Final Evaluation Report of the Being Here Programme

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Stakeholder experiences of changes to remote and rural healthcare services

Isle of Gigha

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EXECUTIVE SUMMARY

The Being Here Project was an initiative to build the sustainability of health and care services in remote and rural areas by developing and testing new delivery models for service provision in Scotland. The Project was managed by NHS Highland and funded by the Scottish Government. The research and evaluation component was managed by the NHS Highland Research and Development Department. The University of the Highlands and Islands (UHI) was subcontracted to carry out some of these activities. Completed in May 2015, the baseline evaluation established pre-Programme status in the pilot areas in West Lochaber and Argyll & Bute operational areas (Small Isles, Acharacle practice area, Mid Argyll and Kintyre) via stakeholder telephone interviews and reviewed activities to be covered by the Programme.

From August 2015 to June 2017 semi-structured interviews were undertaken with over 200 community residents, health and social care professionals and third sector workers as well as drop-in visits made to a range of community groups. The aim was to verify the status of Programme activities and obtain stakeholder views about their experiences of service change. On completion of every fieldwork round a summary of urgent issues arising from each visit was sent to NHS Programme managers. Following a thematic analysis of interview data, interim reports were produced for NHS Programme managers and community updates were sent to all participants. A review of Programme documentation identified the key changes that the Programme aimed to achieve and a set of Programme indicators was developed for monitoring progress towards Programme aims over the three-year period.

The level of change in the Argyll & Bute and West Lochaber pilot areas differed; with the former focusing on GP recruitment and practice mergers while the latter tested new community-based roles and service delivery models. Although interview data analysis revealed the breadth and diversity of individual experiences, key themes (e.g. service quality, communication/consultation, continuity of care, community capacity, technology) were shared across all the pilot areas. Differences were largely evident in areas trialling innovative services and roles, where specific views were voiced about service delivery models.

Key themes

Most interviewees were satisfied with service safety, breadth and standards. For patients, service proximity, continuity of care and a personal relationship with a GP remained key to safeguarding service safety and quality. The fear of losing continuity was the main driver behind concerns about practice mergers which meant becoming part of a larger, usually more town-based GP team. In communities with

a small local practice or resident single-handed GP, interviewees were less likely to perceive any advantages in becoming part of a wider GP team practice especially if they feared it would result in their local surgery closing. The retention of a local surgery and, thereby, a visible GP presence was fundamental to reassuring patients about maintaining a local service and signifying that their needs were considered in service planning. When a GP or nurse no longer lived within the community, many interviewees missed the sense of reassurance and security embodied in this healthcare professional's presence. Although many thought a single-handed GP was no longer a desirable model for doctor or patient, interviewees often felt having a relationship with a single, consistent GP who gets to know you and your family, enhanced patient care especially for long term conditions and mental health. A multi-disciplinary team-based approach, however, was widely accepted, although more information on training and responsibilities would facilitate a greater understanding of different roles, reducing levels of fear and reassuring patients about new service models.

Generally, the breadth of primary care services was satisfactory, but people worried about any changes perceived to be eroding local hospital provision, such as the closure of wards. The lack of mental health services was also a concern where services and support groups were not available locally. Following implementation of Programme changes, most interviewees believed local services would be sustainable in their current form. Concerns remained, however, that long-term sustainability may be undermined in the future by any potential decreases in NHS budgets, turnover of staff or lack of engagement with technology. Some community residents associated the sustainability of a GP service with how much they felt it was required and used locally, i.e. it will be publicly funded and thereby be sustainable because there are people who need it.

Although communities were aware of GP recruitment problems, the reasons were not necessarily understood by those who felt their rural community was an attractive location offering a good quality of life to professionals. Views were mixed over the impact of the Being Here advertising campaign with some indicating professional networking was more important in sourcing applicants; whilst others thought it had helped significantly by raising the profile of rural GP practice across the country.

Although communication was viewed to have improved in West Lochaber over the life of the evaluation, a lack of effective communication was commonly reported in other areas where community interviewees talked about their opposition to change being hardened because of frustration and disillusionment with the engagement process. Even where it was acknowledged consultation opportunities had been provided

on service change, dissatisfaction and uncertainty were expressed routinely about the extent of community influence on policy decisions, which people often felt had already been made prior to public engagement events.

Extending Video Conferencing (VC) use was a key suggestion to reduce lengthy, stressful and expensive patient journeys to secondary care, but there was little evidence of any significant expansion over the course of the evaluation, in spite of a widespread openness to greater use amongst staff and patients. Poor Broadband and patchy mobile coverage were seen as barriers to expanding technology, which was regarded as an important factor in ensuring future sustainability.

Divergent views were expressed about how to define and measure community resilience. Some participants felt resilience had been strengthened by the community taking on more responsibility (e.g. First Responders, Health & Social Care Workers), whilst others thought resilience was undermined by the loss of conventional mainstream services and professional roles. A large number could see no change in their local community resilience either because their community was already highly responsible and resilient or because the level of change had not been significant enough to have an influence.

Attitudes to the First and Emergency Responder Schemes were in the main were positive, especially where residents had seen them in action. However, specific issues continued to arise at all stages during the evaluation about volunteer capacity, lack of adequate training and seeking permission to give pain relief (which affected community confidence and volunteer morale). Residents on the Small Isles were generally open to the idea of the new Health and Social Care Support Worker role and felt positive about it strengthening community resilience. As with the First Responders, uncertainty, however, was expressed over confidentiality, community capacity and the necessity of treating your own relatives or friends as well as skills maintenance as the workers had not been widely utilised at the time of interview.

The aim of completing a health economics review, and then a financial flows analysis, was not achieved. This was due to a lack of data at all levels, with inconsistent and poor data collection, processing, quality assurance and access across a number of organisations, including, but not solely, the NHS. While it was possible to get some limited indication that the Being Here programme was capable of lessening some of the financial burdens on some of the stakeholders concerned, perhaps most obviously patients, it was not possible to confirm that any long-term financial reductions had been achieved. From a different perspective, it was also not possible with the data available to determine accurately the actual financial

impacts of sparsity and peripherality within the case study areas – such conclusions would rely on obtaining staff recruitment and pay data for various roles, as well as transport costs, VC use and other relevant data, and such data was just not available in any consistent form. One of the main outputs of the exercise was a recommendation to consider the ways in which data collection, processing and aceess could be made much more consistent and high quality to enure that future work could be evidenced effectively from a financial perspective.

Conclusions

Project indicators showed progress towards the achievement of Programme aims in all pilot areas e.g. high level of service quality, sustainability, service breadth, multi-disciplinary team working, introduction of new roles, out-of-hours provision, less reliance on locums, practice mergers (except Kintyre) and recruitment. Being Here has shown that multi-disciplinary teams and more 'dispersed' models of provision can be implemented in remote and rural areas in ways that both communities and healthcare professionals find safe, acceptable and consider to be sustainable in the short to medium term. Concerns remained, however, over the impact of recruitment, retention and NHS budgets on long-term sustainability as well as the burden of volunteering, lack of increase in technology usage and adequacy of community engagement. Secondary care VC has been piecemeal in the past and an overall strategy could help facilitate sustainability alongside local initiatives. Service models encompassing new roles, particularly those that are voluntary, require tangible, visible, reliable support structures, training programmes and communication channels for those taking on the roles. The perceived lack of transparency in both policy consultation and implementation was seen to have contributed to dissatisfaction, frustration and disillusionment with the engagement process compounding the difficulty of introducing change in some areas. Differing expectations over the aims of consultation and engagement should be taken into consideration in order to facilitate meaningful community involvement and develop future models for co-production. Nowhere did the overall perception within the community become one in which they saw themselves as active agents of change. Our analysis of the evaluation materials suggests that engendering such feelings will require a greater degree of decision-making power to be given to community members; a greater transparency over how community views are taken into account and a greater degree of feeling within the community that they received adequate levels of feedback and opportunities for dialogue. Ensuring communities feel involved, confident and secure is key to fostering trust, strengthening local capacity and building community resilience.

1. Introduction

The Being Here Programme was an initiative to build the sustainability of health and care services in remote and rural areas. The Programme was managed by NHS Highland and part-funded by the Scottish Government. In order to build sustainability, the Programme aimed to develop and test new models for remote and rural health and care services in Scotland. The Programme comprised research and evaluation work, which was managed by NHS Highland Research and Development Department, with the University of the Highlands and Islands (UHI) subcontracted to carry out some of the activities.

The Research and Evaluation work comprised five work-packages:

1. Programme Management
2. Baseline Stakeholder Review
3. Programme Review and Community Engagement
4. Reports, Evaluations and Recommendations
5. Health Economics

Completed in May 2015, the baseline evaluation established pre-programme status via stakeholder interview and reviewed activities to be covered by the programme intervention. From June 2015, UHI Rural Health and Wellbeing team carried out activities related to work-package 3: Programme Review and Community Engagement. Three cycles of fieldwork have been conducted in the pilot areas in West Lochaber and Argyll & Bute operational areas (Small Isles, Acharacle practice area, Mid Argyll and Kintyre) with the aim of verifying the status of activities and obtaining stakeholder (community members, health and social care professionals and third sector workers) views about the programme and level of change. Islay was also included in the evaluation fieldwork as a non- Being Here funded example of primary care service change. The first round of fieldwork was undertaken from August 2015 to December 2016 and involved semi-structured interviews with a total of 111 residents, health and social care professionals and third sector workers in Kintyre, Islay, mid- Argyll, Acharacle and the Small Isles. In addition, drop-in visits were undertaken with eleven community groups. The second round of fieldwork was conducted from April-September 2016 and also consisted of semi-structured interviews with a total of 127 residents, health and social care professionals and third sector workers. Conducted from April to June 2017 the final round involved semi-structured interviews with 124 residents, health and social care professionals and

third sector workers as well as visits to four community groups. A summary of urgent issues arising from each visit was sent to NHS programme managers at the end of every round of fieldwork. Following a thematic analysis of all interview data, interim reports were produced for NHS programme managers. A baseline report was completed on 26 May 2015 followed by Fieldwork Report 1 on 29 January 2016 and Fieldwork Report 2 on 31 January 2017. Community updates were sent to all participants after the interim reports had been submitted and discussed with programme managers. As the Fieldwork 3 visits were still underway at the time of the NHS Being Here Legacy Event (the programme's final conference 11 May 2017), the research team produced an interim summary of findings for delegates. Following completion of all fieldwork, updates were given from all the pilot areas to the programme managers as previously and an interim report (28 June 2017) summarising evaluation findings up to that date was submitted to the Being Here Steering Group. The community updates on the third round of fieldwork were distributed to participants in November 2017. A final update on project findings was sent to participants following completion of the evaluation report.

The following section of this report is a brief literature review. Section 3 describes the methodology used by the research team and details the aims, tasks and methods employed to conduct the evaluation research. In Section 4 the report outlines the results from the baseline review. Changes implemented in each pilot area during the duration of the Being Here programme are described in Section 5. Sections 6 discusses the results from the Programme indicators. Recommendations given to the programme managers, following the fieldwork visits, are outlined in Section 7. Key themes emerging from the interviews with stakeholders from all fieldwork visits are detailed in Section 8. Section 9 discusses the health economics review. The conclusion discusses new models of sustainable primary care delivery, assesses whether the Being Here aims have been achieved and examines the implications for remote and rural primary care in Scotland.

2. Brief Summary Literature Review

The Provision of Effective Healthcare Services in Remote and Rural Areas and the Recruitment and Retention of Staff in Remote and Rural Areas in the National Health Service

2.1 Introduction

The factors determining the effective provision of health and care services in remote and rural areas are complex and cannot be assigned to one specific type or group. Indeed, within the Being Here programme and its evaluation it was expected that there would be factors relating to the provision of those services, the drivers to seek different models of provision, as well as factors relating to the relationships and interactions between the healthcare providers and the communities located within this remote and rural region.

This brief review of literature seeks to identify some of the factors and issues that may have had an impact on the ways in which the Being Here programme was delivered, the objectives it sought to achieve and the outcomes that resulted, both in terms of service delivery and the interactions between the participating communities, health board and other stakeholders. As indicated previously, there are many factors and perspectives involved and it is the aim of this literature review to briefly highlight some of the key aspects, thus providing a background context to the evaluation report for the Being Here programme. Two of the main issues that affect service delivery and service redesign are the availability and retention of staff to support such changes and the degree to which communties and individuals accept such changes through effective processes of engagement and stakeholder interaction.

In 2002, the Wanless Report stated that "*the size and composition of the workforce is one of the most important determinants of the capacity of the health service*" (Wanless, 2002:87). This remains just as true some sixteen years later. In relation to the provision of sustainable and flexible health and care services for the populations of remote and rural regions of the UK such as the Highlands of Scotland, it has become just one of the key challenges of seeking to develop new models or strategies or healthcare provision that are acceptable to the residents of such areas, as well as to the organisations providing that healthcare.

In the UK, the National Health Service (NHS) employs over two million people. The thousands of different professions, posts and careers that exist within the NHS present the organisation with many human

resource challenges, one of the most difficult being the recruitment of new staff in locations perceived as 'unattractive', for whatever reason, by those seeking employment. Even more challenging, perhaps, is the issue of retaining new staff once they have been engaged, especially in areas where locational factors combine to make staff feel dissatisfied with their post. The Being Here Programme aimed to tackle these issues head-on in a region where recruitment and retention of staff is made particularly difficult because of the remote and rural nature of the largest NHS Board (by landmass) in the UK. Not only is there a challenge in attracting and retaining staff in this region, but these staff also have to face demands to deliver services in ever more flexible and cost-efficient ways (Mead et al, 2017). At the same time, the populations of remote and rurals areas appear to demand an increasing range of high-quality services, often whilst seeking to retain the traditional model of GP provision. Therefore, there is a dual problem for the NHS in such areas as the remote and rural regions of the Highlands and Islands of Scotland.

This literature review aligns the general theories of staff recruitment and retention with the particular challenges faced by remote and rural areas. It considers the role played by individuals and communities in engaging with these staff and in encouraging them to stay in post or in stimulating them to leave, as it is sometimes interactions within the context of remote settlements that staff find difficult to manage (Nicoll and Heaney, 2016). It further identifies the role of community engagement and models of relationships in developing new ways in which healthcare can be provided at the community level and seeks to identify those particular challenges relating to such engagement, if it is to be effective.

2.2 The Recruitment and Retention Issue in the NHS

It is widely acknowledged that the NHS throughout the UK has a problem with staff recruitment and staff retention. It is not alone in this, as local government has been shown to be in a similar situation (The Smith Institute, 2015). This is relevant to the NHS where there has been an integration process between the NHS and Local Authorities to jointly deliver health and care services – which has been the case with both Northern Highland, and more recently within Argyll and Bute.

Kaidi and Atun (2017) argue that the health workforce crisis is sufficiently severe to jeopardise the future of the NHS (in England). They suggest that one of the reasons for this is the hours that some people work and point to junior doctors working 72 or even 100 hours a week, consultants working 60 or more hours a week and 59% of all NHS staff working unpaid overtime every week (Kaidi and Atun, 2017).

Pay is another factor identified as causing staffing issues. In comparison to the pay earned by equivalent staff in other developed countries, the pay for many NHS staff appears to be considerably lower, leading to levels of disatisfaction. Rimmer (2017) points to the opinion of the health unions that the continuing pay cap imposed on the NHS in 2010 limiting pay increases across the NHS to 1%, had had a negative effect on recruitment and retention. It was, it was argued, preventing the 'best people' from being recruited and retained, and was leading to a shortage of staff across every discipline (Rimmer, 2017).

From a retention perspection, the picture is even more concerning. 48% of junior doctors in 2015 in their second year of training dropped out of the NHS, and nearly 1% of doctors leave the NHS every month (Kaidi and Atun, 2017). The picture is similar in relation to GPs. Barrow (2015) points to the fact that in England and Wales that the number of GPs per 100000 of the population was down to 60 by 2013, that onlt 27% of GPs are under 40, and that only 21% of medical students intend to be GPs, when it should be over 50% to make the provision of GPs sustainable.

In Scotland, it is argued that the processes for identifying and funding training numbers for posts across the NHS including doctors, nurses and midwives are not sufficient to meet the risk of not training enough staff with the right skills for the future, especially in relation to changing demand (McTiernan, 2017). It is also pointed out by Audit Scotland, that in Scotland, one in three nurses are over the age of 50, and that an over reliance on bank and agency staff means that money that should be used to train new staff in the medium to long-term is instead being used for short-term stop-gap staffing provision, especially in the North and North-East of Scotland (McTiernan, 2017). Criticisms have been raised about poor long-term workforce planning, although the Scottish Government has also argued that it has already developed a strategy to ensure effective workforce planning, that will recognise changing demand as well as external factors such as Brexit (McTiernan, 2017).

2.2.1 Theoretical Aspects

There are a number of theories relating to recruitment and retention, not only as processes contibuting towards the management of human resources in an organisation, but also as factors affecting the decision-making of healthcare individuals in seeking jobs and then in deciding to stay in them, or not.

Rubery et al (2011) suggest that these factors can be clustered under five headings, known together as the MaROT model. Here, the factors are related to:

"*Management of recruitment and retention, including the use of 'high performance bundles' of HR practices, and mechanisms for employee voice; Reward policy, including pay rates, pay premiums and travel pay, and particularly in relation to part - time work and women returners; Organisation of work, including the nature of care work, the pace and timing of work, the skill content and scope for autonomy and discretion; and Training and development, including formal training provision and the effects of regulatory standards*" (Rubery et al, 2011:2).

Here, then, the authors indicate that a range of positive reinforcement mechanisms may be deployed to both attract people to jobs and to encourage them to remain in them. This does not take into account, it appears, the financial implications of some of these measures, which may be difficult to justify in times of severe financial pressure on public bodies such as the NHS, although it might be argued that investment in such posts might be financially beneficially in the medium to long term. Another criticism that may be levelled at the MaROT model is that by developing such attractive processes, if initially to encourage individuals to apply for specific posts and not as a policy across the whole organisation, then current incumbents may justifiably argue that they are being treated inequitably.

From a theoretical perspective, there has been the development of a number of differing models of primary care provision in remote and rural areas. Unsurprisingly, a lot of research of this nature has been carried out in Australia, where some key findings have been identified. Wakerman and Humphreys (2011), for example, argue that systemic changes are needed in obtaining effective primary care provision in remote and rural areas. They suggest that a range of interlinked factors such as leadership and management, adequate funding, governance, infrastructure, service linkages and workforce need to be aligned not only with the health service provider, but also with every level of government. They also argue that to achieve improvements and to comprehensively monitor and evaluate services, adequate national information systems are required, that are supported by high quality and consistent data at all levels (Wakerman and Humphreys, 2011).

2.2.2 Rural Heathcare Workforce Management

While recruitment and retention continue to be an issue in all rural areas globally for healthcare workers, it is not just the number of staff available, but also the degree to which they are integrated successfully into health system processes and functions that determines the ways in which they are enabled to use their skills effectively (Buchan and Aitken, 2008). A number of studies have stressed the relationship between nursing shortages and the remote and rural areas where the staff situation can be acute (WHO, 2010). Several factors have been identified as to why recruitment and retention in remote and rural areas is particularly challenging. These include professional isolation (Williams, 2012); relatively poor working conditions (Dussault and Franceschini, 2006); low access and poor provision of services in the rural environment for quality of life (Lehmann et al, 2008); and increasing mobility of healthcare staff leading to more staff seeking working opportunities in other countries (Mbemba et al, 2013).

In 2015, the Good Governance Institute continued to identify key problems with recruitment and retention across the health sector. It pointed out that poor workforce morale, high attrition rates, an ageing workforce and an over reliance on agency staff and foreign recruitment meant that in some staff areas, such as nursing, the situation across the UK with regards to adequate workforce planning for recruitment and retention was poorly addressed (Good Governance Institute, 2015). This has perhaps been especially a concern in primary care in relation to GPs.

2.2.3 Recruitment and Retention of GPs

The recruitment and retention of General Practitioners has long been recognised as a problem in the UK. Young and Leese in 1999 argued that the ongoing difficulties faced in trying to attract GPs to certain practices included considerable differences in the ability of local areas to match labour demand and supply, and that better retention of existing GPs within an area would be one of the most effective measures to combat this (Young and Leese, 1999). Barrow (2015) suggests that to recruit and retain GPs requires a different way of thinking about their role, and that the specific activities and responsibilities of GPs should be identified and celebrated. He also suggests that the variety of the GP's job and the rewarding aspects of the work should be the centre of engagement by employers i.e. Health Boards. He also proposed that, along with daily treatment of patients, training, minor surgery, research in practice, multi-discilplinary decision-making, business and innovation activities, engagement with medical students

and school children to encourage new people to come into the profession, should be enhanced and supported for GP job satisfaction (Barrow, 2015).

It is clear from the rapid review of some of the recruitment and retention issues, that attempting to maintain traditional models of healthcare in remote and rural areas i.e. the rural GP practice often staffed by very few GPs, is really not sustainable. Even with more GPs planned for Scotland through Scottish Government investment, this model cannot continue if a wide range of healthcare services are to be provided to the widely dispersed and ageing population that characterises many remote and rural areas including the Highlands of Scotland.

2.3 Relationships Between Community and Healthcare Providers

Theoretical perspectives also relate to the relationships that develop and exist between communities and the health and care organisations that provide services to them. In 2012 a report by the King's Fund on leadership and engagement within the NHS identified a 'culture of engagement' that was deemed vital if the NHS was to implement reforms to service provision, and to achieve transformational improvements in the healthcare system in the UK (The Kings Fund, 2012). It was also argued in the same report that patient (and by default community) engagement can deliver more appropriate care and improved outcomes, especially at the local service level (The Kings Fund, 2012). Patient engagement here is defined as the degree to which individuals and communities are empowered to to be fully involved in their care, and in shared decision-making, and in working with NHS staff to meet their community and individual needs. The King's Fund report states that to achieve successful engagement amongst staff and communities, the process needs to be grounded in values of collaboration, openess, empathy, listening, mentoring and support.

