to, or understood, by NHS</td>
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<td>• Services are perceived to cover the breadth and variety required of</td>
<td>management.</td>
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<td>rural primary care.</td>
<td>• Instances of communities reporting a lack of feedback following NHS consultations.</td>
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<td>• In some areas, the community feels listened to within consultation</td>
<td>• A lack of Patient Participation Groups, or similar.</td>
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<td>processes.</td>
<td>• Where Locum need is high – <strong>issues: continuity of care, poor geographical knowledge, lack</strong></td>
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<tr>
<td>• Perceptions are that recent changes have enhanced continuity of care</td>
<td><strong>of skills, negative impacts on other staff</strong></td>
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<td>and access to experienced healthcare professionals.</td>
<td>• Lack of social care particularly in remote &amp; rural areas</td>
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<td>• Team practice models are perceived as safer than single-handed GP</td>
<td>• Feelings that Glasgow hospitals have no idea of logistical problems for rural patients.</td>
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<td>models.</td>
<td>• Reliability of boat services.</td>
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<th>OPPORTUNITIES</th>
<th>THREATS</th>
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<tr>
<td>• Increased use of technology, e.g. <strong>Telephone, Video Conferencing,</strong></td>
<td>• Professionals feeling over-burdened due to long hours.</td>
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<td><strong>email, single patient record</strong></td>
<td>• Inability to recruit appropriate staff.</td>
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<td>• Increased community engagement through local Community Health</td>
<td>• Lack of time and resources for staff training.</td>
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<td>Partnership with identified contact points.</td>
<td>• Inability to share databases, particularly between health and social work professionals.</td>
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<td>• To engage with the ‘healthy’ as well as patients.</td>
<td>• Lack of mobile phone coverage.</td>
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<td>• Increased use of Advanced Nurse Practitioners, community nurses,</td>
<td>• Different perceptions of level and value of community consultation between professionals and</td>
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<td>unscheduled practice nurses and paramedic practitioners (other health</td>
<td>communities.</td>
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<td>care roles).</td>
<td>• Increasing numbers of people with long term conditions managed in the community.</td>
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<td>• Enable/support more self-management and community resilience.</td>
<td>• First responder recruitment, training, and skills maintenance.</td>
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<td>• Improved communication between primary and secondary care.</td>
<td>• Quality of technology when used.</td>
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<td>• Potential for further health promotion events.</td>
<td>• Poor availability/reliability of other services – road and sea transport, broadband.</td>
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<td>• Increased support and training for First Responders.</td>
<td>• People take service for granted and only become engaged in crisis or emergency.</td>
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<td></td>
<td>• Community may feel changes needed to primary care.</td>
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<td></td>
<td>• Lack of public transport.</td>
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