2.3.1 Community Engagement and Building Trust

One of the key factors in determining acceptance of change in the model of health and care service delivery in any health and care context is the level of trust between the provider and the recipient. For changes in the delivery of primary or community care, this means engaging with the community and the individual. Whilst this has 'traditionally' been achieved through a process of consultation, it has been increasingly acknowledged that the delivery of information and gathering of responses to that information

is insufficient to ensure real participation between healthcare provider and community or individual. Instead, the concept of 'engagement' has become more widely accepted. The traditional 'top-down' culture of the NHS which has been associated with a command and control target driven approach, is argued to be a prime cause of staff demoralisation and poor care (The King's Fund, 2012). The NICE Guidelines of 2016, 'Community engagement: improving health and wellbeing and reducing health inequalities', recognises the importance of community engagement. It states that overarching principles of good practice should include being clear about which decisions local communities can influence and how this might be supported to happen (NICE, 2016).

Co-production and community control have been key themes in approaches to enhancing community engagement in developing effective approaches to the management and delivery of health, as recommended by the NICE guidance of 2008 (NICE, 2008). A systematic review in 2013 (O'Mara-Eves et al, 2013) argued that community engagement could be employed to address a wide range of health issues and service delivery strategies. Bolton et al (2015) suggest that there are a number of different models that can be used to foster such engagement and build relationships and networks to achieve agreed objectives. They argue that key features of successful engagement include building trust-based reciprocal relationships with individuals in existing communities, as well as fostering networks between all of the different stakeholders and developing community leadership that can work towards health goals decided by those communities (Bolton et al, 2015). One way in which such community engagement strategies can achieve success is by building on the social capital available i.e. enhancing and supporting participation in formal organisations, such as the NHS, as well as informal social networks and voluntary organisations (Putnam, 1993).

At the same time (at least in the English NHS and arguably within the NHS in Scotland) it has been recently argued that whilst there remains a public commitment within the NHS at the policy level of engaging with the public and recognising the 'ownership' of the service as lying in the public domain, there have also been increasing tensions at the local service delivery level, where financial pressures and fragmentation of services have led to criticism of a lack of accountability within some NHS organisations (Carter and Martin, 2017).

From the perspective of the individual participant in any programme of engagement, it is argued that a measure of success can be achieved if that individual feels that they have been respected, that their

contributions have been valued and that they have trusted the staff that they have encountered during the period of the engagement (Carter and Martin, 2017). At the same time, when individuals express frustration because they feel that they lack control over decisions being made, or feel that they have been excluded from specific activities, have concerns about confidentiality or feel that they are being 'pushed' in a certain direction by more 'powerful' stakeholders, there is a likelihood of the process of engagement failing, or at least not achieving its potential (Carter and Martin, 2017).

Community and individual engagement is not simply a matter of information transference, however. Coulter (2012) argues that effective engagement is vital for NHS sustainability, as it strengthens patients' ability to manage long term conditions, to deliver the right care at the local level and to improve health outcomes. At the same time, this author identifies some key barriers in the NHS in seeking a change to a more integrated and collaborative process – including entrenched management and clinical styles, time pressures, a desire to maintain a distance from patients' emotional problems, a fear of losing power, perceptions that it is not as important as patient safety or financial management, feeling hidebound by regulation or procedures, insufficient resourcing and investment in improvement teams and processes and negative or defensive reactions from some NHS staff (Coulter, 2012).

GPs are identified as a key group in determining successful community and patient engagement. The Royal College of General Practitioners have stated that "*Patients and staff will look to GPs to influence and help determine the future direction of services, and in leading and managing change….*" (RCGP, 2012:1). In England, the Health Foundation Report in 2017 states that in developing new models of care i.e. place based models of better coordinated care for people with complex health and social care needs (such as those that may be found in the older population of the Highlands), primary care should be involved from the start and time should be devoted to obtaining a shared understanding of the challenges. This would apply not only to NHS staff but also to individuals and communities affected by such models.

It should be recognised that the need for engagement and the development of trust is not just a requirement for healthcare providers such as the NHS towards a community or individual. Indeed, it is argued that a majority of people in communities in Scotland have a very positive attitude towards participation and co-production in the design and delivery of public services. It has been identified that "*at least 8 in 10 felt that people either "definitely should" or "probably should" be involved in making decisions about how local services are run, making decisions about how money is spent on local services*

and should be able to volunteer alongside paid staff to provide local services" (Marcinkiewicz, Montagu and Reid, 2016, p.3). There appears to be a correlation between those individuals within a local community who feel that individuals or communities more generally should get involved and the perception that those individuals have of the public body that is delivering services, i.e. if the individual is not satisfied with the service delivery then that individual is more likely to consider that the community should become more engaged in the development, design or delivery of such services (Marcinkiewicz, Montagu and Reid, 2016, p.20). However, having such attitudes and actively translating them into positive actions or engagement with healthcare providers i.e. by taking part in community events or meetings, or consultations, or agreeing to be an active member of a service delivery process, is an entirely different matter. This can be frustrating for the service provider, such as the NHS, which may work hard at providing accessible options for community engagement which are then not taken up. There may be a number of factors involved in this lower than expected engagement – poor communication and lack of resource within a community may be seen as a barrier to engagement or participation (Howard-Grabman, Miltenburg, Marston and Portela, 2017) and the strength of local community leadership (or lack thereof) may also determine the extent to which communities respond coherently to such approaches (Howard-Grabman, Miltenburg, Marston and Portela, 2017).

The implications of this challenge of engagement and community participation are that while an intervention, a change in service or other innovation in service provision may work successfully in one location, it may not be so successful in another and may even fail entirely. Bovaird et al (2015) argue that individuals and communities are more likely to engage when they have a strong sense that they can make a difference. They also suggest that 'nudges' to increase participation or co-production are only likely to have a weak effect, meaning that even quite high levels of work by the healthcare provider may meet with limited response from communities or individuals.

2.4 Potential Solutions to Solving the Remote and Rural Service Delivery Issues

There have been a number of studies that have examined the different ways in which the issues of recruitment and retention may be addressed. Mbemba et al (2013) suggested that in relation to nurses as a specific group of staff, there was some evidence that ICT support could play a part, either in attracting staff through effective highlighting of recruitment opportunities, or through the provision of professional

training, education or workplace support. Other strategies or interventions that were identified included financial incentives, mentoring and clinical supervision and clear career pathways as possibly successful approaches that could attract new staff and retain them once engaged (Mbemba et al, 2013).

In the North of Scotland, the importance of working collaboratively with other stakeholders has been recognised by NHS Highland in the development of the 2017 workforce plan, identifying the importance of NHS Education for Scotland, other NHS Boards and the Scottish Government, and suggesting that new 'employment routes' would be an important component (McTiernan, 2017).

Whatever the solutions decided upon, there are a number of considerations that should be taken into account when employing and implementing a programme such as that encapsulated in Being Here. These considerations include the need to understand and recognise the existing context, both geographical and historical, to ensure previous change initiatives and their outcomes are identfied and integrated where appropriate into the changes. The changes also need to focus on the redesign and delivery aspects of the solution first, i.e. support the development of the stakeholders in the development and successful delivery of any change first, ensuring that the governance and organisational structures are then fully addressed. Next, it is considered vital that co-design and collaboration should begin at the planning phase of any new model of change and continue throughout its life and that sufficient time and resources should be assigned to a set of tasks that is seeking to promote a cultural change within the NHS (and in remote and rural areas). Finally, the role of evaluation is an important one, as without such scrutiny, the observer of any change model is unlikely to understand what is happening to the individuals within communities.

3. Methods

The methods used to capture and analyse evaluation data are detailed in this section. The same approach was adopted for all three fieldwork cycles.

3.1 Aims and Objectives of the research and evaluation

The evaluation aimed to identify a set of appropriate indicators to monitor change, obtain stakeholder views on programme change, verify service innovations in the pilot areas and feedback data to programme managers at agreed stages. NHS Highland intended that the Being Here Programme take an action research approach whereby the research findings were fed back to the programme's operational team to enable the development of ongoing programme activities and to respond to the needs of health and care staff and local communities.

3.2 Tasks of the research and evaluation (Work-packages 2-4)

3.2.1 Work-package 2: Baseline Stakeholder Review

The baseline research aimed to gather the views of all relevant stakeholders on the potential interventions and to establish the pre-programme status of service provision. The main tasks were as follows:

- Carry out review of existing areas of concern covered by the programme
- Agree interview questions with research team and programme managers
- Identify sites and stakeholders in pilot sites
- Conduct interviews with stakeholders
- Transcription of interviews
- Analysis of interviews
- Baseline final reporting

3.2.2 Work-package 3: Programme Review and Community Engagement

The programme review and community engagement involved three cycles of fieldwork in each of the pilot areas. The following tasks were completed during each cycle:

- To obtain an update of latest programme activities from operational staff
- To verify the current status of activities from fieldwork visits
- To obtain stakeholder views about programme activities and level of change
- To feedback stakeholder views to programme managers
- To feedback summary of results to participants and communities

3.2.3 Work-package 4: Reports, Evaluations and Recommendations

In addition to this final report and the regular feedback to the research team, programme managers and participants, the following formal reports were produced:

- Baseline Interviewing: Interim Summary Report November 2014
- Baseline Evaluation Report 26 May 2015
- Fieldwork 1 Report 29 January 2016
- Fieldwork 2 Report 31 January 2017
- Being Here Evaluation: Interim Summary 11 May 2017
- Being Here Evaluation: Interim Summary 28 June 2017

The UHI research team also contributed to the NHS Being Here Legacy Event (the Programme's Final Conference; held in the Centre for Health Science, Inverness) on 11 May 2017 by giving a presentation of interim findings and holding a workshop on the challenges emerging from the evaluation in addition to writing the interim summary for all participants (listed above).

3.3 Methods

The evaluation employed qualitative research methods consisting of semi-structured interviews and thematic data analysis. Interview schedules, participant recruitment, fieldwork organisation and data analysis are detailed in the sections below.

3.3.1 Baseline

A review was undertaken of the document entitled *'An Approach to Building Sustainability of Health and Care Services in Remote and Rural Areas: Proposal to Cabinet Secretary for Health and Wellbeing' (NHS Highland)* as this report lays out the rationale for the programme. The review allowed the UHI research team to identify the key changes that the programme aimed to achieve. In addition, two meetings were held with the Programme Manager to discuss areas to be covered by the programme. The review addressed three questions:

1. What evidence about rural health primary care services delivery and challenges is the programme based on?
2. What are the expected changes from the Being Here Programme?
3. What are the potential indicators for use in baseline interviewing and continuous evaluation?

In addition, two meetings were held with the Programme Manager to discuss areas to be covered by the programme and to agree the indicators of change to be used over the course of the evaluation. A list of the agreed set of indicators revised following the workshop with programme managers on Friday 22nd May, 2015 is given below:

Health and care professionals and community members feel that the new model is:

1. Inclusive of the community's voice
2. Sustainable
3. Safe
4. Of an acceptable standard

5. Cover the breadth of remote and rural healthcare scenarios
6. Cover the breadth of primary care
7. Building community resilience

COMMUNITY INDICATORS

1. Change is no longer feared
2. Out-of-hours and unscheduled care acceptable
3. Relationship with healthcare professionals becomes more reciprocal, with greater community and individual responsibility
4. Practice mergers are acceptable
5. View capability and capacity building and strengthening resilience as acceptable
6. Feel that they have been active agents in the change process
7. Value clinical standards over the maintenance of traditional health and care professional roles
8. No longer equate quality of service with geographical distance from service
9. No longer equate an appropriate emergency response with only the GP or Scottish Ambulance Service
10. 'See and treat' and ongoing care being done by non-GP/healthcare professional is acceptable
11. Team based approach to ongoing care acceptable

HEALTH AND CARE PROFESSIONAL INDICATORS

1. Reduced feelings of isolation and/or over-burden; they, and their families, are content with work-life balance
2. Out-of-hours and unscheduled care acceptable

3. Change is no longer feared
4. The relationship with the community becomes more reciprocal with greater community and individual responsibility
5. Practice mergers acceptable
6. Multi-disciplinary teams have clear lines of co-ordination and accountability that they understand
7. New roles/teams/practices are functioning with multi-disciplinary teams
8. Local clinical leads have participated in the change process and publicly support/demonstrate the model

OTHER INDICATORS

1. All new posts advertised and filled
    - Number and type of posts advertised
    - Whether and which posts were filled, and with same or different type of post?
    - How long took to fill?
2. Appropriate use of supplementary staff (locums, bank, agency)
    - Reduced spend on supplementary staff
3. Increased use of technology
    - Use logged - VC, text, phone, email, other
4. Increased 'see and treat' being done by non-GP/healthcare professional

The results of the review were used as the foundation for devising an interview schedule which was designed to capture as much information as possible about stakeholders' views, whist at the same time

limiting the duration of the interviews to between 45 and 60 minutes. The interview schedule, as well as the information sheet and consent form, can be seen in Appendix 1.

The identification of stakeholders was based on a contact list obtained from the Programme Manager and included several NHS staff members whose remit covered the geographical areas involved. Often only one contact was given per site and, therefore, the researchers asked this named contact to supply the details of additional interviewees. We aimed to include members of the public by asking the named health professionals to facilitate access to Patient Participation Group members or Public Partnership Forum members.

The baseline interviews were conducted by telephone in order to ensure completion in the time available before programme changes began (this would not have been possible if we had travelled to each pilot site in order to conduct face-to-face interviews). A thematic analysis of the interview notes was undertaken to identify the main themes emerging from the baseline.

3.3.2. Fieldwork methodology

Before the initial round of fieldwork, the first task was to obtain an up to date picture of the Being Here programme activities. Key NHS contacts were identified to supply this data and information was also collated from different sources such as NHS progress reports and Being Here Programme newsletters. Following discussion, the research team decided to re-interview existing stakeholders from the baseline where possible and to identify and interview new participants as appropriate. Patient Participation Groups and Community Councils were used as starting points to gain information about communities and appropriate groups. Additional interviewees were found by contacting previous participants, patient groups, Community Councils, local community organisations and third sector workers. It was decided to include third sector interviewees and to organise drop-in visits to community groups to widen the range of interviewees.

After potential stakeholders were identified, fieldwork visits were arranged, a timetable of interviews drawn up and new interview schedules were written. Interviews were conducted face-to-face, area by area, and transcribed following each visit. Immediately after each fieldwork cycle, a summary of urgent issues arising was given to the Programme Manager. The results were then discussed with the research

team and programme managers. Detailed analysis of all data from the fieldwork visits was then undertaken at this stage and presented in interim reports (1 and 2). A summary was then finalised and shared with the participants and their communities.

Following discussion with the research team and programme managers in May 2016, it was decided that the second round of fieldwork should not involve returning to all the locations in Argyll and Bute visited during the first cycle. It was agreed that the second visit should concentrate on the two areas experiencing the greatest level of change, namely Furnace/Inveraray and Muasdale/Gigha/Southend. Previous participants in other locations were offered the opportunity to update the research team by e-mail or to be interviewed over the telephone. New interviewees were identified by contacting previous interviewees, Community Councils and other local community organisations. For the final round of fieldwork, all previous participants where possible, both individuals and community groups, were contacted to request an interview.

3.3.2.1 Semi-structured interviewing

The majority of all interviews were conducted face to face. Telephone interviews were carried out when this was not possible, e.g. due to participants' availability or preference. The duration of the semi-structured interviews varied in the main between 30 to 60 minutes (the longest interviews were in the region of 80 to 110 minutes). The interview schedule was reviewed and amended as necessary at each stage of the fieldwork. Interview schedules as well as the information sheet and consent form can be seen in Appendix 1. Interview notes were transcribed and subject to a thematic analysis by the UHI research team.

In addition, drop-in visits were undertaken with a range of community groups. Participants' views were gathered either informally (one to one or in small groups while the group met) or during structured group discussions facilitated by a researcher.

3.3.2.2 Numbers and type of interviewee

Completed in May 2015, a total of 53 people were interviewed for the baseline evaluation. The first round of fieldwork (August-November 2015) involved semi-structured interviews with a total of 111 residents, health and social care professionals and third sector workers in Kintyre, Islay, mid-Argyll, Acharacle and

the Small Isles. In addition, drop-in visits were undertaken with eleven community groups in the Argyll pilot sites. During the second round of fieldwork (April-September 2016), semi-structured interviews were undertaken with a total of 127 residents, health and social care professionals and third sector workers. One community group was visited while another discussion (based on an outline provided by the research team) was facilitated by a group leader outside the fieldwork dates and the results were sent to researchers. The final round involved semi-structured interviews with 124 residents, health and social care professionals and third sector workers as well as visits to four community groups in the Argyll pilot sites. The numbers and type of interviewee are given by area and fieldwork round in Table 1 below. Please note that many of these participants have been interviewed in more than one round of fieldwork.

TABLE 1

Stage	Type of interviewee	Number of interviewees	
		Argyll and Bute	Small Isles & West Lochaber
Baseline	HSCP*	17	8
	Non-clinical professional**	7	4
	Third sector	1	0
	Resident	11	5
	Total	**36**	**17**
Fieldwork 1	HSCP	17	15
	Non-clinical professional	1	0
	Third sector worker	12	0
	Resident	24	42
	Total	**54**	**57**
Fieldwork 2	HSCP	5	15
	Non-clinical professional	3	2
	Third sector worker	9	0
	Resident	36	57
	Total	**53**	**74**
Fieldwork 3	HSCP	10	17
	Non-clinical professional	3	2
	Third sector worker	10	
	Resident	39	43
	Total	**62**	**62**

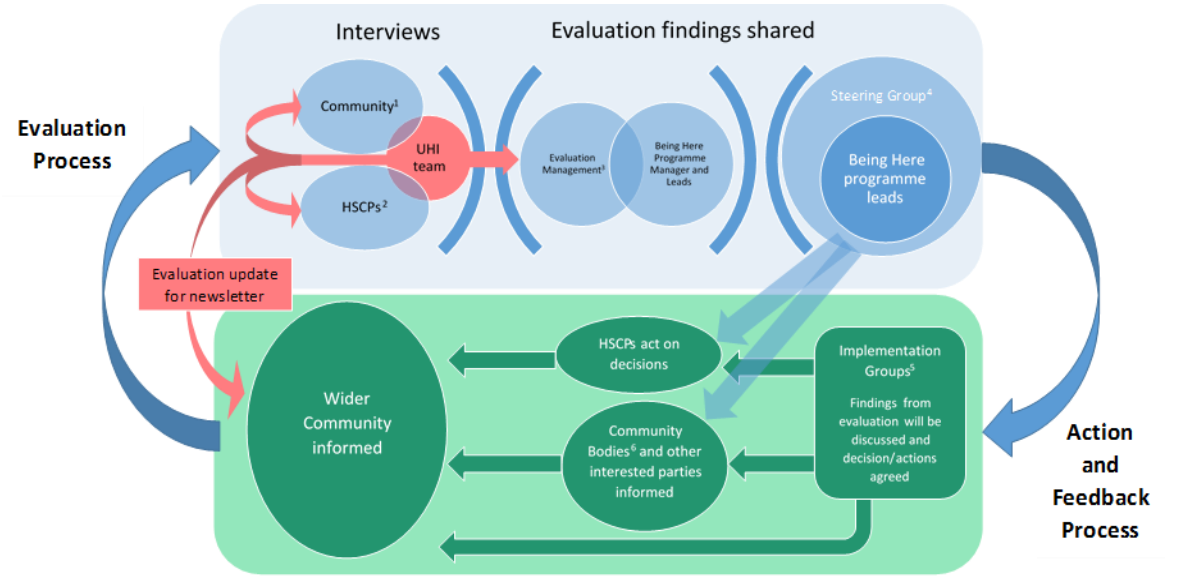
* Health and social care professional
** Non-clinical management/administrative staff who were not part of GP practices, including those having a clinical background but who were primarily employed in management roles in pilot areas.

In total, 203 individual participants and 14 community groups took part in the evaluation. A few of the participants were interviewed only in one round of fieldwork while others were interviewed up to four times in different rounds of fieldwork. The fieldwork consisted of 364 interviews some of which involved up to three participants in one interview. In total, there were 49 health and social care professionals, 16 non-clinical professionals, 121 community residents and 17 third sector workers. Over the course of the project, two individuals were interviewed firstly as community residents and then, by the time of the final round of fieldwork, they had become health and social professionals.

3.3.3 Feedback mechanism

The diagram below illustrates the feedback process agreed by the research team and programme managers. The Being Here Programme took an action research approach. This means that as programme activities took place, they were monitored and assessed by researchers. The findings were fed back to the programme managers so that they could be used to develop ongoing programme activities and to respond to the needs of health and care staff and local communities.

DIAGRAM 1



[1]Community – for baseline this included Health & Social Care professionals & community representatives, ongoing evaluation includes wider community representation
[2]Health and Social Care Professionals – includes GPs, social care professionals.
[3]Evaluation Management – NHS RD&I Manager, Being Here Programme Lead, UHI Rural Health and Wellbeing
[4]Steering Group – Being Here Programme Manager and Leads, Director of Operations, Head of Strategic Planning, NHS RD&I Manager
[5]Implementation Groups such as Islay&Jura Implementation Group, R&R SGHD Project – Mid Argyll, GP Subgroup
[6]Community Council, Patient Participations Group (PPG), Health and Social Care Forums (formerly Public Partnership Forums)

4.0 Results from Baseline Programme Review

4.1 What do we already know about rural health services?

- Stakeholders feel services are fragile and under threat (unsustainable).
- Stakeholders can be fearful of change.
- Communities have become reliant/ dependent on traditional local models of care.
- Training, skills maintenance (professional isolation) and recruitment are difficult in remote and rural areas.
- Single-handed GPs or GPs/nurse dependent services are not sustainable in small communities.
- Distance, sparsity of population and weather bring particular service delivery challenges.
- Remuneration not always deemed adequate.
- It is challenging to provide out-of-hours care and emergency response.
- There are concerns about the workload of rural GPs and their own health and wellbeing.

4.2 How does the Being Here Programme relate to what we know about rural health services?

- The Being Here Programme is operating within the remote and rural context.
- The things that we know about rural health services are the things that the Being Here Programme is attempting to change/tackle/improve through an action research intervention.
- The mechanism of change is iterative development and testing of new models of remote and rural service delivery.
- The aim of the evaluation is to evidence whether, and if so how, these models work.

4.3 What are the expected changes from the Being Here Programme?

- New service models become sustainable.
- Services provide coverage in new ways, e.g. use of different forms of transport.

- Sole GPs are phased out and practices merge.
- New models involve multi-disciplinary teams.
- New types of post are created.
- The community are consulted/ involved in the development of new service models.
- Community capacity building and resilience are enhanced.
- New models are grounded in clinical governance (risk) and not the maintenance of traditional healthcare professional roles.
- New models cover episodic, long-term condition management and emergency response.
- There is increased use of digital technology.
- Rural practitioners are connected into networks of support and training.
- Emergency response becomes more efficient.
- Recruitment becomes easier.
- Healthcare professionals' own health and wellbeing is not negatively impacted upon by their workload or working context.
- Local NHS staff 'buy in' to the new models.
- Scottish Ambulance Service ability to 'see and treat' is enhanced.

5.0 The Being Here Pilot Sites: Stories of Change

An outline of the changes to primary care services provision in each area, as captured by the UHI research team, is given in this section of the report.

5.1. Argyll & Bute

5.1.1 Islay

Islay Medical Services operated independently of the Being Here programme and the practices did not receive any Being Here funding. The following changes were introduced independently of the Being Here Programme and Islay Medical Services did not want its successes ascribed to the programme. The evaluation was funded by the programme. At the time of Fieldwork 1 (August 2015) all three practices were already being managed centrally by one GP partnership, whereas in the past they had operated independently. Although some surgery opening hours have changed, the GPs cover the same three surgeries in Bowmore, Port Ellen and Port Charlotte which have separate contracts and patient lists. In addition, the GPs are also responsible for out-of-hours, A & E and the wards in Islay Hospital on a rota system. Staff now work within one bigger organisation and can be deployed across the three sites if necessary. During the life of the evaluation, 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 had recruited successfully in 2015 and had a full complement of five GPs at the time of Fieldwork 1 (August 2015). In addition to the principal GPs and salaried GPs, the practice also took on placements under the Rural Fellowship Scheme. The Rural Fellowships are one-year posts in different locations which are aimed at doctors who are interested in remote and rural practice and have completed General Practice Specialty Training. One of their GPs left in 2016 but the practice successfully recruited a replacement as well as an additional GP to create a team of six. A former Rural Fellow was recruited on a permanent basis. Although a GP partner will be leaving in 2018, it is understood this should leave the full complement of five doctors. The practice also works closely with the two part-time GPs on Jura. Establishing itself as a teaching practice is seen as a key development and Islay Medical Services held an event in 2017 for 60 medical students to get to know the island and introduce them to rural medicine. In order to ensure skills are kept up to date, the practice has introduced a training system whereby all the GPs will work in Glasgow secondary care for up to two weeks a year.

Formerly one Practice Nurse was attached to each surgery whereas now the three surgeries are covered by a team comprising a specialist Diabetic Nurse, Health Care Assistant and a Practice Nurse. A review of GP appointments had been conducted to investigate whether giving a patient an appointment with a nurse or Health Care Assistant would be more appropriate. Patients can be seen by any practice nurse, specialist nurse or healthcare assistant at any surgery. However, on-going IT problems have delayed further practice integration. The Rhinns surgery was refurbished including the provision of a new dispensary (2014). Improvements were also made to the telephone systems at the Rhinns and Port Ellen surgeries but Bowmore surgery was more difficult because it was within the hospital infrastructure.

At the time of the baseline interviews (December 2014) concern was expressed about the lack of dental services. During the evaluation a resident dentist was recruited on Islay but the potential backlog of patients continued to cause concern. At the time of Fieldwork 2 (April 2016), the optician had also left but a visiting service was in place.

During Fieldwork 1 (August 2015), Islay had a Health Implementation Board which included health and social care professionals and community residents. Members of the public joined from the Community Council health care subgroup and the Public Partnership Forum. The latter is now the Islay and Jura Health and Care Forum. In April 2017, the Health Implementation Board was replaced by the Locality Planning Group (LPG) which includes health and social care professionals, third sector representatives and community residents.

Towards the end of the evaluation it was understood there had been a number of changes: the A&E Department had been re-sited within the hospital and refurbished; Trust Housing had reduced warden cover at its sheltered housing units in Port Ellen and Bowmore from 35 hours to 12.5 per week; a new Senior Citizens' Forum had its inaugural meeting in November 2017; a new neighbourhood team was being developed involving the integration of community nurses, hospital nurses and care staff across Islay and Jura; the hospital may receive funding for a day case unit in order to avoid patients having to travel to the mainland, particularly for pre-operation checks and minor surgery (some pre-op checks are already undertaken).

5.1.2 Kintyre

The programme aim, in this pilot area, was to establish a single out-of-hours, community hospital in-patient and A&E service to be led by one GP practice. Day time GP services are provided across the area by three separate practices, namely Campbeltown Medical Practice, the Carradale Surgery and the Kintyre Medical Group. Since July 2015 the Campbeltown practice has been responsible for in-patient care in Campbeltown Hospital and out-of-hours services for all patients in Kintyre with the support of Emergency Nurse Practitioners in the hospital and the community nursing team on duty until 21.30 daily. In 2015 1.5 WTE GP posts were filled in Campbeltown. At the time of Fieldwork 3 the practice still had six full-time partners sharing out-of-hours and 1.5 salaried GP posts covering surgeries but not out-of-hours or the hospital. This allows GPs to take time off following their turn covering out-of-hours.

In March 2016, a GP left the Kintyre Medical Group which, at the time of Fieldwork 3, continued to operate with one part-time GP and locums across its surgeries in Muasdale, Gigha and Southend. A patient focus group was established in the face of the departure of the GP from the practice. NHS Highland has proposed that Campbeltown take over the practice. At the time of the last fieldwork visit (April 2017) negotiations between NHSH and the practice were on-going over the proposed merger. Although a two-stage process had been suggested whereby Southend would be taken over first followed by Muasdale and Gigha at a later date, it was subsequently proposed to take over all three locations simultaneously. It is envisaged that Campbeltown would probably require another GP to fulfil this commitment. The patient focus group received reassurances that the local surgeries would stay open if a merger goes ahead. In addition, it had been proposed that a pharmacy in Campbeltown would provide dispensing services currently offered by the Kintyre Medical Group practice. At the time of writing it was understood that negotiations between the Campbeltown practice and NHS Highland were on-going and the possibility of the Campbeltown practice dispensing was being discussed to overcome concerns about the pharmacy service. Southend surgery has also switched to more appointments-based clinics rather than the former wholly ‘sit and wait’ system.

5.1.3 Mid-Argyll

As in Kintyre, the programme aim was to establish a single out-of-hours service to be integrated with the Lochgilphead community hospital in-patient and A&E services, which would be led by one GP practice. Lochgilphead Medical Practice is attached to the Mid Argyll Community Hospital and Integrated Care

Centre. In recognition that the triple duty role of these GPs requires a set of additional skills, dedicated GP training courses have been delivered in Lochgilphead and have been designed specifically to maintain the skills of doctors working in non-bypass community hospitals. Emergency and out-of-hours services are now provided from Lochgilphead with support from Emergency Nurse Practitioners based in the hospital and the community nursing team on duty until 20.30 daily.

Lochgilphead practice was awarded the contract to provide GP services for Furnace and Inveraray in 2015. The Furnace and Inveraray practice had been a single-handed practice staffed by locums since the retirement of the GP. The Lochgilphead practice took over all GP services for Furnace and Inveraray including out-of-hours cover.

Although four new GPs had been recruited in Lochgilphead since the start of the programme, one of them left in autumn 2016, another long-standing GP left in 2017 and a third GP was due to leave later in the year. The initial round of advertising for the first vacancy was not successful. At the time of Fieldwork 3, a senior Practice Nurse had also retired. In total, two Advanced Nurse Practitioners were recruited in the summer of 2017, 1 '2 session' salaried GP was recruited and left summer 2017 and 1 new full GP partner was recruited in August 2017. The present GP team is made up of 6.25 WTE doctors. A core of 4 GPs cover Inveraray and Furnace and patients can ask to see specific GPs if they wish. Appointments are bookable in advance and on the day.

In order to manage patient demand, the practice introduced a new telephone consultation system as a means of assessing patients before deciding whether to allocate a face to face appointment with a GP or nurse. The new telephone appointment system began on 29th May 2017 to make a more efficient and effective use of GP time. At this point it was not envisaged that this would apply to Furnace and Inveraray for the time being. Although towards the end of the evaluation, it was reported that the new system was working well, some patient concerns had been raised via the Lochgilphead Community Council e.g. some patients do not want to have to tell the receptionist their reasons for wanting to see the GP, particularly in a small community. An Advanced Nurse Practitioner has also taken over one of the GP clinics in Furnace.

5.2 West Lochaber

5.2.1 Acharacle

The aim of the Rural Support Team was to create a multidisciplinary team to prevent professional isolation and minimise reliance on GPs with the deployment of Advanced Nurse Practitioners and Unscheduled Care Practitioners in addition to GPs. The team of health and social care professionals work in different parts of a large geographical area linking up for professional support and to provide cover as required in remote and rural areas. They may have a main base or rotate. As well as providing daytime primary care services, they also cover annual leave and sickness in salaried GP practices. However, the high turnover of professional staff on the Rural Support Team has regularly been highlighted in the interviews. In Acharacle a second salaried GP was appointed in October 2015 as part of the Rural Support Team to replace another doctor who left earlier in the year. The new GP is full-time and the existing one works three days a week. In the past, there were two full-time GPs in post. Although the practice is based in Acharacle, regular surgeries are held in Strontian and Kilchoan so the communities still retain a GP presence. One of the practice nurses left and a new Healthcare Assistant post was created and filled. Acharacle also has a First Responder team. In 2016 there were three Emergency Responders in Kilchoan, but one has since left. However, at the time of the third round of fieldwork in 2017, another was being trained.

In January 2016 a new three member team comprising Advanced Nurse Practitioners and unscheduled care workers was introduced to cover weekends and evenings with the aim of replacing the GP locum service. Initially an Advanced Nurse Practitioner and a paramedic joined the Rural Support Team to deliver this service. At the time of the second round of fieldwork (May 2016) they were covering the weekends and the locums were still providing an evening service Monday to Thursday until another Advanced Nurse Practitioner was to take up her post in July 2016. However, by the time of the third round of fieldwork (June 2017) both those original workers had left these posts. Two different Nurse Practitioners were covering the area out-of-hours and it was then proposed to extend the geographical area to include the Lochaline practice because the GPs were no longer covering the practice out-of-hours.

The Dail Mhor Care Home in Strontian closed temporarily in August 2017 and the residents were moved out to care homes in Fort William and Mallaig. The community was awaiting a report on the condition of the building and cost of repairs. Towards the end of the evaluation it was reported that a pharmacy booth

proposal was to go ahead and would probably be housed in the local community library at the Sunart Centre in Strontian. The practice was also going to trial 'Florence', Technology Enabled Care (TEC). First aid training for the community in West Ardnamurchan was also being planned (3D160u).

5.2.2 Small Isles

In January 2015 Broadford practice took over the Small Isles practice which had been covered by a range of locums since 2012. A charter boat service brings one of three GPs from Armadale on Skye to the Small Isles. Every Tuesday it goes to Eigg, every Thursday it alternates between Canna and Rum in Week 1 and Muck and Eigg in Week 2. Outside these times telephone and VC consultations can be arranged via the Practice Administrator based in the Eigg surgery. In the earlier stages of our fieldwork, many patients expressed concern over the reliability of the boat to the islands in poor weather especially in the winter months. However, the boat charter had been temporarily taken on by a different contractor at the time of Fieldwork 2 (June 2016) and, since then, it has been generally reported that the service is more reliable. This contractor, Seafari Adventures Skye, was formally awarded the Small Isles Boat Charter Service from 9th December 2016 for a period of two years. The contract included an additional provision whereby patients could be picked up from Muck and Rum and taken to the surgery on Eigg for appointments. A very small number of patients had been taken from other islands to see the GP or other health professional at the Eigg surgery at the time of Fieldwork 3 in May 2017.

Out-of-hours patients can contact NHS24 but have to wait until a regular GP visit to be seen on the islands. There are emergency drug stores on each island which can be accessed by a designated key-holder. In an emergency there are First Responders to attend a patient who can subsequently be taken off the islands by air or lifeboat. At the time of Fieldwork 1 (October 2015), there were eight voluntary First Responders on Eigg and six on Muck. The teams have attended several incidents since they started in January 2015. The aim was to have two Responders on duty where possible. In 2016 the First Responder team on Eigg had five core members with three additional trained volunteers (two in 2017) who either did not want to join the team formally or had limited availability. On Muck two of the original six First Responders had left the island by the time of the third fieldwork visit in May 2017. Since the end of Fieldwork 3, the Scottish Ambulance Service have provided the First Responders on Eigg with a new Landrover. Towards the end of the evaluation it was also understood the First Responders were to be trained to give Entonox for pain relief as well as to take blood pressure and temperature in order to do the diagnostic assessment

for GPs and paramedics. It was also reported that two people were waiting to be trained on Eigg. At the end of the evaluation it was understood that the training for Eigg First Responders had been postponed from February to March (3C026u). As the Muck First Responders could not attend the proposed training in Fort William due to family commitments, a trainer was due to come out to them in March (3C095u).

Four Rural Health and Social Care Support Workers were initially appointed in April 2015 on Eigg and Muck. Developed as a way of building community resilience, the aim of the role was to support islanders to take control of some health and social care needs by training the workers in routine tasks such as changing dressings, taking blood and home care duties. The role was inspired by the 'customer-owned'[1] approach of the Southcentral Foundation's Nuka System of Care in Alaska whereby community members became 'owners' of healthcare rather than 'recipients of services' through their involvement in service design and development[2].

It was envisaged the new Small Isles role would support existing health and social care professionals and enable more people to return earlier following hospital admission and remain at home for longer as needs increase. Health promotion was also seen as a potential aspect of the new role. The aim was to provide flexible tailor-made training to enable the workers to meet local needs as they arise. They were contracted for two hours per week and were being trained and managed by the Area Integrated Team Lead in Mallaig. Training was provided both on-line and in Mallaig. Of the original four, two left the Small Isles in 2016 and another three were subsequently recruited by the time the last fieldwork visit was undertaken (May 2017). To address problems experienced with IT hardware and access to IT training for staff, a new project, funded by the Remote and Rural Healthcare Education Alliance and Mhor Collective, was due to deliver a 12-hour digital skills training package for staff in Eigg.

The former doctor's house on Eigg has been renovated to provide a new surgery with a consulting room, waiting room, dispensary, office and stores. Staff accommodation has been included in the refurbishment to enable the GP or other professionals to stay overnight as required. Proposals to further develop the building currently used as the surgery and its surrounding garden ground are being discussed by community representatives and NHS Highland staff. Towards the end of the evaluation community

[1] https://www.southcentralfoundation.com/nuka-system-of-care

[2] https://www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska

members were looking at the feasibility of taking over the old surgery in discussion with NHS Highland. A proposal for a gym on the site has been taken forward by one resident.

Rum and Canna currently have no dedicated surgery space. Patients on Muck are still using a room in the community hall, but by the last fieldwork visit (May 2017) a large cupboard had been adapted to create an additional private consultation space within the hall. It also provided storage for the First Responder kit and the emergency drug box. Two Eigg staff have also completed their Dispensing Assistant Level 2 Course of Buttercups Training (reported May 2017).

As well as first aid training, there was a Public Health workshop to elicit residents' views on their assets and challenges. Following this, mental health first aid training was delivered. Health professionals, other NHS staff and visitors from the South Central Foundation in Alaska came from the mainland to attend a health fair which was combined with the official opening of the new health centre in May 2016. NHS Highland produced Small Isles newsletters to keep residents up to date with service developments. A community midwife, health visitor, community nurse, podiatrist and a physiotherapist have all visited Eigg. A leaflet entitled 'Making it work together' was distributed among Eigg residents informing them of how and when to contact specific services. General first aid training for some residents on Eigg has been delivered.

In November 2017 NHS Highland launched a pilot scheme called 'Attend Anywhere', a new online portal which allows patients to access health appointments via a video call from their own home using their existing devices and video technology. This may also enable residents from Rum, Muck and Canna to access the Small Isles Health Centre or the Broadford surgery via a 'video call'.

Two Eigg residents were nominated to join a proposed Health Panel, but at the time of Fieldwork 3, it had not yet met. Towards the end of the evaluation it was understood that there will not be a formal panel but an informal communication link with NHS Highland management will remain.

6.0 Results from the indicators

As described above, a set of indicators of change were identified as a result of the Baseline Review, interviews with programme staff and other stakeholders. The indicators that were used for the purposes of the evaluation are listed on pages 25-27 of this report. This section highlights the key findings in relation to the use of these indicators with a particular focus on which indicators changed over time, in which pilot sites. Following thematic analysis of the transcripts generated during every round of interviewing, the research team assigned each indicator to one of the following categories, based on the majority view:

Indicator has been met:			
NO	**PARTLY**	**YES**	**Not tested/applicable**

The following section of this report (8.0 Key Themes from the Qualitative Evaluation) details the themes that came out of the large amount of qualitative work done at each case study site. The in-depth descriptions give us an understanding of the how and why indicators changed, or remained stable, over the course of the Being Here Programme. This is reflected on further in the concluding sections of the report.

6.1 Stable Indicators

Some indicators were assigned to the green 'yes' category after the end of fieldwork cycle 1 in all test site areas. These remained green for all test site areas for the duration of the evaluation. This showed that in all the sites, the majority of community residents and healthcare professionals interviewed considered the new primary care models to be:

- Safe
- Of an acceptable standard
- Covering the breadth of rural primary care

In addition, from the start of the evaluation work, the majority of community interviewees also felt that:

- A team-based approach to service delivery is acceptable (except in Small Isles, where there was initially more scepticism)

In terms of the healthcare professionals who took part in the interviewing, the majority consistently felt that:

- out-of-hours and unscheduled care arrangements were acceptable
- The change (to service model) was not something to be feared
- The concept of practice mergers is acceptable
- MDTs have clear lines of co-ordination and accountability
- New roles, new teams and new practice set ups are functioning
- Local clinical leads have participated in the service changes

6.2 Perceptions of the New Models

As outlined above, the Being Here Programme aimed to test new models of primary care provision that would be considered by communities *and* healthcare professionals to be:

- Inclusive of community voice
- Sustainable
- Contribute to building community resilience
- Not something to be feared

And that community members would find acceptable new service delivery models that:

- Involve a more reciprocal relationship between healthcare professional and patient
- Include practice mergers, where appropriate
- Value clinical standards over the maintenance of traditional health and care professional roles
- No longer equate quality of service with geographical distance from service

Therefore, through semi-structured interviewing, community members' and healthcare professionals' opinions on each of these areas were collected.

6.2.1 Community Engagement

In Islay, Kintyre and Mid-Argyll, early fieldwork suggested that the majority view amongst residents was that their voice was not included in the service change deliberations. However, over time, this changed towards most feeling that there was some consideration of their local views. In the Small Isles and

Acharacle, there was always at least a partial feeling of inclusivity that, over time, increased; suggesting that in these two sites, the Being Here Programme did achieve its aim of inclusivity.

Related to this indicator is that of whether community members felt like active agents of change within the service redesign and delivery. At the end of the first round of fieldwork, it was clear that the majority view within each of the case study sites was that they did not consider themselves to have been active agents within the change process. However, over time the view changed within Islay, the Small Isles and Acharacle to one where many community members felt they had been involved actively to a certain extent. This change was not seen in Kintyre or Mid-Argyll.

A similar trend was seen in relation to the indicator that monitored community members' perceptions of fear in relation to the service changes. Associating service change with fear decreased in Islay, Mid-Argyll, the Small Isles and Acharacle but remained within Kintyre.

6.2.2 Perceptions of Service Sustainability

By the end of the evaluation period, the majority of interviewees in each of the case study sites reported feeling their new service model was sustainable. In Kintyre, Mid-Argyll and the Small Isles this perception increased over time. However, in Islay and Acharacle, the general feeling from the *beginning* of the data collection period was that the new models were sustainable.

6.2.3 Community Resilience

At the beginning of the evaluation period, there was very little evidence that the interviewees felt their new service models were contributing positively to community resilience (although, discussions about this were positive in Campbeltown and Lochgilphead). In general, however, the view that the services did contribute to community resilience increased within each of the communities over the period of the programme.

6.2.4 Reciprocity

One of the aims of the Being Here Programme was to find new service delivery models that community members felt comfortable with, involving a more reciprocal relationship between healthcare professional

and patient than in the past. However, the indicator measuring this perception did not change over time – representing very mixed views on this within each of the communities interviewed.

6.2.5 Acceptability of out-of-hours provision

In general, community members' perceptions of the acceptability of their new out-of-hours service provision became more positive in each of the test sites over the course of the evaluation period. Although in the Small Isles, some concern persisted throughout each of the interview cycles.

6.2.6 Practice Mergers

One of the underlying drivers of the Being Here Programme was to move away from single-handed GP practices, where appropriate. It was hoped that this could be done in a way that community members found acceptable. Practice merger activities were most prominent within the Kintyre and Mid-Argyll test sites. Over the course of the evaluation, attitudes towards the acceptability of practice mergers increased in mid-Argyll but remained low in Kintyre.

6.2.7 Acceptability of New Roles

It was hoped that, through its activities, the Being Here Programme would contribute to rural community residents' perceptions of primary care quality and acceptability becoming uncoupled from notions of traditional healthcare professions, such as the GP. A shift towards this attitude was seen over time in Islay and Mid-Argyll, but not in Kintyre. Levels of acceptance in this regard were higher in the Small Isles and Acharacle at the start of the fieldwork periods but they also increased over time to become near ubiquitous in these areas by the end of the fieldwork cycles.

In a similar vein, an indicator was also used to track whether community members linked the quality of primary care to the distance that they had to travel to see a healthcare professional face-to-face. One of the aims of the Being Here Programme was to find new models that would challenge any community members' pre-held assumptions that distance and quality and necessarily linked. This indicator remained low in Kintyre for the duration of the evaluation period. However, in Islay and Mid-Argyll there was a move towards some acceptance that quality and distance are not necessarily linked. In the Small Isles and Acharacle the link between distance and quality was already broken for some interviewees at the start of

the evaluation – and this view became widespread within our interviews by the end of the fieldwork cycles.

6.3 Healthcare Professional Specific Indicators

An additional set of indicators were developed in order to monitor the perceptions of healthcare professionals as regards to the service delivery changes; and any impacts on them of the changes. In Islay, Kintyre and Mid-Argyll the vast majority of the indicators had already been achieved by the end of the first fieldwork cycle:

- Contentment with work-life balance
- Out-of-hours and unscheduled care arrangements are acceptable
- The service changes are not feared
- Practice mergers are acceptable (excepting two specific community locations)
- Multi-disciplinary teams have clear lines of co-ordination and accountability
- There are new roles/teams/practices functioning with MDTs as appropriate
- Local clinical leads have participated in the change process and publicly support/demonstrate the model

An indicator of reciprocity was used within the analysis of the healthcare professionals' interviews in the same way as described above for community interviewees. It stands out as the only healthcare professional indicator that emerged as not fully achieved in Islay, Kintyre, Mid-Argyll, the Small Isles or Acharacle at the end of the first round of fieldwork and remains so for the duration of the evaluation period. In additional, concerns over work-life balance in the Small Isles remained at around the same level over time. Although, it should be noted that the majority felt the work-life balance was appropriate.

7.0 Recommendations Given During the Action Research Process

Fieldwork updates were sent to programme managers following the completion of each cycle in order to report the views of professionals and residents, to feedback any emergent concerns and to monitor the progress of change. In addition, formal recommendations were made in the first two fieldwork reports as outlined below.

7.1 Recommendations from report of Fieldwork 1 January 2016

- **A transparent feedback mechanism** is required so participants know how and when the fieldwork issues are to be raised and what they can expect to happen as a result. A rapid response to urgent issues is necessary to demonstrate that evaluation fieldwork does feedback to NHS management. Future participation in the evaluation is dependent on building and retaining confidence in the process which needs to be clear and effective.

- **Better NHS communication with local communities and organisations** would help foster trust and understanding. Other methods of communication could be used e.g. non-NHS locations such as libraries, community halls, local shops and community noticeboards etc. The purpose of changes and wider objectives should be explained. Ineffective communication will exacerbate fears, undermine trust and increase resistance to change.

- **Raising the profile of the Being Here Programme** would increase understanding as it is still largely unknown especially amongst the community residents and organisations. It is understood that the Being Here newsletter is now distributed more widely in communities.

- **Programme activities should be transparent** and advertised to increase understanding of the programme amongst all professionals and communities

- **Greater community representation within Being Here Programme**. The reasons for the lack of Patient Participation Groups could be examined.

- **First Responder Schemes** need more support. Regular training is urgently required to keep skills up to date and strengthen community and Responder confidence. More flexibility and enhanced training is required to respond to types of incident that occur regularly. The permission to administer pain relief is necessary, given time taken for emergency response to reach islands and other locations. More oxygen cylinders are needed and radio reliability improved on the Small Isles.

- **Small Isles boat cancellations** –Transparency is required on the monitoring of journeys and boat cancellation statistics.
- **GP surgery space** issues should be addressed on Muck and Rum
- **Small Isles visiting services** – clarification is required on who will visit and how patients are referred. The query about the community dental service only visiting Eigg needs to be answered.
- **Kilchoan Emergency Responders –** more are required to create a six-member team as originally planned. Options for training people from non-medical backgrounds need to be explored.

7.2 Recommendations from report of Fieldwork 2 January 2017

7.2.1 Small Isles

- **Regular training programme** to be agreed with all First Responders and should include simulated multi-agency exercise. A system for regular communication and support is required.
- First responders to be trained further and authorised to give **pain relief** (Entonox). This decision lies with the Scottish Ambulance Service.
- Provide more **oxygen cylinders** to First Responder teams.
- Improve First Responder **radio reliability**.
- **Enhanced training options** for First Responders should be examined in order to broaden their role to meet identified needs on the ground. Flexibility required over range of circumstances attended. Interaction with health & social care workers should be explained.
- **Emergency call centre –** the remote island location should be flagged up.
- **GP boat cancellations** –community input into boat tender (September 2016).
- **R & R health & social care support workers** – method of accessing workers should be clarified. Training should be made clear to patients and reassurance given on confidentiality requirements.
- **Dental services** – explore possibility of providing dental bus to other islands. If this is not possible, explain reasons to residents.
- **Visiting services** – options to be clarified and more information provided to all islands on what is available.
- **GP surgery space** on Muck, Canna and Rum – clear strategy needed to take issues forward.
- **VC link** – outline for improving the link with Eigg and extending service to other islands.

- **Practice management -** If patients are responsible for alerting surgery about tests, etc. then this must be clear to the patients.

7.2.2 Acharacle

- **Kilchoan Emergency Responders** –insufficient Emergency Responders with only three not six as originally planned. Difficulty finding suitable people with medical backgrounds locally. Need to look at different model for training.
- **Out-of-hours cover** – Many interviewees were unaware of the change. General lack of understanding and knowledge about the exact roles/skills of the new practitioners and how the new system will work. Importance of dovetailing with daytime primary care services.
- **VC facility** – not being used in Kilchoan. Interest in extending technology but limited use of VC across the area.
- **Health visitor/school nurse** – experiencing difficulties within the integrated service, primarily with the withdrawal of the NHS pool car.

7.2.3 Kintyre and mid-Argyll

- **Lack of communication and community engagement** - Issues reported in 2015 following the Inveraray/Furnace practice merger have arisen again this year in Southend, Muasdale and Gigha, namely lack of communication and community involvement. Ineffective communication risks exacerbating fears and increasing resistance to change.
- **Community trust undermined** - perceived lack of communication potentially increasing resistance to change
- **Acceptance of GP team model** – practice team including Practice Nurse, GP, Healthcare Assistant generally acceptable
- **Practice mergers –** not necessarily accepted by some community members
- **Continuity of care –** seeing the same professionals is highly valued and some people fear practice mergers can threaten this

7.2.4 Islay

- **Lack of communication** between practice and community – no change
- **Community resilience** – health service not seen as major factor
- **Community capacity** – third sector activities require investment
- **IT** – technical barriers to further practice integration unresolved
- **Breadth of service** – although people are satisfied with the breadth of primary care, concerns remain about maternity, mental health, addiction and children/youth services
- **Impact of any reduction in hospital nursing staff** as potential problem for sustainability of GP out-of-hours coverage
- **Potential for VC consultations**/ultrasound scans on island
- Potential for more **integration with third sector**
- Potential for **increased social prescribing**
- **Patient travel policy** – awaiting outcome of NHS Highland review

7.3 Fieldwork 3 (2017)

As the Fieldwork 3 visits were still underway at the time of the Being Here Legacy conference (11 May 2017), the research team produced an interim summary of findings (3 May 2017) which outlined the following learning opportunities:

Explanation of professional roles: the explanation and clarification of professional roles and qualifications to the public to help reduce levels of fear and engage residents with new models e.g. Health Care Assistant, First and Emergency Responders as well as the new Health and Social Care Support Workers.

First & Emergency Responder training & support: the qualifications required and training given should be clarified for both the community and the volunteers. The scheme can work as long as the people involved are clear about their roles, receive on-going support and can see a tangible schedule of training into, at least, the near future.

Technology: Being Here aimed to increase the use of technology as part of making services sustainable. However, many of the changes in Being Here have not been linked specifically to the use of technology, e.g. new Health and Social Care Worker roles and merger of GP practices. Implementation of these changes can be seen to be related to sustainability in several ways but have not yet been accompanied by increased use of video conferencing for patient consultation. This is regarded as one of the most important ways to further increase sustainability of remote and rural health services by many of the community members and NHS staff that were interviewed as part of the qualitative evaluation. In order to implement this, those working in remote and rural areas (both on the ground and in management) will need to be supported not least in terms of gaining access to specialist services in larger centres such as Inverness/Glasgow. Secondary care VC has been piecemeal in the past and an overall strategy could help facilitate sustainability alongside local initiatives such as the new roles and GP models tested in Being Here. A clear connection in people's minds is the link between having to travel for secondary care and personal/community economic resilience. Initiatives could build on this link to encourage self-care and use of technology.

Mental health services: Across all the pilot areas, concerns were expressed about access to mental health services, particularly where patients lived a long distance from dedicated services and support groups. Delivering services such as counselling was identified as a particular problem in small communities because of the difficulty of ensuring confidentiality. Primary care and online resources could potentially have a greater role where patients cannot regularly access any other mainstream services such as CPNs.

Local knowledge: Being Here qualitative evaluation acted as a channel for feeding the local voice to managers and operational staff. It has highlighted the need to look at how we build such processes into everyday locality operations.

Recognition of the third sector: Improved communication and integration with local third sector organisations was though by many interviewees as a way to improve the breadth of service delivery. A more integrated approach could also increase the potential for social prescribing to be offered within the community and thereby build local capacity.

Consultation and community engagement: differing views about the role and extent of consultation between community and healthcare professional interviewees highlights a need for more creative solutions to be tested. Employing a wider range of methods could help to reach and involve a greater number and variety of community members. Differing expectations over consultation aim and outcome should be explored in order to facilitate meaningful community involvement and develop future models for co-production.

7.4 Fieldwork 3 updates

The fieldwork updates presented to programme managers following the final visits to each pilot site are summarised below area by area:

7.4.1 Acharacle

Although attitudes to the practice remained very positive, there were concerns emerging from the fieldwork which are summarised below:

- **Kilchoan Emergency Responders** –insufficient Emergency Responders with only three not six as originally planned.
- **First Responders** – training, support and equipment.
- **Out-of-hours cover-** skills maintenance and covering bigger geographical area.
- **Management issues with RST –** lack of communication/not invited to Legacy event.
- **Technology -** VC facility not being used in Kilchoan. Limited use of VC across the area. Drug dispenser not progressed.
- **Health visitor/school nurse** – experiencing difficulties within the integrated service, primarily with the withdrawal of the NHS pool car.

7.4.2 Islay, mid-Argyll and Kintyre

The main issues emerging from the fieldwork remain similar to previous findings and are summarised below:

- **lack of communication and poor community engagement**

- **community trust undermined and potentially increasing resistance to change**
- **acceptance of practice mergers in Kintyre & Furnace**
- **continuity of care**

Issues reported in 2015 following the Furnace/Inveraray practice merger arose again in the second and third round of fieldwork in Southend, Muasdale and Gigha, namely lack of communication and community involvement. These issues also persist in Furnace and Inveraray, although interviewees were generally satisfied with the quality of their service. Ineffective communication risks exacerbating fears and increasing resistance to change. On Islay this was reflected in dissatisfaction expressed over the operation of the LPG.

7.4.3 Small Isles

In summary, there was a high level of satisfaction expressed with the quality and breadth of the GP service. The improved reliability of the boat service was appreciated. Community confidence had increased in the new model and in the principle of First Responder and support worker roles. However, little progress had been made with the persistent First Responder issues. The main concerns amongst interviewees were as follows:

- **First Responder scheme** – Need to be able to administer pain relief (Entonox), given time taken for emergency response to reach islands. Urgent need for more training and support to keep skills up to date and strengthen confidence. More oxygen cylinders. Enhanced training options for First Responders should be examined in order to broaden their role to meet identified needs on the ground. Flexibility required over range of circumstances attended. Interaction with health & social care workers should be explained.
- **Underused VC link** on Eigg and lack of VC link on other islands.
- **Lack of GP surgery space** on Muck, Rum and Canna.
- **Community dental service** – Rum, Muck and Canna.
- **Visiting services** – some progress had been made but it was felt to be slow.
- **R & R health & social care support workers** – method of accessing workers should be clarified. Training should be made clear to patients and reassurance given on confidentiality requirements.
- **Dental services** – explore possibility of providing dental bus to other islands. If this is not possible, explain reasons to residents.

8.0 Key Themes from Qualitative Evaluation

The types of change in the Argyll and Bute and the West Lochaber pilot areas differ in character - with the former focusing on GP recruitment and practice mergers, while the latter has been testing out new roles (Health and Social Care Workers) and service delivery models (visiting GP service). However, the key themes to emerge from the qualitative evaluation were shared across all the programme areas.

When differences were observed in the themes between the pilot sites, this was largely due to interviewees' discussions of particular service delivery issues that only applied in their local pilot site. After conducting a thematic analysis of the data collected through interviewing, it was evident that there were several central themes present across all three rounds of fieldwork.

A summary of the combined emergent themes from all fieldwork cycles is given in the following section of the report. We attempt to represent the breadth and diversity of experiences and opinions that were given by the interviewees. Interview numbers are placed in brackets following references and quotations.

8.1 Service quality

Most interviewees were satisfied with service standards and perceived their primary care services to be adequately safe; however, patients tended to see lack of continuity of care as the main threat to the perceived quality of service. Patients placed a high value on having a personal relationship with one GP, who, they felt, knew their history and family background. This was a key factor in building up trust and reassuring patients, which was particularly important for those with long term, multiple or mental health conditions. Patients associated quality of service with the level to which a healthcare professional was familiar with their personal and/or family background. Access to the same GP was a common priority amongst community interviewees. Their sense of continuity was disrupted by the prolonged use of different, short-term locums who did not know patients, the geographical area or the way the particular practice worked e.g. familiarity with IT systems or access to patient notes. However, community interviewees reported that this relationship could be built up with a longer-term locum. The fear of losing continuity was the main driver behind concerns about practice mergers which meant becoming part of a larger, usually more town-based GP practice. Patients feared the loss of a more personalised service when moving to a bigger team practice. Being able to make an appointment easily and see a GP rapidly were

given as a key advantage of a small, rural practice compared to a town practice. If urgent, interviewees felt their practice would 'squeeze' them in at the end of a surgery so they did not have to wait, particularly in places without a daily surgery. In these smaller practices, patients also valued the apparent flexibility of consultation times to enable them to spend longer with their GP if they felt it necessary. Interviewees often thought their local rural practice provided higher quality care than would be available in a large town or city. Instead of being seen as an advantage in terms of wider skills and experience, moving to a larger team practice was often associated with waiting longer and being more anonymous. However, in areas with existing large, group practices, interviewees were also satisfied in the main with the quality of their primary care services.

Some interviewees believed primary care services had improved as a result of the changes instigated as part of the Being Here Programme, whereas others still feared that changes to the organisation of their local care (e.g. practice mergers) had already, or would in future, undermine the quality of the provision. Although health professionals tended to think the changes, particularly practice mergers, would improve services by offering an up-to-date and multi-disciplinary service, the potential benefits of these structural and clinical changes (such as medication reviews) were not always recognised or understood by patients. Improvements to chronic disease management, for example, following a practice merger were highlighted by one professional interviewee (2B003) as a very significant benefit of the change. However, if individuals were happy with the accessibility, convenience and attentiveness of their local service, then it was difficult for them to imagine how care can be improved if they have not had an alternative service with which to compare it.

8.2 Sustainability

Following the implementation of Being Here Programme changes, most interviewees believed that services would be sustainable in their current form. Although some saw no reason why the primary care practices would not be sustainable, others were uncertain, expressing simply the hope that they will be sustainable. Concerns remained that this sustainability may be undermined in the future by potential decreases in NHS budgets, turnover of staff, difficulties with GP recruitment, poor Broadband connectivity, poor IT infrastructure and lack of engagement with technology (by both healthcare professionals and community residents). Worries were expressed about the continuation of specific

services such as the community nurse on Gigha, the First Responder Schemes and the new out-of-hours team on the Ardnamurchan peninsula.

Some patients associated the sustainability of a GP service with how much they felt it was required and used locally, i.e. it must be sustained because there are local people who need it. They thought if a service was 'required' by the local population, then it would have to be publicly funded and continue to operate. Concern was expressed by one interviewee that GPs could decide not to cover a particular area anymore and withdraw the service because a practice is essentially a business (2I08). However, the business structure of a GP practice was not necessarily understood or referred to by many community interviewees. Some of the GPs in the pilot areas were salaried but interviewees did not always make a distinction.

One resident described the relationship between services and sustainability as "*chicken and egg*", saying if services *"are not sustainable then the population will decline even more. If you don't have a GP service, then you've no chance of keeping people*" (2B135). Community sustainability was linked to service sustainability where people believed a community was 'composed' of key professional roles e.g. doctor, teacher, etc. which made the community viable:

"*If you were playing Katie Morag and building a community, you'd stick a doctor in there, wouldn't you? When they did the Taransay experiment in 2000, they had a doctor and a teacher and a farmer and that's how you would start to put a community together, so I can completely see that on paper that's our mentality*" (1C073b).

A larger practice model was considered to be more sustainable by a few community interviewees and most professional interviewees because it reduced both the dependence on one or two local health care workers and the need for expensive locums. According to one professional interviewee a team-based model also offered the potential opportunity for greater innovation and creativity (2B037). Professionals tended to view the practice mergers and multi-disciplinary team working as fundamental to future sustainability because they believed this would reduce professional isolation and facilitate recruitment, retention and training.

Cost was identified as a key factor in sustainability, but views were divided on whether the public wanted more information about NHS budgets and what impact this knowledge might have. One community interviewee said that "*they just want the services never mind the cost*" (3D158b). Another (3D158a) thought cost should not come into the discussion. According to a different community interviewee (3D174) patients in remote areas are entitled to the same health care as people in cities. Although there was an apparent recognition that it cost more to provide rural services, many interviewees thought they had a 'right' to the same level of primary care as in an urban area:

"*No, I'm not interested in the … cost. I understand we will be dearer, but it doesn't mean we shouldn't get the service*" (3D104).

However, people did not generally expect the same access to wider secondary care services and accepted it was more difficult to deliver these services in a remote rural area.

When asked about access to budget information, one person was unsure whether it was really "*their business or their right*" to know and thought patients cannot really "*interfere*" (3D105a). On the other hand, a large number thought the public had a right to know because they pay taxes which contribute to the running of the services. For some, it was thought that increasing public knowledge about cost might mean patients appreciate their services more. A professional interviewee thought the public did not understand that there is a "*finite pot*" for health:

"*We are constantly asking a lot of people in today's world what they want but there is no check and balance to that … there's no concept that this is costing money*" (1A051a).

This interviewee felt "*passionate*" that "*it's all our responsibility to spend public money where it is needed*".

In contrast others feared the information might prevent some people, particularly older patients, coming forward for help and feeling guilty about using services.

8.3 Breadth of service

Generally, the breadth of primary care services provided in the test sites was viewed as satisfactory. Worries were more likely to be expressed about local hospital provision, particularly where changes were perceived to be eroding this service, such as the reduction of beds and closure of wards. The availability of care home places was also highlighted in the Argyll pilot areas, particularly where it was feared older people would have to leave their communities in order to get a care home place. The lack of mental health services was a commonly reported concern across the pilot areas, particularly in communities where services and support groups were not available locally and access to both formal and informal service provision or support necessitated lengthy journeys. Participants often called for more visiting consultants to come to their areas, although they did not expect the same level of provision as in an urban setting and accepted access to healthcare services was necessarily more difficult and limited, as well as more expensive to deliver in a remote and rural area.

On Islay, concerns were raised about access to maternity, mental health, addiction and children/youth services. At the time of the Fieldwork 3 (April 2017) there was no longer an optician based on the island, although there was a visiting service. A long-standing problem with the dental service was also addressed during the duration of the programme with the appointment of a new dentist, although the perceived backlog of cases continued to cause concern.

Although travel to secondary care was not within the remit of the programme, the impact of time-consuming, stressful and costly journeys was raised routinely by patients and staff across all the areas especially when breadth of service was discussed. Suggestions included more visiting consultants, consultations via VC links, communicating results by telephone and an increase in local pre-operation checks/post-operation reviews.

At the time of Fieldwork 2 (April 2016) the revised patient travel policy was still causing confusion and dissatisfaction among community members on Islay with mixed views over who authorised the mode of transport and whether any change had been implemented. Some community members reported that the policy had changed with patients being able to fly to secondary care appointments on the mainland if they wished to. However, a few were still unaware of any change and remained unhappy about the perceived

policy revisions on mode of transport and escort arrangements. During Fieldwork 3 (April 2017) interviewees thought the policy was operating as previously with patients being able to fly to the mainland for outpatient appointments if they wished. Some interviewees felt the high cost of travelling, use of resources and potential abuses of the system had been highlighted and it is understood that savings had been made.

Although Small Isles interviewees were very happy with the breadth of primary care, concerns were expressed about access to midwifery, health visiting and mental health services. It was understood that a formal complaint had been made by a patient on Eigg about midwifery at the time of Fieldwork 2 (June 2016). In particular, a lack of mental health and Community Psychiatric Nurse (CPN) services was raised because of the difficulty patients experienced attending regular appointments or support groups in Fort William. During Fieldwork 2 one resident (2C085) described a distressing experience trying to access mental health services following the recurrence of a problem raised in the first round of fieldwork. She found attitudes were "*really old-fashioned*". When she was away on the mainland, she could access a support group but said "*here it is just like a blank wall*". Additional visiting services had been expected by many residents as part of the new service model, but at the time of Fieldwork 3 (May 2017) it was still reported that these had been very limited so far with one-off or occasional visits from a physiotherapist, midwife and community nurse. A visit by a podiatrist did take place after Fieldwork 3. Interviewees who had understood these visits were to be part of the new model, expressed disappointment that, in their view, this element had not been fulfilled. A lack of clarity was evident about how such services could be accessed and the referral system was not generally understood amongst interviewees. The community dental bus goes to Eigg but not to the other islands where many residents would like similar access to dental services to avoid long and expensive journeys to the mainland.

8.4 GP recruitment

Although communities were largely aware of GP recruitment problems locally and/or nationally, the reasons were not necessarily widely understood. Factors cited include:

- professional isolation
- de-skilling

- the burden of long hours and/or out-of-hours work, not wanting to work 24/7: "*that type of doctor doesn't exist anymore*" (3D158a)
- the 'goldfish bowl' lifestyle within a small community
- lack of suitable employment for a spouse
- rural lifestyle (e.g. access to services like shops & entertainment); "*it's like a dying thing to live rurally*" (2B132a)
- not good career start for young doctors
- lack of healthcare support services (e.g. secondary care), transport and infrastructure
- small number of patients
- relatively low remuneration attached to small practice
- lack of accommodation (dedicated GP houses sold off)

According to one interviewee (3D117) it is necessary to look at the "*whole spectrum of needs*" from housing to schooling if trying to attract a GP and this requires a "*joined up strategy*" encompassing the Highland Council and NHS Highland, which could apply to other professionals like teachers or dentists. Increasing remuneration was sometimes viewed as the key to recruitment. Two community interviewees suggested a remote 'weighting' (3D174) or 'allowance' (3D104) for the Highland area.

It was commonly said that living and working in a remote and rural area required a specific type or "*special kind of person*" (3D158a). For example, according to one resident (1A056) island life can have a lot of benefits, e.g. in terms of safety and lack of pollution, but "*it takes a certain person to be able to adapt to living on a small island*" with severe weather, lack of shops/services and potential social isolation, particularly for young mothers.

However, other interviewees could not understand why a GP would not be attracted to their rural community which they characterised as an attractive location offering a good quality of life. Having a smaller practice than in an urban area was believed to be an attraction because a GP could spend more time with patients, "*practising better quality medicine*" (3D174). A few community interviewees did not accept the reasons given by NHS Highland and thought insufficient effort had been made to attract the right person to their particular area. For instance, one interviewee (3D104) asked if it was true that rural places were not attractive to professionals, describing this as "*something they throw out there*". In Kintyre, some interviewees criticised the length of time taken to advertise the GP post and believed the

short-term contracts being offered in Kintyre Medical Group were a disincentive because GPs would be drawn by a permanent post. However, a professional interviewee (2B037) thought younger doctors did not want permanent placements but preferred to move around to different locations early in their careers. She said GPs were looking a "*flexible career path*" (2B037) offering job satisfaction and allowing creativity. Similarly, another professional (3B177) believed only a few wanted the security of a partnership and that the extra responsibilities of partnership and financial management were not attractive to younger doctors.

Reasons given for successful recruitment by practices included networking with universities, developing as a teaching practice, the Rural Fellow Scheme, increasing remuneration, promoting challenging and interesting work, quality of local hospital facilities, fostering a multi-disciplinary team approach and the availability of dedicated GP training. Becoming a teaching practice was seen as important in maintaining enthusiasm, professional interest and skills. Views were mixed over the impact of the Being Here advertising campaign and website with some indicating that professional networking was more important in sourcing applicants; whilst others thought it had helped by significantly raising the profile of rural GP practice across the country. According to one professional there was only one applicant for a salaried GP post to do non-out-of-hours work in his practice and he did not think the Being Here advertising campaign had been a factor in attracting the candidate (2B017). He believed the applicant had accessed the vacancy via a conventional advertisement in the British Medical Journal (BMJ) and he thought doctors generally are looking for different ways of working that fit into their lives. In the view of another, networking and social media had had a bigger impact than the advertising campaign (2B003).

Other NHS managerial level interviewees believed the advertising campaign had been successful and thought the Being Here programme had enabled practices to recruit by offering competitive wages combined with a reduced on-call commitment (2F137). However, one of them added that he thought it was difficult because there were few GPs with the range of requisite skills for rural GP practice. In addition, he thought there is a general perception that community hospitals largely offer rehabilitation rather than acute services. However, Campbeltown and Lochgilphead can both cater for acute services and only transfer where necessary. He also believed the Rural Fellow Scheme was making a contribution to recruitment and retention. In his view recruitment of the wider multi-disciplinary team personnel is also crucial and that "*whole service sustainability*" should also be addressed (2F137).

Professional interviewees, who had been recruited in recent years, often said they had been actively seeking rural work when applying to join their current practice and were not influenced personally by the new Rural GP website or advertising. A professional expressed frustration that advertising campaigns have focused very heavily on "*come and live in a beautiful part of the world, go hill walking every afternoon*". The interviewee believed this targeted the wrong kind of applicants and not those who are going to come and create a sustainable high-quality service. In this interviewee's view they should be promoting exciting medicine and professional development opportunities combined with team working, teaching and training:

"*You won't get to the beach very often, but you are going to be the type of person who is committed to making the service work for the benefit of patients*" (1A051a).

Another felt the recent advertising campaign had been one approach but it should not be the only one and the return on investment should be examined (2B037).

Outdoor recreational opportunities were an attraction for certain individuals, but this tended to be secondary to job satisfaction amongst existing professionals. Professionals tended to highlight the attraction of the challenging, interesting and varied nature of the rural GP workload which allowed them to spend more time with individual patients. One said it was not the lifestyle that attracted them but the fact the work was more rewarding. It enabled more time to be spent with patients and more of a partnership to develop when managing their conditions (3D173). Having a team-based practice with a larger pool of GPs was seen as an attraction in the view of professional interviewees because the burden of out-of-hours work was reduced and any fluctuations in GP numbers could be tolerated more easily.

Working rurally demands an extra skill set and appropriate training according to professionals. In order to ensure these skills are kept up to date, Islay Medical Services have introduced a training system to enable the GPs to work in Glasgow secondary care for up to two weeks a year. The GP training organised by the Lochgilphead practice for rural GPs was also highly praised by professional interviewees. It was felt that a rural GP is expected to undertake a greater number of tasks without the immediate support of nearby specialist doctors or nurses (3B177) or an ambulance in the vicinity. Rural GP skills are extremely important because GPs are effectively on their own for longer with a patient.

The recruitment problem could not be solved entirely by GPs themselves according to one interviewee (2B037). Professional support and "*visionary and visible leadership*" were critical in attracting medical students. In the view of this interviewee it was not all about geography but also about culture. Training, professional support and a network to avoid professional isolation were essential elements (2B037). A different interviewee also thought changes to pension arrangements were having an adverse effect on GP retention (2B003).

Exposure to rural medicine was seen as key to recruitment whether though electives or as a Rural Fellow. One suggestion was that trainees needed to be reached before final exams (3B176). Rural working was described it as a "*big jump*" (3B177) but rurally located training and electives were a good opportunity to experience the issues of working in rural area. Some interviewees thought a rural element should be made obligatory. Islay Medical Services held an event for 60 medical students to get to know the island and introduce them to rural medicine in 2017.

Amongst professional interviewees out-of-hours was not necessarily a disincentive (3B177). For example, manning both out-of-hours and daytime practice ensured continuity of care which was an attraction, although the out-of-hours rota had to be fully staffed (3B176). Having a larger team to share a rota and enable time to be taken off after being on call helped to ease the out-of-hours burden according to one interviewee (2B017).

The need to attract suitable candidates from rural areas to medical education via earlier promotion at secondary school was highlighted. Limitations, such as the range of subjects available at some rural schools, was put forward as a potential obstacle to entering medicine.

Rural primary care should be promoted as an interesting, dynamic and flexible career choice according to professional interviewees. The status of GP practice needs to be higher and more valued by those running the service as well as other professionals (3D173). Rural GPs work long hours, partnership income has fallen and a lot of the work GPs do is not easily measurable (3D173). This ethos of 'only a GP' pervades secondary care. Another thought the "*bad press*" (2D103) about GP practice in hospital should be countered and the message conveyed that being a GP is more attractive, dynamic and varied than it used to be.

According to a professional (3D173), community members did not always understand how being a rural GP had changed over the last few years with an increase in workload due to demographic change and increasing life expectancy, resulting in complicated cases such as frail older patients. In addition, clinical improvements enable increased survival rates for heart attack and cancer patients. In their view, GPs are expected to manage more complicated cases than in the past and this change means team working and up to date training are essential (3D173).

Although several practices had successfully attracted new GPs during the programme, recruitment remained a concern for both patients and professionals who worried about future staff turnover and GP retirement. The issue of filling vacancies in the wider multi-disciplinary team was also raised, although GP recruitment was largely regarded as the main problem.

One of the professionals (2C025) had doubts about long term sustainability foreseeing a deepening recruitment crisis with substantial knock on effects. This interviewee did not see this currently being tackled with what were believed to be "poor" initiatives and did not think doctors choosing a remote and rural stream at university would be enough, given the number of doctors due to leave in the next the three to five years. In this professional's view, the GP contract should be changed completely and entry requirements into medical school should be altered to allow medical training to be more accessible for people from rural areas.

8.5 Practice model

Interviewees already registered with larger team practices were on the whole satisfied with their primary care services. Although choice and continuity were valued, interviewees were generally willing to see any available GP if they were suddenly very ill. In communities with a smaller local practice or resident single-handed GP, interviewees were less likely to perceive that there would be advantages in becoming part of a wider GP team (especially if they feared it would be associated with their local surgery closing). For them, proximity to and a personal relationship with one GP remained the key to safeguarding service safety and quality. Although some thought that a single-handed GP was no longer a desirable model for the doctor or the patient, there was still a feeling that a single GP got to know you and your family, establishing a relationship which enhanced patient care. A strong desire to keep a GP resident in the local community was evident to varying degrees across all the pilot areas, because it made people feel more

secure and reassured in remote communities. However, at the same time, interviewees were generally in favour of a wider multi-disciplinary team approach in their practice and willing to see other professionals if appropriate. A team model comprising a Healthcare Assistant and a Practice Nurse in addition to a GP was widely accepted by community interviewees in all pilot areas with access to a local multi-disciplinary team. On the whole people were happy to see a Practice Nurse or Healthcare Assistant if they felt it was appropriate rather than a GP e.g. for taking blood. However, interviewees did not always understand the different educational levels reached, training undertaken and responsibilities of the various professional healthcare roles. This could be fairly easily addressed through the provision of more information to the public on different healthcare roles, with the potential for this to give reassurance. During the programme, the increased use of Advanced Nurse Practitioners also seemed to be accepted generally. In Acharacle Advanced Nurse Practitioners replaced out-of-hours locum GPs to a large extent and had started taking clinics if a GP was away for a day e.g. study leave. It was not envisaged this would happen to cover longer periods like annual leave when a locum would still be employed as necessary. In Furnace it is also understood that an Advanced Nurse Practitioner now runs a weekly clinic on Thursdays instead of a GP.

Patients do not always demonstrate an understanding of the practice structure or workforce planning and ratios. For example, one interviewee (2D157) thought a team of eight GPs was required to man his local practice where there were currently 1.75 WTE GPs, although professional interviewees did not identify a problem with the workload in that area.

8.5.1 Kintyre – proposed practice merger

In both Kintyre and mid-Argyll people readily accepted a team model comprising a GP, a Practice Nurse and potentially a Healthcare Assistant, but they did not generally perceive that a larger team of GPs offered any advantage over a small or single-handed practice in terms of service quality. Although most believed that a single-handed model was no longer practical, they generally preferred a small practice with two or three GPs rather than a larger team. In spite of the recognition that it was not ideal for a GP to work '24/7', a few still believed this traditional system worked better for the patient. In Carradale where a single-handed GP model was still operating, there was a high level of satisfaction with the quality and responsiveness of the local service. Continuity of care was prioritised by patients and viewed as a fundamental quality safeguard with a high value being placed on a GP who knew them well, particularly

if they had a long-term illness or mental health condition. Knowing a patient's history and family background was believed to be key in maintaining a safe service.

NHS staff saw the merger of the Kintyre Medical Group and Campbeltown practices as a potential improvement which would be more attractive to new doctors by delivering a more efficient, safer service with dispensing provided by a pharmacist and smoother referrals/transfers to Glasgow hospitals because the GPs were more familiar with the necessary processes and systems. This view was shared by very few community interviewees with the majority opposed to the merger because of concerns voiced in both Fieldwork 2 (September 2016) and Fieldwork 3 (April 2017) as follows:

- The local surgeries would close – "*part of the heart of the community is to have a good doctor near at hand*" (2B119).
- Patients would have to go to Campbeltown to collect prescriptions. Doubts were expressed over the ability of the Campbeltown pharmacy to meet the extra demand created by the takeover.
- Lack of continuity of care with a team of rotating GPs.
- Lack of public transport – especially difficult for older people who do not drive to get to Campbeltown.
- Reduction in home visits.
- Availability of appointments – high level of satisfaction with current availability in Kintyre Medical Group.
- Impact on local nurses.

Although many interviewees were aware of assurances given by NHS management that the surgeries would not close and the medication would be delivered from Campbeltown, these assurances were not necessarily believed to be reliable. Only a few could see any advantage in the move, suggesting greater choice and the increased availability of GPs as potential improvements. A minority could see an advantage in having a bigger pool of GPs and wider expertise, but generally they did not think this outweighed the apparent disadvantages. They expressed the belief that all doctors are trained to the same standard and, therefore, there is no advantage to having access to more than one doctor within a larger team. In addition, they felt that if a single-handed doctor came across something that they were unsure how to deal with, they would refer the patient on to a specialist and, thus, there was no need for a large team of GPs with different professional experience. They saw no point in having a wider team of GPs if the patients

themselves did not know what their different expertise was and how to access it. Community interviewees valued their existing service, believing they received a better, more attentive service than in urban areas and they were worried that this high-quality care would be eroded by a practice merger. One interviewee, for example, was critical of what he saw as the lack of attention in larger practices:

"*In bigger practices that's what you get, in the door out of the door, in the door out of the door. It's all volume, they have to tick boxes*" (2B126).

In his view, rural areas are different. Their local system worked for them and there are "*some things that cannot be modernised*". Another patient expressed her sense of the underlying community value embedded in a local surgery:

"*We also have to accept we are old people set in our ways and it's very nice having our own little surgery. It is quite a social centre and you see everybody*" (2B136b).

This interviewee identified the local surgery as a focal point for her community, which held value beyond the clinical services provided. Other interviewees also feared the potential impact on the viability of their communities if local surgeries were to close. As seen in the section on sustainability above, community sustainability was commonly linked to maintaining mainstream services and a viable community was characterised as being 'composed' of key professional roles e.g. doctor, teacher.

8.5.2 Mid-Argyll – takeover of Furnace & Inveraray by Lochgilphead

In mid-Argyll, where a GP practice merger had taken place in 2015, residents were on the whole very satisfied with the quality of primary care and some thought it had improved as a result of the takeover. However, the concerns expressed by some interviewees remained largely unchanged since Fieldwork 1 (September 2015) as outlined below:

- Fear of the closure of local surgeries in the longer term
- Impact on the ageing population, many of whom do not drive
- Perceived lack of continuity of care

- Lack of understanding of appointment system and GP rota - "*I presume in their eyes it's not random but to me it appears totally random*" (2B065)
- Difficulty getting appointments – having to phone each morning for an appointment rather being able to make one in advance
- Lack of communication from NHS and lack of GP engagement with the community.

As with Kintyre interviewees, the potential advantage of a 'pool of expertise' was not necessarily accepted by patients. Although some accepted that a single-handed GP was no longer a satisfactory model, there was still a feeling that a single GP got to know you and your family, establishing a close relationship which enhanced patient care. A few accepted that the expertise might be there, but they questioned how a patient would access it. While some patients did not report any problems accessing a preferred GP even if this meant waiting longer, others found the system difficult to navigate and reported being told by reception that they had to phone up at 8am each day rather than make an appointment in advance. Lochgilphead interviewees also commented on the perceived difficulties with the appointment system. At the time of Fieldwork 2 (September 2016) two interviewees described how they were told they could not make an appointment in person when they were at reception but had to telephone instead. It was reported that patients in Furnace and Inveraray were not yet able to make appointments in Lochgilphead to fit in with their work. The impact of the merger on appointments in Lochgilphead was highlighted by a professional who believed Inveraray and Furnace were getting a "*gold star service*" which protected continuity (2B003). Complaints about the appointment system were a cause of frustration to the practice as they felt the rota and procedure had been explained to patients (2B003). A letter from the Practice Manager explaining the appointment system for patients was available at the front desk.

The service provided by the Inveraray pharmacy was also raised as an issue, particularly the opening hours. During the course of the evaluation, the pharmacy changed hands and there were expectations that the service might be more flexible in the future. It is understood that an Advanced Nurse Practitioner now covers a former GP clinic on a Thursday. The Lochgilphead practice introduced a new telephone system in May 2017. A patient now calls the practice, outlines the issue and a GP or Advanced Nurse Practitioner phones them back. If the issue is not dealt with over the phone, a face to face appointment can be made. It is understood that concerns have been raised by the Lochgilphead Community Council about the new system e.g. some reluctance to disclose information to receptionists.

8.5.3 Islay

On the whole interviewees were positive about the re-organisation of primary care and the quality of care provided by the new service, which was considered to offer both a sense of continuity and an element of choice. For example, one resident commented at the time of Fieldwork 2 (April 2016):

"*I just think there is a really good buzz about the medical services and I think that is really good. They are thinking of the community a lot more I believe*" (2A138).

It was understood that there is only one GP on duty on any given day in each surgery, but at least two different GPs cover the same surgery during the week. Although patient interviewees were uncertain about how the rotas worked, they were mostly confident of being able to see the same GP. The practice was still subject to persistent IT problems, by the end of our fieldwork data collection period, which meant it was still difficult for a GP to access patient notes at different surgeries.

Although having a larger pool of clinical expertise and potentially a second opinion was generally recognised as an advantage, patients commonly expressed the wish to see the same GP. Continuity of care was given as an advantage of the former single-handed GP practices, but the majority of interviewees reported having no problem seeing the GP of their choice. Generally, residents liked the potential flexibility of being able to visit any of the three surgeries, but persistent IT problems have prevented further practice integration. General satisfaction was also expressed with out-of-hours services. Having a GP on duty at the hospital was welcomed as an improvement. Transport to the hospital for frail older patients remained an issue.

Although interviewees were generally happy to see practitioners other than a GP, when appropriate, some concerns were expressed by a few patients about a perceived reduction in the number of Practice Nurses. Formerly one Practice Nurse was attached to each surgery whereas now the three surgeries are covered by a team comprising a specialist Diabetic Nurse, Health Care Assistant and a Practice Nurse. Workforce planning was seen as a key element by the practice in ensuring an efficient service (2A051c). However, the interviews suggested that greater explanation of the new roles and the training required for each of them would help to reassure patients about the function of new staff.

8.5.4 Small Isles

On the whole, interviewees were very satisfied with the quality and breadth of the GP service. Having a team of GPs offering a choice to patients as well as a wide range of experience was seen as an advantage of the new system. It was widely believed that continuity of care had been restored and that the new GPs had got to know patients. Attitudes to the service were generally very positive and the GPs were well liked. Many interviewees understood the issues of GP recruitment, skills maintenance and professional isolation. A large number across all the islands thought service quality had improved following the changes and initial concerns about the GP service had largely been allayed. For example, one resident described how early fears had been overcome:

"*It is an improved system. For the people on Eigg it was a bit of a scary move because we were used to having a doctor actually on the island whereas the other islands had never had that. So it took a bit of getting used to. It was a bit scary at first to think we hadn't got a doctor on tap … but I think, now we have got over that, I think the service is really good*" (2C086).

In general patients saw the following factors as positive about the new practice:

- Choice of GP (also the availability of a female GP)
- GPs have wider clinical experience coming from a bigger practice
- GPs work as part of a team and not in isolation
- Quicker referral to secondary care
- Efficient appointment system managed by the Small Isles Surgery Practice Administrator

Coming from outside the community was also deemed to be an advantage by many interviewees:

"*I can see the benefit of where a GP is seeing a wider range of people, a wider range of illnesses, different situations. Whereas I think maybe if they were just stuck on Eigg seeing the same people over and over, it might be a bit stagnant for them. I think maybe the GPs are a bit sharper coming from a bigger surgery with a bigger range of patients*" (2C146).

Being a larger practice was seen by some as a factor in creating sustainability. The service was generally believed to be sustainable with NHS budgets and GP recruitment judged to be the biggest threats. At the

time of Fieldwork 2 (June 2016) very few interviewees still called for a professional to be based on the island. These interviewees tended to envisage a system of rotating nurses or locum GPs even if only to cover the winter months rather than a permanent resident GP. However, although the change was generally accepted and interviewees felt more secure about the future of their service, there was still a feeling amongst some interviewees at the time of Fieldwork 3 (May 2017) that having a GP or other professional resident on the island would always be preferable and would take the 'burden' of the new roles and responsibilities away from residents. The management of the practice was widely praised, as was the dispensary and prescription service. At the time of Fieldwork 3 the Practice Administrator had recently won, and been presented with, a Highland Quality Award for her work. The emergency medication stores were generally thought to work very well; although on Rum there was uncertainty expressed over the most appropriate key holder. During Fieldwork 2 some patients felt they would like more detailed information from the practice. For example, it was suggested that practice e-mails to patients should give an outline of any attachments, so recipients were made aware of the contents. Updating the '*Making it work together*' information sheet, which outlined which healthcare service to contact in a given situation, was also suggested.

Very few discussed any potential burden of the takeover on the Broadford practice (2SI22). One resident could imagine the new service putting a lot of strain on them and thought they were probably overworked:

"*Although it's kind of a minimum service for us, it is probably quite involved for them*" (2C150).

Many preferred the salaried practice in Broadford to the take-over by the Mallaig practice proposed initially. However, a very small number of interviewees thought a link with Mallaig would be preferable as they could visit the surgery using the scheduled ferry. For example, an interviewee remarked:

"*Broadford may be … 30 miles as the crow flies but it feels like 150 … because it is not just somewhere you relate to*" (2C085).

A few people raised the issue of communication between the GP practice on Skye with other services like community nursing, midwifery and health visiting which are based in Mallaig or Fort William.

During Fieldwork 1 (October 2015) and Fieldwork 2 (June 2016) interviewees reported that the reliability of the GP boat had been poor, especially during the winter months. Although many believed that the service had improved at the time of Fieldwork 2, they found it difficult to assess the extent to which the

improvement was due to a temporary change in contractor or the seasonal change in the weather. However, most residents believed the boat contractor and the type of boat were factors in its reliability. At this time many interviewees were aware that the contractor had changed but did not know what the long-term outcome would be. One of the subsequent evaluation recommendations was that there should be community input into the forthcoming tender process in order to harness local knowledge about the island conditions and service requirements. If the boat was cancelled, then many patients wanted to see a contingency plan with greater flexibility e.g. visiting on another day or the following week. Interviewees appreciated any occasional flexibility already demonstrated.

At the time of Fieldwork 3 interviewees thought the change of contractor in 2016 had improved reliability. The temporary contractor operating at the time of Fieldwork 2 was awarded the new two-year contract from December 2016. The availability of an ex-lifeboat, capable of tackling almost all weather conditions, was deemed to be a significant improvement by professional and community interviewees. The fact that the community had input into the latest tender process was also welcomed.

8.5.4.1 Surgery space

The newly renovated health centre on Eigg (opened formally in May 2016 at the Health Fair) was welcomed by residents. However, on the other islands it was not generally envisaged this new facility would be available for them, given the difficulty taking ferries from island to island under the current timetables. Travel between the islands in one day is not routinely possible. As one interviewee commented:

"*With the best will in the world, most of it is being run by and for the people on Eigg*" (2C025).

However, at the time of Fieldwork 3 (May 2017) the GP boat had picked up two patients from Muck to see a GP and a visiting consultant on Eigg. This capacity has been built into the new boat contract. Although the new surgery was widely appreciated, concerns were raised during Fieldwork 3 by a few residents over the recent decision not to allow an alternative therapy practitioner to use the building (which raised issues over 'ownership' of the building). The community was also interested in taking over the old surgery building and it was understood that options were still being explored as the evaluation was finishing. The other islands do not have dedicated or purpose-built surgery space. Although many residents were happy to see the doctor in their homes, it meant he/she has to carry equipment and this could be difficult as there was not always transport available to go from house to house. At the time of Fieldwork 2 (June 2016), the GP saw patients in a meeting room at the community hall on Muck.

Interviewees highlighted the lack of privacy as the room had double glass fronted doors and there was nothing to stop other residents or visitors coming up the stairs and entering the space. Waiting patients could also hear what was being said between the GP and patient. At the time of Fieldwork 3 a very small alternative space, previously used as a storage cupboard, had been adapted to be a more private and soundproof consultation space which also enabled the secure storage of health-related equipment and the emergency medication supply. The conversion was regarded as a great improvement, but concerns were still expressed that the area was not sound proof. On Rum, no progress had been made on a dedicated consultation space by the time of Fieldwork 3. Home visits were preferred by some interviewees, while others thought a surgery space would be an improvement and a good community resource which could potentially house a VC facility and enable the provision of publicly available information and advice leaflets. As one resident commented: "*I feel that the fact that we haven't got a surgery space now is a step backwards*" (2C072). On the whole interviewees did not know how this issue could be addressed, but, during Fieldwork 2, the potential for using the former teacher's house (or part of the building) was suggested as an option that would need to be negotiated with Highland Council (as the owners of the building). Another plan to build a combined environmental and visitor centre was outlined, which could potentially house designated surgery space (2SI17, 2SI19). At the time of Fieldwork 3, it was understood that the former teacher's house was not suitable because of the current condition of the building. However, it might be possible to include a consultation space within a newly proposed development which could include new housing and a building associated with a possible fish farm business.

During Fieldwork 2 Canna residents outlined long term plans for a community building which could contain a surgery space. Interviewees thought the community building could have a role in providing health information and enabling community events which would enhance residents' health and well-being. However, issues with funding and land ownership, which prevent the release of the proposed site for community use, remained unresolved during Fieldwork 3 and plans were currently on hold.

8.5.4.2 Health & social care support workers

Community interviewees were generally open to the idea of the new role and felt positive about it strengthening community resilience, but uncertainty over confidentiality and accessibility remained during the programme. At the time of Fieldwork 3 (May 2017) most interviewees had not needed to access the workers and knew very little about their remit or referral process. Understanding of the new

role would be enhanced if patients were made more aware of their training programme and any obligations about confidentiality. However, workers found it hard to explain their role because of the danger of breaching confidentiality by describing what tasks they had carried out for patients (3C028). Little awareness of the new role was evident on Rum and Canna even at the time of Fieldwork 3. Some interest was expressed in the role but there were concerns over community capacity, trust and the lack of anonymity especially given the lower populations on these islands. For example, one resident (2C148) was unsure how the role would work in a small community consisting of a limited number of families, necessitating treating your own relative and friends. For him it was a good idea in principle, but it would depend on the extent of community acceptance of the new role. Similarly, another resident said although it was useful to have someone carrying out some of these tasks, it was not the kind of relationship she necessarily wanted with a neighbour or friend:

"*We're such a close community … it's not that kind of relationship that I want to have with anyone*" (BSI36).

According to another resident (2C071b), it was the next generation that should be educated to accept the new role because there were people currently on all the islands who would never adapt to it. He felt that the new role would be more acceptable to new residents than those who had been resident on the island for a number of years. He suggested that there are some people who will never be comfortable with this new kind of service delivery and felt that the measure of success should be whether it would work in 20 years' time.

On the whole the workers were very satisfied with training and support, but there was an apparent lack of clarity over the patient referral system. The link with the Rural Support Team in Broadford was appreciated. Skills maintenance was a concern as the workers were not widely utilised even at the time of Fieldwork 3. Accessing statutory training away from the islands and poor broadband were cited as barriers.

8.5.5 Acharacle

On the whole, views were very positive about the two current GPs and the quality, breadth and sustainability of the service. Although the practice is based in Acharacle, regular surgeries are held in Strontian and Kilchoan so these communities still retain a GP presence. During Fieldwork 3 (June 2017)

some interviewees reported it was more difficult to get an appointment than previously. According to one, having to wait longer for an appointment must mean that an increase in GP time (i.e. additional hours on the post) was required. Having a car, she was happy to go to Acharacle to be seen more quickly rather than wait for an appointment in one of the outlying surgeries (3D105). Although distance from the GP was not generally a concern for the interviewees who could drive, the lack of public transport on the peninsula was a commonly reported issue. The current level of 1.75 GPs was deemed highly sustainable by professionals (2D103, 3D173), but certain community interviewees thought the service required two full time GPs as previously. One thought the service must be understaffed in the belief that eight doctors were required to run the practice (2D157). Another believed the service was "*stretched to the limit*" necessitating an additional GP to alleviate the stress levels of current GPs (2D104). According to professional interviewees the team model makes the practice more sustainable because it is no longer reliant on one or two individuals. One said the primary care team was working together to an "*old - fashioned recipe*" with the GP at the centre and other health care professionals alongside including Social Work and the third sector, describing it as "*absolutely wonderful, exhilarating, fantastic*" (2D103). Developing as a teaching practice also provided a stimulating and engaging opportunity for practice staff. The success of multi-disciplinary team-working and anticipatory care planning were viewed as the key to managing and reducing out-of-hours cases.

In Kilchoan, community views that the local community nursing service had been changed tended to be driven by expectations and perceptions about the scope and character of the former service, which revolved around a resident professional seen widely as available whenever needed. Calls were still made for a nurse to be based in the village (3D104). One interviewee said in his view a resident nurse was required (3D158a); while another asked, "*what is wrong with having people in the village*?" (3D157) rather than at a 'hub'. The community nursing visits to Kilchoan had been reduced from twice weekly to once a week in-line with patient demand. Since the Fieldwork 1 (November 2015), the Health Visitor/School Nurse had experienced difficulties with the withdrawal of the NHS pool car, particularly given the increase in workload due to the introduction of the Universal Health Visiting Pathway (2016) which necessitated more home visits across a large geographical area.

The Rural Support Team was described as such a "*changing machine*" by one professional participant because of experiencing the high turnover of clinical and management staff while, at the same, time having to test out what works and what does not work within the new model (3D103). Issues with

communication between management and staff on the ground were raised by some professional interviewees.

8.6 Professionals: MDT, support and training

The majority of professional interviewees were very satisfied with the accessibility and availability of training. Effective multi-disciplinary team-working was viewed as central to preventing professional isolation. However, Health Visitors were more likely to express concerns about integration of NHS and Social Services, professional isolation and lack of inclusion in primary care multi-disciplinary team meetings. The Lochgilphead GP training was highly valued and the need for rural GPs to have a wider skill set was highlighted.

8.7 Communication & consultation

This theme encompassed four distinct areas:

- **routine communication from the GP practice** e.g. opening hours, closures, appointment of new staff
- **strategic level engagement** - GP engagement in community/local development planning
- **public engagement and consultation** with the community about fundamental changes to service provision
- **communication between management and staff** on the ground

Since Fieldwork 1, improvements in communication were reported in Acharacle (between the community and practice) and in the Small Isles (between the community and NHS Highland) over the course of the programme, but a lack of effective communication with GP practices and/or NHS management continued to be reported in other pilot areas. Community interviewees talked about how this has hardened their opposition to service change by creating frustration and disillusionment with the NHS public engagement process.

8.7.1 Communication with GP practice

Primary care practice staff and community members often had differing views on the types and amount of routine communication that were necessary. Changes to, for example, surgery opening times, were

most likely to be publicised on surgery noticeboards, in local papers or on practice websites. However, community interviewees often called for additional information such as introductions to new staff and an explanation of different roles; particularly if the practice had undergone significant change. For example, one interviewee (3D105a) described how they would like to see photos of practice staff in the surgery alongside their title and a brief outline of their role. A few thought letters to patients would be an ideal way to convey changes if practice numbers were small. Some interviewees were prepared to give their feedback directly to the GP or practice staff if they were not happy with the service. One of the interviewees thought his local practice was very defensive with "*an aura that you can't complain*", regarding feedback as a threat rather than as an opportunity to learn (2A052). The increased workload for practice staff involved in producing newsletters and other communications was raised as another pressure put on practices (2B003).

Of all the Being Here pilot sites, only Carradale had a formal Patient Participation Group. Islay Medical Services had attempted to set up a group but practice staff reported that there had been very limited interest from the community. One interviewee was wary of "*interfering*" but thought it would be useful to have a means of expressing concerns in order to reduce the chance of practice staff being unaware of community concerns. She thought "*if people meet regularly, it breaks down barriers*" (3D105a). However, she also acknowledged that it would be something extra for medical practice to deal with but she thought a patient group was the way forward, believing it would "*settle*" people if they felt their concerns were being heard (3D105a).

8.7.2 Strategic GP engagement

Opinion was divided amongst community interviewees about the extent to which GPs should be actively involved in community engagement and whether GPs and/or Practice Managers should go to local meetings such as Community Councils or Locality Planning Groups. Although the majority of healthcare staff interviewed thought that good communication with their practice population was important, it was sometimes expressed that it was not part of a GP's role to attend such meetings (3D112). On Islay, members of the practice team had attended a community group for older people to answer questions about the re-organisation and this engagement was reported as a great success. However, across the sites, professional interviewees did not necessarily see a need to involve the community in developing services or communicate with patients on a regular basis. In the view of one interviewee (2A051c), there

were some things a practice should be able to change without consultation and GPs have to weigh up the time taken to travel to and attend community meetings with the benefits that may arise from their attendance. Similarly, another (2B003) did not think GPs had the time to attend meetings given the demands of their clinical work.

One example of a community residents' dissatisfaction with communication related to a perceived lack of wider community engagement from her practice:

"*I don't know who or what within the practice is blocking this. Their interaction with the community is appalling at every level other than the one to one*" (2B065).

In the practice area in question, following a re-organisation of services, the Community Council had attempted to contact the local practice to invite GPs to meetings to establish "*a line of communication*" (2B123) in order to feedback to the practice and give them an opportunity to communicate with their patients. However, GPs did not feel they had the time to attend such meetings when they were struggling to cover clinical time and feared being a "*punch bag*" for complaints (2B003).

GP engagement with the community was advocated by one interviewee as a means of understanding the subtleties of how people feel about services. For him, a reluctance to engage and communicate represented "*an era which is 10 years out of date*" (2A052). The importance of community engagement and having a two-way dialogue was highlighted by a professional interviewee who believed it was key to learning about the community and ensuring that "*at least people know you are listening*" (2B037). In the view of this interviewee it was important to explore different ways of communicating and meeting the community helps because "*you see people as people rather than patients*" (2B037). This level of GP engagement was unusual amongst the professional interviewees who tended to think it was not part of a GP role; that they did not have time to do it on top of their clinical workload and that there were other channels for feedback. In the opinion of one interviewee, smaller practices did better than larger ones at local engagement because they saw themselves as part of the community as opposed to a service provider for the community (2F137). He thought larger practices responded to patient surveys but did not necessarily see the patients having a role in influencing how the service should operate. In his view the potential benefit to GPs should be an increased level of patient satisfaction as long as they responded to feedback.

8.7.3 NHS public engagement and consultation

Lack of communication and transparency remained an on-going concern reported by interviewees in several communities especially when it came to wider service change, rather than surgery specific issues like opening times. In particular, interviewees in the Argyll sites routinely expressed dissatisfaction with the level of information from the NHS and criticised what they perceived as a lack of transparency and openness. One interviewee described his experience of trying to find out information:

"*In a lot of ways, it suits the Health Board not to say anything and work in the quiet like the way some big organisations do, 'this is going to happen, oh we did make it public' but you have to go and look for it. They could say they put it in their web pages or something. It's public knowledge but it's not actually*" (2B126).

Another community interviewee (3D157) remarked that he felt sorry for the "*messenger*", who he felt had the job of trying to make the community accept a change they did not want. He suggested that the NHS should be more honest and try to discover and discuss people's greatest fears. Community interviewees tended to believe a greater explanation of change would allay fears and counteract rumours, as outlined by one resident:

"*the more you communicate the less scary the change is and for the elderly particularly it is a scary thing. They have been used to all their life … to one doctor and then suddenly to be told you might see one of five. That is a scary thing*" (2A054).

Another interviewee outlined a similar view:

"*People don't understand what goes on behind the scenes and it could be explained to them and then there wouldn't as much apprehension and complaints*" (2A052).

This demand for explanation was highlighted by another community member who wanted the NHS to "*show people the workings out*" (2A056). In her experience people can be cautious, sometimes thinking the worst rather than the best if they are not informed about change:

"*people don't like to be treated like they're stupid and it is their service after all, so I think they have a right to know how things come about*" (2A056).

She believed consultation should be about empowering people and that failure to inform patients of key decision-making processes was patronising and disrespectful. Explanation of change and decision-making was regularly called for; so that even if an idea could not be taken forward, the public knew the reasons why:

"*If communities understand the reasoning beyond decision-making and planning, then that goes a long way to bringing us on board*" (3D114b)

Similarly, another interviewee believed the NHS has to "*prove in action that they are actually listening or explain why it's not possible to get what is being asked for, then it's much easier to come to a compromise. It's much easier to compromise if you are told 'you can't have this, because …*'" (3D104).

Community councils appeared to be one of the main sources of information for the public. One person emphasised the importance of 'taking the Community Council with you', keeping them informed and, if necessary, coming out to meetings (3D114b). Some community interviewees felt that open days do not necessarily work without the involvement of the Community Council or other community groups. Public meetings like the one on Islay about the travel policy (February 2016) and in Ardnamurchan about planned changes to out-of-hours services (May 2017) were cited as exemplars of good communication. However, it was generally felt public meetings were not always the best way to reach people.

8.7.4 Communication between management and clinical staff

Some professionals also highlighted a lack of communication from management outside their areas, particularly a lack of support with taking forward local ideas for improvement. For example, after local professionals had suggested a new service proposal, an interviewee felt "*their locally sourced and money saving idea hadn't been appreciated or even acknowledged*" (3D103).

8.8 Community involvement/co-production

Even in areas where community members felt relatively well informed about changes to their primary care services, they generally did not feel that they had been actively involved in the service development or change process. Most community interviewees felt 'consulted' but not actively part of a 'co-produced' service. Making changes to services in response to community feedback was not generally considered by community members to be active involvement or co-production in service design on their part. Dissatisfaction, frustration and uncertainty were expressed routinely about the extent of community influence on decision-making in all pilot areas, with final conclusions being imposed from 'outside'; equated in one community members' mind with NHS management writing policies "*in their ivory towers*" (2A052). During the evaluation the definition of consultation varied with differing views expressed by community interviewees on whether the aim was simply to inform patients or gather usable feedback and whether this feedback could or should be acted upon. The parameters of community engagement were not defined by interviewees, who talked in general principles about being informed, consulted or involved in services rather than outlining specific policy areas where they felt the community should be actively involved in decision-making. The level of community influence on policy-making which was achievable or required was not specified. Some interviewees expressed the view that community members had a 'right' to be involved in service design because they contribute taxes to the public purse and, in addition, have valuable local knowledge that could be used in the design process. However, others spoke more negatively about community members' involvement in design – believing most people to be ill-informed about service requirements, obligations and parameters and, therefore, unable to contribute meaningfully to service design. According to one interviewee, because patients pay for the NHS, they should have influence:

"*At the end of the day we are the people that fund it, it's for us. We pay their wages. I know that's an old cliché … they should be answerable to us. In a perfect world they would take into consideration what we think, what we actually want and need and tailor it round that way … in a way that's fair*" (2B126).

Greater community involvement and responsibility were also advocated by one interviewee:

"*For too long we've done things to the community and said 'this is how it is and this is what we are going to provide because this is what our boxes somewhere say we should provide'*" (2A053).

He believed that the legislation makes clear community engagement should not simply be an add-on or token gesture but should ensure that "*we should be doing things with people and listening to the people*" (2A053). Others felt the community could not have influence due to financial and strategic constraints. For example, an interviewee (3D174) commented that it would be nice for the community to have a say and should be kept abreast of what is going on, but it did not necessarily mean they were right in their response because they did not know what goes on behind the scenes. One resident felt that NHS Highland had tried very hard to make the new primary care service work in his area, but he did not think the community had played a role in developing the model:

"*The NHS … have done a very good job and have worked very hard at it but I think we've got what the NHS ultimately intended for us to have and I think that while they did a good exercise of appearing to listen to us, I'm not sure our input mattered awfully*" (2C083a).

One interviewee called consultations a "*sop to the community*" (2A050) and explained she felt cynical because, in her view, the acts of consultation carried out by various sections of the health service did not have a direct influence on any decisions or actions subsequently taken. Interviewees commonly complained about a lack of communication and 'token' community engagement in spite of being aware of health and care policies that call for consultation and engagement:

"*The so-called consultation process was a joke. They obviously did not either listen or, if they listened, they didn't pay attention to anything anybody told them … it was a tick box thing. You've got to with consult people … you consult with people and then tell them what they're going to get*" (2B068a).

"*You feel they have their agenda and they just go through the motions of having the odd meeting, so it can appear democratic*" (2B136a).

"*There is this feeling that the apparatchiks of the NHS are here to hand down the solution without us being consulted*" (2B134).

This interviewee went onto say, "*what they mean by consultation is you will be told what's going to happen*" (2B134). Although he understood change was very difficult to manage and was treated with

suspicion by communities, he was critical of the NHS portraying change necessarily as improvement, believing:

"*People in their minds know it isn't. It is a detriment. It is a way of saving money*" (2B134).

The association of service change and saving money was very common amongst community interviewees. A former Community Council member (3D114b) described his experience of consultation. He thought the Community Council had been informed to some extent but often had had to "*dig*" for itself and drive community engagement. He felt only partially satisfied with community engagement and thought the NHS would send staff members for meetings and would respond to correspondence, but not in a way that he considered to be pro-active. During earlier community discussions he felt change was "*done to them*" rather than in partnership:

"*That seemed to be coming down to us rather than being done in partnership with us*." (3D114b)

When it became obvious the first proposal about primary care provision (take-over of Acharacle primary care by the Mallaig practice) was not going to work, he felt the Community Council did a lot of pushing to move the process on in a different direction but there were long periods when nothing really happened:

"*They would come to us when they wanted us to do something or when they wanted input, but I don't think they were particularly good at keeping us informed of progress or lack of it*" (3D114b).

The importance of maintaining a dialogue was routinely highlighted by interviewees who wanted to be kept informed, even at times when the only message would be nothing is happening or changing. In the view of the same interviewee, the community is not an expert and has to rely on the NHS to communicate why they are doing things (3D114b). Describing the consultation process as a "*mixed bag*", he thought the NHS did get better at it over the last few years (3D114b).

In contrast another (3D158a) said community engagement had been inadequate, promises had not been fulfilled and the community had "*zero*" influence in the consultation:

"*It was one of these situations, 'I hear what you are saying but …'. And that will always be the case. We have no teeth. We cannot say we demand this … everyone put forward their views … within the financial constraints and all other constraints. I am sure this is how we've ended up where we are at this moment in time*" (3D158a).

According to another interviewee (3D104) the community voice was definitely heard but she did not know if it had any effect, believing what might look like 'acceptance' was in fact frustration and disengagement:

"[*The community] can't see that anything is going to change … we've been knocked … about so much and been ignored. It's more of a case everybody has been worn down … It's getting to a 'what's the point?', … it's a 'what's the point?' acceptance rather than it is fine … We accept that we live out on the edge here ... I get a wee bit fed up with folk saying, well you chose to live here. Some people didn't choose, they were born here … I came to work here …Yes, I chose but I was doing a service*" (3D104).

She thought consultation had been a 'tick box exercise' so that the NHS can say that they held public meetings. This view of acceptance was also shared by others:

"*It is a situation that has been forced upon us, accepting it is the bottom line definitely ... I don't think anybody would agree that it is the ideal situation but there is a level of acceptance that's human nature, you just wear them away*" (3D158a).

Another interviewee thought satisfaction with services was characterised by a lack of complaint rather than actively commenting on improvement. She associated community 'silence' with acceptance:

"*Communication is a bit better. I think people are more satisfied … when people are not as upset about something, everything just goes quiet. People don't come back and say well this is better. They just don't complain*" (2C102).

Some interviewees felt the NHS had listened and that their communities had been able to influence some aspects of their service model even if they had not been involved more actively in the change process. However, interviewees often found it difficult to give specific examples. For example, community protest did achieve concessions from the NHS about emergency provision in the opinion of one interviewee

(3D157). In Kintyre during Fieldwork 3 the example of resisting the change to fixed appointments in Southend surgery was given by one interviewee (3B131). Across the Small Isles the majority of interviewees thought they had had the opportunity to take part in consultations and to give their views. As one resident said, "*I think there was every opportunity for people to say what they thought and still is*" (2C149). On Eigg, interviewees generally felt communication with the NHS had improved over the course of the programme. However, opinions differed on whether their views had had any influence on NHS decision-making and what, if any, community suggestions had been taken on board. Examples given of community influence included the GP boat tender process, suggesting employing the GP boat more flexibly for patients' use and the use of the old surgery.

A few interviewees were not convinced that the community could ever have much of a role in service design and development. Caution was expressed by one interviewee who likened the Health Board having a meeting and inviting people to design their service with taking a child to a candy shop and saying you can help yourself, commenting "*you can consult about anything but … you can't just be given a wish list*" (2A051c). He added, "*they are asked so much for their input and comments and suggestions and with all due respect they don't know what they are asking for*" (1A051c). Scepticism was expressed by another: "*the idea that the community is always going to solve the problem is a bit naïve*" (1A051a):

"It's like la la land … everybody is constantly asked about what they would like rather than any concept of the whole thing costing some money or being a limited resource" (1A051a).

Other interviewees highlighted the need to manage community expectations within the context of a consultation:

"P*reviously we've gone to communities with a bit of a blank sheet and said what do you want and that turns into a discussion that maybe isn't as focussed as it could be or isn't as aware of the barriers and constraints that any new model has to work under*" (2D160.).

He thought building relationships with the community had been successful in helping to develop the service model in one particular area, but was uncertain whether this could be replicated in a number of communities given time and financial pressures combined with the rate at which GPs are reaching retirement. He believed there was a compromise between the extremes of telling people this is what

they are getting and giving them the budget to control. He did not think that either of those extremes would work:

"*To impose a model on a community that doesn't meet needs is pointless and to just give them the budget is to take away a huge amount of organisational support and knowledge and institutional and professional expertise that realistically the provision of good healthcare needs*" (2D160).

He pointed out the constraints on service management and planning, believing there will never be a perfect solution and there will be frustration on both sides:

"*The community will always feel to an extent that they've had something imposed on them because to an extent they always have because there are national standards which are quite important*" (2D160).

Although some thought the formation of a Small Isles Health Panel to facilitate communication between the islanders and NHS Highland was unnecessary because there was already a Residents' Association and the Small Isles Community Council, many were positive about the idea. However, at the time of Fieldwork 3 (May 2017) the proposed Small Isles Health Panel had not progressed. It is currently understood that a formal Panel will not be taken forward, but more informal lines of communication will remain open between members of the Residents' Association and NHS management. It will no longer encompass the wider west Lochaber and Small Isles idea that was initially envisaged. Monthly staff tele conferences still take place which include the Health & Social Care Support Workers and the Practice Administrator.

8.9 Community participation/responsibility

Encouraging wider public participation in service planning and development was frequently believed by many professional and community interviewees to be difficult unless the community perceived an urgent 'threat' to service provision e.g. changes to patient travel policy (Islay), changes to nursing services and emergency cover (Ardnamurchan), proposed practice merger (Kintyre). It was suggested that different communication methods are required to reach all parts of the community rather than just those generally characterised as the 'usual suspects' or 'same old faces'. Interviewees recognised that reaching all community members within a consultation can be difficult. One person remarked that there are people who shout about everything, but they are not always the people that need the service (2D118).

Consultation events were often criticised by those who did not attend them as being inconvenient due to location, timing, lack of transport or lack of notice. There was a call for more engagement with local community groups when organising consultation days or events and when disseminating information about change. The Islay meeting (February 2016) about the patient travel policy organised by the Health and Social Care Forum was very well attended and had been advertised successfully via the Islay community Facebook page, the Forum Facebook page, articles/letters in the local newspaper (Ileach) and Forum meetings as well as visits by Forum members to various community groups. General suggestions for improvement included the timing of meetings (to allow working people to attend), more publicity particularly in the local newspaper/on Facebook/signs in the surgery and more direct contact with local community groups.

Community engagement could always be improved according to a resident, but it was a question of being creative and finding different ways that work by gathering feedback in different ways e.g. open days or online surveys (2D159). For her community involvement was important in fostering a sense of responsibility:

"*There's always a danger that people just expect everything to be done for them, so I think the more people are encouraged to be involved and take a part in keeping it sustainable is always good*" (2D159).

Similarly, a different interviewee also commented on community involvement:

"*People are coming onto that sort of idea that if they want something to happen, they've got to make it happen. You just can't do it with money, they've got to get involved themselves*" (2D105b)

Views were divided on whether the communities could do any more for themselves with some believing they did all they could already while others thought more could always be done such as walking groups or First Responder Schemes. The pool of active people in the communities was felt to be relatively small and concerns about the burden of community roles were highlighted. However, some communities such as in the Small Isles and Strontian were very active in local service planning and community-led initiatives. It is understood that the Sunart Community Company (established 2005) has been successful with its community hydroelectric scheme and is also looking at options for developing village facilities like a community hub, jetty and heritage centre as well as building some affordable housing.

8.10 Technology

One of the aims of the Being Here Programme was to encourage an increased use of technology within healthcare in the test sites (see section on indicators). Expansion in telehealthcare and Information Communications Technology (ICT) are being promoted generally to increase the efficiency and sustainability of health care provision with the aim of reducing both service delivery costs and the stress and discomfort of long journeys for patients. During the Being Here evaluation there was little evidence of expansion in the actual use or uptake of technology in the test sites, even though attitudes generally remained positive towards Video Conferencing (VC) in particular. Increasing the use of VC was identified by a majority of the interviewees as an important factor in reducing costs, increasing patient choice and promoting sustainability of remote and rural primary care. Although travel to secondary care was not within the remit of the Being Here programme, it was raised routinely by interviewees across all the pilot areas by patients when discussing breadth of service and building community capacity. Interviewees were generally very positive about the potential for VC consultations, especially if it meant avoiding long, stressful and expensive trips to hospital appointments in Glasgow or Inverness. Patients complained about travelling for several hours for very short routine consultations such as post-operative reviews. Travelling to appointments also has an impact on work and caring responsibilities. Increasing the use of technology and subsequently reducing the time taken off work could contribute to the economic and social resilience of rural communities. It was suggested that a GP or nurse could do examinations or observations in the local surgery. Views were mixed about whether this would be a burden on GPs or not. Interview data suggested that existing VC facilities are underused e.g. in Eigg and Kilchoan, particularly for patient contact. Health care professionals tended to use VC for training or staff meetings to avoid the costs of travel with some professionals identifying an opportunity to seek specialist clinical advice and information. For example, a professional referred to the loss of a VC link with the paediatric retrieval service (2B017), a pilot which he had found extremely useful. The fieldwork visits found few examples of telehealthcare.

The Eigg VC link in the new health centre is one element of the new healthcare model on the Small Isles and aims to enable patient consultations at times when a GP visit is cancelled (e.g. due to severe weather) or unscheduled. Although patients are, on the whole, very positive and open about using the VC link, very few have actually done so and they remain largely unaware of how to access it. The facility could

potentially be used for out-of-hours cases and secondary care follow up appointments as well as for accessing mental health services, counselling and support groups. Residents on the other islands were also interested in setting up a VC link to the Broadford practice for their communities. Acharacle gives one of the few examples from the interviews of a more pro-active approach to increasing technology use. Local community nurses were investigating the possibility of accessing patient notes whilst out on home visits e.g. using an iPad with mobile Vision to enable them to update notes immediately. At the time of Fieldwork 2 (May 2016) it was understood they had asked management about sourcing iPads but not yet received a response. During Fieldwork 2 practice staff expressed interest in increasing telehealthcare and were also hoping to acquire a drug dispensing machine to be sited in Strontian. At the time of Fieldwork 3 they had tried to pursue this but had not been able to make any progress. However, at the end of 2017 it was reported that the 'pharmacy booth' was going ahead and would be housed in the local community library at the Sunart Centre in Strontian.

Throughout the evaluation poor Broadband connectivity and mobile coverage remained apparent barriers to further technological expansion as well as cultural and organisational factors as outlined below:

- poor internet and mobile coverage
- poor quality and reliability of VC link e.g. For example, a professional found it adequate to monitor other staff undertaking tasks but not of sufficient quality to examine a skin rash (2C025)
- logistics – the hospital consultant having to find a suitable time and space
- lack of hospital consultant buy-in
- relatively small number of rural patients to make a dedicated VC clinic viable
- lack of leadership at a strategic & managerial level to support and enforce the change.

A recent NHS Scotland report, 'The Modern Outpatient', outlines a new strategy to reduce hospital visits and make services more responsive and sustainable. Aiming to maximise the effective use of clinical time and improve consistency, it focuses on self-management, community care services, multi-disciplinary team working and the utilisation of e-health and digital resources. Promoting telehealthcare is a key element:

"*Reducing the need for face to face consultant appointments by, for example, optimising E-health and digital solutions such as supporting self-management, managing patients more remotely or reviewing patients in the comfort of their own home using online tools will be essential to providing care closer to the patients' home*" (p 3).

The strategy aims to make "*the default position to be that the Modern Outpatient is safely managed at home, or close to home – either by managing their own health or being supported by a member of the wider primary care team*" (p 5). Commitment 2 explicitly states "*Patients will not incur unnecessary inconvenience when accessing outpatient services*" (p 12) and the use of video consultations is specifically recommended (p 14). "Attend Anywhere" together with Health Direct Australia have been chosen to develop an introductory video clinic platform for Scotland. The strategy finds growing evidence to support the use of telehealth including VC for patients and professionals, listing advantages such as reducing hospital stay, reduced use of emergency services, improved service quality and access and decreased costs (p 33). During Fieldwork 3 interviewees were generally open to the idea of an 'Attend Anywhere' type technology and an 'Attend Anywhere' pilot was being proposed for the Small Isles, which was launched in November 2017.

Sometimes patients were unsure about using VC but remained generally open to having it as an option because of the perceived advantages. Reservations centred on differing levels of confidence with technology and the extent of patient choice about whether it was appropriate for their consultation. For example, one interviewee was in favour (3D172) as long as it was not the only means of consultation offered to patients for the sole purpose of cost saving. Interviewees felt VC should not be the only option and used only when appropriate for a particular condition and/or stage of illness. Face to face was usually regarded as the preferred option, but VC was viewed as a valuable resource to avoid travelling and improve access to professionals. Worries were expressed that older people may not feel as comfortable as younger patients with using it. One person wondered if it was "*getting further away from the patient*", but was willing to try it, even if she felt uncomfortable at first in the belief that you cannot block progress (2B069b). In the view of another interviewee (3D173) patients should push for VC appointments, saying that it is being done in other areas of Scotland but not widely in the Highlands.

8.11 Out-of-hours/emergency care

During Fieldwork 1 (2015), interviewees often described feeling vulnerable when changes were perceived to necessitate a greater distance to travel to access services, particularly given the lack of public transport and potential for severe weather. During Fieldwork 2 and 3, patients reported fewer concerns about out-of-hours care, although there were still worries about a lack of home visits for older people and lack of public transport. In areas that had previously, but no longer, had a GP or nurse living within the community, interviewees often spoke about missing a sense of reassurance and security which this professional presence had given them. Some patients worried about the responsibility of making the decision to call the emergency services themselves rather than asking the local GP; as they felt they did not have the level of medical knowledge needed to avoid unnecessary call outs.

In Acharacle, patients were largely positive about their new model for out-of-hours care in which new practitioners (Advanced Nurse Practitioners and paramedics) took over from locum GPs in January 2016. Although community members were not all fully aware of how the new system would work at the time of Fieldwork 1 (November 2015) e.g. whether a GP would ever be called out, they believed the new practitioners would refer on any cases that they could not deal with themselves. During Fieldwork 2 (May 2016) the efficiency and sustainability of the new service tended to concern professional interviewees, given the low number of out-of-hours cases per week, estimated by one professional to be around one to five patients from Friday evening to Monday morning (2D161) at this point. Professionals also raised concerns over cost, skills maintenance and integration with the primary care team as well as the improvements to anticipatory care planning which have meant fewer out-of-hours cases in the area. The community nurse team also work seven days a week and are on call for palliative care cases. The sustainability of the new out-of-hours service was questioned by one professional (2D110) given the amount of finance being invested versus what they believed was required. According to this interviewee, the new system was not investing in personnel already living and working in the local area but rather employing 'fly-in fly-out' type workers at that time, which they did not view as positive or sustainable. Another interviewee commented "*at the moment there are more clinical staff out-of-hours than in hours doing the work*" (2D103). In their view, GPs are essential to the MDT ethos and not easily replaced in primary care by other practitioners from a secondary care background because their experience and skills do not necessarily fit into a GP practice. According to this interviewee such skills are not easily transferable and primary care experience is slow to gain meaning "*short sharp spurts of training*" (2D103)

are useful but not a solution on their own. Although it was planned to involve the new out-of-hours staff in surgery clinics, they had different backgrounds and skills to the primary care team and were also managed separately and therefore integrating them was not seen as straightforward by professionals. During Fieldwork 2 (May 2016), professionals suggested an alternative model in the interviews, by which out-of-hours could be covered by the wider local multi-disciplinary team or by the Primary Care Emergency Centre in the Belford Hospital.

At the time of Fieldwork 3 (June 2017) attitudes were more positive. It was suggested that the primary care backgrounds of the two new Advanced Nurse Practitioners (previous two post-holders had left these positions) had enabled them to assist more easily with daytime services. If daytime work is properly resourced and properly carried out, then the out-of-hours case load can be anticipated and managed according to one professional (3D103), who found the practitioners with paramedic or hospital backgrounds were useful for out-of-hours but less able to take day time clinics. In the view of this interviewee upskilling people on short courses for a "*smattering*" was inadequate. Therefore, having had a number of years' experience in primary care, the Advanced Nurse Practitioners had been able to backfill for a GP if ill or on study leave. Establishing a settled, stable day time team was the key which made this model acceptable in the opinion of this interviewee. The priority was to maintain investment in the daytime service, which was described it as their "*main business*". From 1 August 2017 the Advanced Nurse Practitioner out-of-hours model took responsibility for the neighbouring Lochaline practice. At the time of Fieldwork 3 (June 2017), the use of out-of-hours GP locums had been reduced, but not eliminated, However, at the end of 2017 it was understood that GP locums had not been required to cover out-of-hours for several months.

In Kintyre and mid-Argyll, interviewees on the whole (particularly those who could drive) did not raise as many concerns about out-of-hours cover during Fieldwork visits 2 and 3. The changes to the out-of-hours cover involved patients being required to make their own way to Campbeltown or Lochgilphead hospitals for out-of-hours services. It was understood that if a patient cannot travel to Lochgilphead, then NHS24 sends a taxi to fetch them (2B003). A contract is in place with a local taxi firm to take people home from Campbeltown hospital (2B017). Although residents had initially expressed worries about the change to out-of-hours cover, very few issues were reported about these services during Fieldwork 2 or 3. Professionals believe it is more efficient to see patients in the hospital in appropriate surroundings, where

transfers or admissions can be arranged more easily (2B017). In Campbeltown the on-call GP now has a day off after covering out-of-hours which was described as a great improvement.

On Gigha, greater concern was expressed about out-of-hours services due to the change to the community nursing service which meant patients can no longer contact the nurse directly after 3pm, but must now use NHS24. However, it is understood that nurses are on call outside these hours via NHS24. One community interviewee believed that it was now safer to put cases through NHS24 instead of being called directly and thought patients had an unrealistic level of expectation (2B129).

Although a few people did worry about becoming ill out-of-hours without a resident GP, many did not have major concerns and felt they would be prepared to wait for a GP appointment or contact NHS24. On the whole they thought they would not be seen any quicker on the mainland, where they thought it was common to wait for a routine appointment. Patients were very happy to use the telephone or VC when the GP was not visiting.

Views remained mixed over NHS24 with a range of experiences reported during FW visits. Participants often felt happier to go straight to their local hospital out-of-hours if possible without calling NHS24. Although NHS24 had worked well for some, it was widely criticised and described by one resident as "*really really poor, it just didn't help at all*" (2C073b). Discussing the same incident, another (2C073a) found it frustrating that, in her opinion, the call handler could not understand their context – living on an island - even though she tried to stress the island location with its poor mobile signal necessitating a quick clinical decision about medical evacuation.

According to another interviewee NHS 24 is a really good service for advice, but in an emergency she would not want to be so reliant on it. She described needing medical advice one Sunday and phoning NHS24 for the first time:

"*I didn't really have another contact, it just says phone NHS24 and then you feel … you've not got a person or someone to speak to, so you feel a little bit lost*" (2C150).

Although she found the people were great and very reassuring, they did not know the island procedure. She wanted a doctor to say what medication was required so she could get access to anti-biotics from the

emergency medication store. After being called back initially, she waited another two hours for a doctor from Broadford hospital to telephone. She found the doctor to be extremely good, telling her what to get from the store and giving her a phone number so she could reach her again if needed. Although she did not need to use the doctor's number, it was reassuring to have the contact. However, it took a long time to sort out and she found it all a little bit frightening. If it had been something more urgent, she would not to wait for someone to ring her back in two hours to tell her the procedure. She would be more likely to phone for the helicopter even if she was not 100% sure.

8.12 Emergency care

Although interviewees were generally satisfied with emergency services, there were a few worries about ambulance arrival times and perceived reduced capacity. In Ardnamurchan worries were expressed about what would happen if the ambulance had been called away and there was an incident in their local village. However, one interviewee described her experience of an emergency situation and was full of praise for the quick response and level of attention given to the patient (3D105a). In spite of general satisfaction with the new out-of-hours service, concerns were still expressed about the lack of a resident professional in the Kilchoan community. For example, one resident was worried that if someone had a stroke, it would take paramedics an hour to reach them:

"*Do you feel more secure? Then the answer really must be no. We've still got that time delay*" (3D158a).

When he first moved to the area, he believed the level of cover was greater than it is now because there was a 24-hr response from a GP and an experienced nurse in the community. Although happy with the Emergency Responders and the Advanced Nurse Practitioners, another also highlighted (3D104) the long wait if someone had a stroke, a heart attack or a bad accident and shared the concern there was not a nurse or GP based close enough to attend such an incident within an adequate time period.

Although interviewees were generally confident about a timely emergency response on the Small Isles, cases were reported where emergency call handlers had not understood the implications of their remote island location i.e. medical evacuation may be required in the absence of a medical professional on the ground. Emergency call outs were commonly believed to have increased on the Small Isles[3] since the

[3] Data not available for quantitative verification purposes.

service changed from being resident GP led due to there not being someone locally to treat minor injuries and, therefore, an emergency call out being necessitated. A few people reported feeling reluctant to call 999 in case their condition was not sufficiently serious.

8.12.1 First Responders

In spite of being widely accepted as a way of building community resilience, interviews indicated that First Responders within the pilot sites felt the levels of support and training given to them have been inadequate over the life of the Being Here Programme. Evaluation updates and recommendations have repeatedly highlighted the issues, particularly the inability to offer pain relief and a reported lack of regular training. Such problems have threatened to undermine the confidence of both the community and the volunteers in this aspect of their service. Lack of training means some volunteers are not happy to respond because they do not feel confident their skills are up to standard.

8.12.1.1 Acharacle practice area

At the time of Fieldwork 2 (May 2016), following a Scottish Ambulance Service (SAS) re-organisation, Acharacle had a core group of six volunteers and they were expecting more training on a two-monthly basis. According to one interviewee (2D159) the Scheme had not been well managed for a time and it had been frustrating when people's applications were not processed in a timely manner. She hoped that the First Responder team might now be able to attract them back. Similarly, another interviewee (3D172) thought their Scheme had worked initially but the changes and restructuring of the service had discouraged volunteers from putting themselves on call. He thought a bigger pool of volunteers would improve the Scheme and that training scenarios had to be made as realistic as possible. According to one interviewee (3D174) the fact that the number of call outs for First Responders in a small community is very low can put people off volunteering because they give up their time but do not get called out to utilise their skills. He also thought funding was a problem and criticised they had to fundraise for on-going training equipment. First Responders are needed because of the time taken for ambulance to reach the community but "*morale went through the floor*" (3D174) when they felt unsupported. In the view of another interviewee (2D160) if there is insufficient on-going support, coupled with a lack of call outs or training opportunities, then volunteers will lose enthusiasm for being part of the scheme. Although an interviewee (3D117) suggested that First Responders might give a false sense of comfort because they are

not medically trained, he thought anything was better than nothing if residents accept them "*for what they are*".

In Kilchoan, by the end of the fieldwork cycles, the Emergency Responder team remained at three, rather than the six originally envisaged; it was felt that this increases the workload and perceived burden of responsibility on the existing team. A high level of satisfaction with the Kilchoan Emergency Responders was evident, although one person (3D112) believed the NHS were relying on the fact that the Emergency Responders were personally prepared to be on call for so many hours due to the small size of their team. The main community concern was not having a sufficient number. When it had been introduced, Emergency Responders had to have a medical background but in a small community they were very hard to recruit on this basis. At the time of Fieldwork 3 (June 2017) a new person without a medical background was being trained to join the team and towards the end of the evaluation the new team was understood to be working well.

8.12.1.2 Small Isles

Attitudes in the Small Isles were generally positive to their First Responder Scheme, with many interviewees feeling that it had been demonstrated to work. However, specific issues continued to arise in all fieldwork visits about capacity, training and permission to give pain relief which affected community confidence. At the time of Fieldwork 3 (May 2017), First Responders were still unable to administer pain relief (Entonox), which had been one of their main concerns from the beginning of the evaluation due to the time required by emergency services to reach the island. Although there was widespread agreement on the need for this capability, professional and community interviewees suggested the decision to go ahead had to be taken by the Scottish Ambulance Service. The possibility of training some members of the team to Emergency Responder level was also discussed during the interviews, because this enhanced training would enable them to use Entonox.

First Responders were also unable to undertake certain patient monitoring tasks e.g. taking blood pressure which could be fed back to GPs or paramedics. From the beginning of the evaluation they were limited in the type of incident they would attend but called for more flexibility to respond to the range of situations occurring regularly. The way in which First Responders could support the Health and Social Care Support Workers was also raised. During all the fieldwork visits the First Responder vehicle was

believed to be inadequate on Eigg given the poor state of roads and tracks. The need for more oxygen cylinders and poor radio reliability/coverage were raised routinely, particularly on Muck. During Fieldwork 2 (June 2017) recent incidents had occurred on Eigg, Rum and Muck where NHS24/Scottish Ambulance Service call-handlers had not understood the remote island location. This lack of knowledge had undermined some confidence in the emergency response at the time.

Following Scottish Ambulance Service re-organisation, quarterly training dates for First Responder were set starting in September 2016 on Eigg and at the time of interview (Fieldwork 3 May 2017) First Responders on Muck were still waiting for dates to be organised. A multi-agency simulation exercise on Eigg had been discussed with the Scottish Ambulance Service. However, during Fieldwork 3 it was evident that this had not been followed through and not all the training had been delivered. New people were also interested in being trained but this had not been taken up.

Throughout the life of the programme, concerns were expressed widely amongst the community about the pressure and responsibility of volunteering on First Responders working within small teams. It was felt that the potential high turnover of volunteers has implications for long-term sustainability of the service. The increasing number of holiday-makers to the island was also highlighted because it creates extra demand on local healthcare resources (Fieldwork 3 May 2017). The option of paying First Responders a retainer in line with, for example, fire fighters, was raised frequently in the belief that this would make it more attractive for new volunteers and aid sustainability:

"*You could make a little bit of money and make a bit of difference as opposed to just making a bit of difference*" (2C028).

In the view of this interviewee, some form of payment would help to create a structure which "*is going to stick and be relied on*" in 10 years' time. Another resident (2C088b) called them "*absolutely brilliant*" and thought they deserved medals. She believed they had been used far more than originally anticipated, but was worried about the responsibility on volunteers:

"*It's still using unpaid volunteers to do what was originally covered by a paid professional. It's putting a lot of responsibility on people who are giving up their time for the good of the community ... It's brilliant but it does seem like taking advantage of their good nature really*" (2C088b).

Working with the Fire and Rescue Service to make First Responders a more robust service was suggested by one interviewee (2D160). The creation of a new role might be required in order to make the best use of different existing roles with overlapping skills and assets (2D160). The possibility of combining it with a Health and Social Care Support Worker was also raised during Fieldwork 3. Interviewees felt First Responders were overlooked as they came under SAS not NHS.

On the whole, residents were extremely positive about the First Responders and valued their contribution to service provision on the islands (describing having seen them attend incidents successfully). However, one person described them "*a bit of a sticking plaster really*" (2C085) and felt they had been "*bigged up as some alternative to … the locum*" although she did not view them as a substitute for a trained paramedic or other professional. Concerns were also expressed, particularly in the smaller island communities, about having to attend a friend or family member and the feasibility of instigating a Scheme given their low populations.

Towards the end of the evaluation (November 2017), it was understood that an agreement had been reached whereby some of the First Responders would be trained to administer Entonox as well as take blood pressure/temperature, etc. to facilitate diagnostic assessment by GPs and paramedics. The trainers were expected to come to Eigg in February 2018 to upskill all the First Responders who were willing to take part. At that point there was a core team of five on Eigg with two part-time and two waiting for initial First Responder training. The First Responder team had also received a new vehicle, a Landrover, to be kept at the surgery and different to the GP car which is kept at the pier. First Responders can also keep equipment in it and a key safe means someone can be given the code to access it when required. They have also stopped the Responder rota which has taken the pressure off the volunteers. Instead of a person ringing 999 in the first instance so the call handler contacts the First Responder on the rota, the volunteers are contacted directly by the individual involved or at the scene. The First Responder then phones up and signs on. It is now accepted that Responders have to go to all incidents because they are the only ones available immediately whereas formerly the emergency call handler would assess whether it was suitable for them to attend. They were also benefiting from a more formalised route to the Broadford hospital for advice. However, they were still waiting for radio training for some members of the team. Although people are willing to do it for nothing, many people still think they should get a retainer because in the view of the interviewee, the service is provided by volunteers where they used to

have doctor. Volunteers have to sit with the casualty for longer, reassuring and reporting, which most paramedics or doctors do not do. One of the interviewees (3C026u) felt that communication was still slow but she felt they were now being listened to and the situation had improved. Towards the end of the evaluation it was understood that the training for Eigg First Responders had been postponed from February to March (3C026u). As the Muck First Responders could not attend the proposed training in Fort William due to family commitments, a trainer was due to come out to them in March (3C095u).

8.13 Community resilience

A large number of interviewees reported seeing no change in their local community resilience over the course of the programme, either because they judged their community to already be highly responsible and resilient, or because the level of change had not been significant enough to have an impact.

Views diverged on whether the communities could do more to help themselves in terms of primary care, maintaining general good health and health promotion. A high value and sense of pride were attached to informal support networks operating in small rural communities. Although it was widely believed that residents already co-operate and look after one another, some interviewees thought their communities could do more e.g. establish walking groups or First Responder Schemes. Since the first round of fieldwork (September 2015), Carradale has developed a First Responder scheme and found potential volunteers. Some interviewees were interested in exploring the First Responder scheme as an additional resource in their communities, while others did not see a need if they lived closer to existing medical facilities. A few feared that First Responders and Health and Social Care Support workers could undermine and replace current mainstream services. They thought it could be a means of replacing professionals and saving money. Fears were commonly expressed about the lack of community capacity with only a small number of residents already taking on several roles in local initiatives. It was suggested that there could be greater support for community members who come forward with new initiatives that will help community resilience.

Interviewees did not readily identify with the concept of resilience and did not tend to link community strength and sustainability to the operation of local primary care services. Health was not necessarily seen as a factor in community resilience, with issues like employment or transport viewed as having a greater impact. However, some interviewees placed the GP and nursing services at the heart of the

community's resilience, especially as they considered the service to be an important factor influencing people thinking of moving in, especially young families. Similarly, interviewees tended to think islanders were already resilient before the Being Here Programme:

"*People here are resilient and therefore I think because of that we have taken the new system on board as part and parcel of being resilient. I'm not sure it has made us more resilient. I don't think in a sense it contributes. I think we have been able to take it on board because we are*" (2C083a).

Although this interviewee did not think the Being Here Programme had increased community resilience, he did think that health was now something that is more often discussed on Eigg and now raised regularly at residents' association meetings.

On Islay, residents were unsure about what more the community could do for itself, but third sector interviewees put forward suggestions for increasing integration of voluntary organisation and mainstream health and social care services. It was proposed that the surgery could act as a hub offering services that did not require a clinical lead e.g. bereavement counselling, support for conditions like dementia or autism as well as health promotion initiatives. This opportunity to work with the community in new ways was put forward as a way to offset the clinical workload. It was also suggested that social prescribing could be enhanced locally with greater support, co-ordination and monitoring. It was felt that signposting to groups and services for mental health support could be increased, in addition to existing physical exercise prescriptions. As in other areas, community members voiced concerns about local capacity and highlighted the need for investment in voluntary organisations and activities.

On Eigg and Muck, interviewees tended to think the new roles (Health and social care support workers and First Responders) had generally improved community resilience, but interviewees on the other islands were less able to identify any specific impacts on resilience because of the Being Here Programme. Most people thought healthcare was a factor considered by people moving to or from the islands, although some thought it was the presence of a service rather than the delivery model that would influence their decisions. The situation was described by one resident as a "*real chicken and egg thing*" (2C073b). She claimed if there were no school, you would not attract families and that people expected a certain level of health service provision:

"*If you don't have a doctor's surgery and a very visual medical provision, you are unlikely to get people …* [except those] *who are really really responsible for their own health wanting to live there … people in this county expect to access* [health services] *quite easily*." (2C073b).

In the view of another, the service change had not made a big impact on community resilience:

"*I don't think that the community has stepped up if you like and said okay we need to have more things in place in case anything goes wrong*" (2C150).

She thought many residents would still not know what to do in an emergency and would probably contact the coastguard. Since the change she did not believe they had pulled together as a community or that individuals had become more resilient. In her view, the situation probably put off people moving to the island because she thinks they are shocked and displeased when they find out that there is not a resident doctor.

On Canna and Rum, residents were positive about the possibility of having First Responders and Health and Social Care Support Workers but in the main thought their islands did not have the current capacity to fulfil such roles given the low populations.

8.14 Individual responsibility and reciprocity

A strong belief in taking individual responsibility for one's own health was expressed by the vast majority of interviewees, but views were divided about whether it this was actually happening or increasing. Although there was a tendency to think the relationship with healthcare professionals was now more of a partnership than in the past, a few thought some patients preferred to be told what to do rather than be given a choice. On the whole, greater responsibility and autonomy for the patient were judged positively. The majority of residents were in favour of a more reciprocal relationship whereby the patient has greater control and responsibility in their health care. One patient simply said, "*you are treated more like a human being*" (2B067). Another interviewee explained the change in attitude:

"*I think it's better than it was. I think the idea of the local GP on a pedestal is disappearing which is good. It's more of a partnership and if you can get that then obviously, you can get people interested in their own health*" (2B121).

He identified the doctor's attitude as an important factor in the relationship:

"*If the doctor's still got this attitude of 'I am the GP and I'll tell you' rather than 'right, we've got a problem, how do we sort it?', I think you won't get the co-operation … it is just better salesmanship*" (2B121).

A few interviewees associated reciprocity and partnership with having a close personal relationship with one GP who was part of the community. These interviewees thought this relationship was in decline with the use of locums and larger GP teams. However, others believed it was healthier for the GP's personal wellbeing to come from outside the community. Everyone should have a named doctor who knows them and is in charge of their care according to one patient:

"[A GP is} *not just there to mend your broken leg and give you pills. They're there to know you and know your family and know what's happening in your life*" (2B058).

In the view of another interviewee, reciprocity would work better if GPs had more time to spend with patients (2B123). Another (2B068a) criticised "*depersonalisation"* in the local practice which he believed was a big part of village life unlike in a larger urban location where you have "*so many centres of gravity*". One resident thought people tend to be more resilient if their doctor is not within walking distance and they have to do more for themselves (2B135).

Interviewees thought individuals should be responsible for their own health, but opinions differed on the extent to which this was the case. Some confusion was evident over whether the patient or the practice were responsible for highlighting that tests or screening were due. It was highlighted that opportunities for improving or maintaining physical health did exist, even in small communities across the pilot areas (e.g. facilities offering badminton or exercise groups). Some thought people were generally becoming more health conscious, whereas others thought it depended on the individual with certain people being motivated about their health while others are not. One resident commented:

"*I would imagine it's a pretty neat split between the people who are actively interested and the people who are actively disinterested in their health*" (2C071a).

Several residents thought living on an island made people more conscious of their health and safety:

"*Being on an island you become more conscious of your health anyway because you know the doctor isn't just round the corner*" (2C074).

According to another resident the change to a visiting GP service on the Small Isles had increased a sense of individual responsibility meaning "*that you minimise the use of doctors … and not go for every small thing*" (2C086). She thought people were more health conscious and took responsibility for leading a healthy lifestyle and not being a "*burden*" on the NHS. Discussing the former GP model, she comments:

"*[The GP] had very little to do to be honest. You would go for a small thing and stay for a chat, whereas nowadays you should try to be as independent as you can*" (2C086).

She also saw the relationship now as more of a partnership with "*more emphasis on a two-way dialogue … rather than just you go to the doctor and expect them to tell you what's wrong and give you some antibiotics*" (2C086). Most interviewees also thought the relationship with healthcare professionals was becoming more of a partnership with the patient taking more responsibility and finding out information for themselves. However, the sense of a personal relationship with a local GP was still seen as an important element in healthcare delivery. Although most felt a sense of continuity was being restored, a small number thought this has been lost with the GP no longer living in the community. In contrast some thought it was preferable not to have the GP closely involved with such a small community and that a sense of professional distance was desirable for both doctors and patients.

The introduction of social prescribing and the establishment of local groups like Jog Scotland were deemed to be positive steps while others believed a more fundamental cultural shift was necessary to engender empowerment and encourage individual responsibility. One interviewee talked about "*disenfranchisement*", commenting "*there is this huge thing called the NHS which is doing things to you and you're a patient sort of in there*" (2A023). She believed the community should have as much support

as possible to get involved in service development and identified a fundamental problem with people's perception of 'ownership' in service provision:

"*the connections between the taxes you pay, the services provided – it is broken – it is them, them, them. Actually, it is us us us*" (2A023).

8.14.1 Health promotion

Knowledge and experience of social prescribing was very limited across the pilot areas amongst professional and community interviewees. The 2016 Health Fair on Eigg was a very successful event enjoyed by many of the interviewees. The health checks e.g. cholesterol, blood pressure, were reported as one of the most popular elements of the fair. Although there was some interest in a health promotion programme which could potentially be delivered by the new Health and Social Care Support Workers, others did not accept a local worker taking on such a role, believing this should be left to the GP or the patient to initiate. Many residents thought islanders generally were in very good health and did not see any need for health promotion. Island residents did not necessarily feel disadvantaged compared to the mainland in terms of opportunities to improve their physical health due to their farming and outdoor lifestyles as well as the chance to cycle and walk. On Muck and Eigg there were limited opportunities to participate in activities e.g. yoga, badminton, jogging, Qi Gong. However, concerns were raised about access to substance misuse support, counselling and mental health services which were seen as particularly problematic to deliver because of their remote location and issue of confidentiality in a small community.

8.15 Home care

Several interviewees, across the sites, talked about home care provision during their interviews. Recruitment and lack of capacity were recurrent themes, although quality of care was generally believed to be very high. Greater workforce flexibility and greater co-operation with community nursing were suggested improvements together with greater promotion of home care as skilled and valued work. In the Argyll areas the inability to train home carers in medication administration was raised during Fieldwork 1 (September 2015) and highlighted again in Fieldwork 3 (April 2017) with a reported impact on the efficiency and coverage of the service. Other home care providers have had to be called in for

these cases. At the time of Fieldwork 3 guaranteed contracts were in place for home carers in these areas but recruitment problems and staff shortages limited the capacity for preventative work and reablement. In order to utilise resources more efficiently and reduce costs, they need to advertise posts and conduct a mapping exercise according to one professional (2B064b).

8.16 Mental health

The provision of mental health services was a key theme discussed by many interviewees. In cases in which interviewees had come into contact with mental health services (whether as third sector workers, patients or professionals), they tended to highlight gaps in the service. A lack of Community Psychiatric Nurses, difficulty travelling to access services and lack of anonymity in small communities were cited as some of the main issues. However, some interviewees also thought smaller communities could be more supportive and tolerant of people with known mental health issues. In contrast a lack of anonymity could also be a disincentive when it came to seeking help and could make people more reluctant to access services. In a remote and rural area, you cannot hide whereas in a bigger place like Fort William you can be invisible (3D114). It is difficult to go into a building where only one service is offered and "*that door is only to that service*" (3D114) rather than a hub with a range of different services. It is possible that the GP may have a greater role as the first and potentially main contact in a rural area. In more remote and rural areas mental health issues could be exacerbated by having fewer services and greater social isolation. Few examples of community-based support services were cited. Ewen's Room was a well-known and respected service referred to by the Ardnamurchan interviewees. A Men's Shed had recently started in Strontian at the time of Fieldwork 3 (June 2017). In spite of having fewer services, some interviewees thought rural communities might be more supportive than urban ones, although tolerance may not always be positive e.g. perceived tolerance of alcohol misuse in small rural communities.

For some the lack of mental health services was universal and not worse in rural areas:

"*It's not just a gap, it's a gaping hole …. It is near enough the same here as anywhere else there is … practically zero assistance when it comes to mental health*" (3D174).

9.0 The Health Economics and Financial Flows Perspective

9.1 Introduction - Health Economics Review

The plan for the evaluation of the Being Here programme was to carry out a health economics analysis to determine to what extent the programme was likely to have an economic impact for the NHS, for other stakeholders and for communities in the Highlands and Islands and to provide an economic impact or financial impact of remoteness and rurality. Following extensive discussion and review with Dr Diane Skatun from the Health Economics Research Uniit (HERU) of the University of Aberdeen, however, it was considered by Dr Skatun that a full health economics review would not be possible. The rationale behind the decision not to undertake any full-scale economic evaluation of testing different models of delivering safe and sustainable rural health care services centred around the ability to i) generalise any findings from the pilot areas and ii) identify an appropriate comparator.

Notwithstanding these issues, an appropriate economic evaluation would also require to take into consideration iii) the multidimensional nature of a whole system evaluation and iv) the need to consider the long term sustainability of any model of care. Dr Skatun argued that it could be considered that any economic evaluation that cannot address these issues could lead to potentially misleading recommendations nor be an efficient use of time or resources.

9.1.1 Background

The role of economics is to study the optimal allocation of scarce resources. Specifically, an Economic Evaluation within healthcare helps determine whether a healthcare intervention/procedure or service is the best use of resources. In doing so it considers "*the comparative analysis of alternative courses of action in terms of both their costs and consequences*" (Drummond et al, 2005). In order to achieve this, the fundamental requirements are the identification, measurement, valuation and subsequent comparison of the costs and consequences of the alternatives on offer.

Economic evaluations are usually defined as full or partial evaluations depending on their ability to fulfil the above criteria in terms of 1) the examination of both costs and consequences and 2) whether they compare between two or more alternatives. A full economic evaluation fulfils both criteria with the comparison between the alternatives characterised as an incremental analysis with the difference in costs

compared to the difference in consequences. A partial evaluation only covers one of the two criteria. In this latter case and following the descriptors used in Drummond et al (2005), with only one alternative being considered, in terms of either costs or consequences or both, the evaluation would be a simple outcome description, cost description or cost-outcome description respectively. If a comparison is made between two or more alternatives but only costs or consequences are examined, then the partial evaluation would be termed a cost analysis or an effectiveness evaluation.

A full economic evaluation provides a framework to compare the costs and consequences across two or more alternatives with the specific type of analysis chosen the most appropriate for the specific problem that it is being asked to address. As such it is only a full economic evaluation that can address issues of efficiency which lie at the heart of the ability to choose the best use of scarce resources.

9.1.2 Full-economic Evaluation Types

The three types of full economic evaluation are cost-effectiveness analysis, cost-utility analysis and cost-benefit analysis. The identification and measurement of resource use and their subsequent costs is similar across these types of analyses, but they differ particularly in the way that they value consequences. As such they differ in their ability to address two types of efficiency, technical efficiency (how to provide health care within a particular programme) or allocative efficiency (what health care to provide across competing health care programmes).

Cost-Effectiveness Analysis (CEA): the effects or consequences of the intervention (and its comparator) is measured in a single, uni-dimensional natural unit of outcome for instance years of life gained, disability days saved, number live births etc. Thus, alternative interventions are compared in terms of cost per unit of effect. This type of economic evaluation can address issues of technical efficiency.

Cost-utility analysis (CUA): The effects or consequences of the intervention (and its comparator) are multi-dimensional and are captured by a combination of life years gained with a judgement (value) on the quality of those life years. The most popular measure is quality adjusted life years (QALYs). Thus, the alternative interventions can be compared in terms of cost per unit of utility gained (cost per QALY). As such this type of economic evaluation can address issues of both technical and allocative efficiency.

Cost-benefit analysis (CBA): this is the broadest form of economic evaluation where the effects or consequences of the intervention (and its comparator) are measured in monetary terms. It can incorporate all relevant effects including health and non-health effects. This type of economic evaluation can address issues of both technical and allocative efficiency, can compare programmes within health care and indeed compare a healthcare programme with one outside of the healthcare sector.

9.1.3 Key Issues in Formulating a Full Economic Evaluation of Testing Different Models of Delivering a Safe and Sustainable Rural Healthcare Service

In considering the key points in assessing an economic evaluation, the following issues are ones that could be deemed weak in their ability to be addressed within the context of undertaking a full economic evaluation of different models of delivering a safe and sustainable rural health care service.

i) Generalisability: The NHS Highland document "*An Approach to Building Sustainability of Health and Social Care Services in Remote and Rural Areas*" states unequivocally that "*there would be no single model of service*" and that "*successful solutions would be grown from local need and local resilience*". This recognises that any one economic evaluation of a particular model of service could not necessarily be generalised to another context and any assumption that it could may give misleading results in terms of predicting economic efficiency within a different setting.

ii) Choice of comparator: For a full economic evaluation it is imperative that an appropriate comparator is identified. Given the recognition that no single model would be appropriate in all areas, a single site, before and after study would be one to consider. This would amount to a non-randomized design using a retrospective or historical control. However, the new models of delivering rural health care services are being developed from a situation where current models of health care provision within, in particular general practice, are unsustainable with services under extreme pressure. Therefore, with sustainability being in essence a dynamic process, a pre-new model of care data would only reflect the pre-new model or the "existing service" at that point of time and would not necessarily capture any continued deterioration of service. On a practical note, a single site, pre and post "intervention" study often can only rely on retrospective data collection unless the evaluation was planned well in advance to gather prospective data in a relevant time-period prior to the intervention being introduced. An alternative comparator could be a current "sustainable" service. However, it could be argued that by nature of the service being sustainable it is by definition fundamentally different on a number of levels that would make

it an unsuitable candidate as a comparator with the return to the argument that no single model would suit all sites.

iii) Perspective: The perspective of the evaluation also needs to be considered whether it is from the patient (or potential patient), the health board or from the broader societal view. The viewpoint from which the evaluation takes place affects the costs and consequences to be identified and valued.

iv) Multi-dimensional nature of a whole system evaluation: It is essential that all the relevant costs and consequences for each alternative are identified. Focussing on the variety of effects/outcomes that might be affected by an alternative model of care, and the time-scale over which they might be realised, it could be argued that this would warrant a full cost-benefit analysis as the most appropriate analysis to fully capture the outcomes possibly affected by the service redesign. While a cost-utility analysis is multi-dimensional, it would not be clear that outcomes measured in terms of a QUALY would be a sufficient measure to adequately capture the breadth, variety or subtlety of effects over the necessary time-frame that would be required to be considered. A full set of outcomes that would be required to capture the consequences of the new model of service would address the general issues of whether a) Access to service has changed? b) There has been an associated change in health status? c) Retention and recruitment of the appropriate healthcare workers has changed?

To understand this fully, appropriate measures of access to service (in terms of quantity, timeliness and type of health care provider), quality of service received (through an appropriate clinical measure), access to related services (such as out of hours services), impact of the interface between primary and secondary care (such as admissions to secondary care, whether elective or potentially preventable hospitalisations, and changes to the use of emergency services/NHS 24. Outcomes relating to patient satisfaction and/or acceptability may also be considered.

As with any evaluation, the need to ensure the most accurate measurement of both costs and consequences is required. The broad range of dimensions within a service redesign that require both identification and then measurement give rise to additional concerns over accuracy with the corresponding potential to bias results if measurements are inaccurate. The inability to achieve measures for all dimensions identified may also be an issue. It is essential in such an event that non-valued outcomes are still identified and an alternative strategy where unquantified outcomes can be identified in terms of

who might benefit from any proposed intervention, including the use of alternative values of benefit where monetary valuations are not feasible.

One outcome that would need not to be forgotten is at the core of the requirement of the redesign of service. The pressure to redesign services is driven by the challenges faced in recruiting and retaining health professionals and, in particular, General Practitioners within rural areas. Therefore, any new model of service would need to consider whether the pressures felt by the workforce and/or the perceived pressures of potential workforce are addressed by the new models. This would include issues such as "*isolation, on-call, no readily available support, lack of career progression, community pressure, professional pressure and new regulatory requirements*" as highlighted in "*An Approach to Building Sustainability of Health and Social Care Services in Remote and Rural Areas*". This is a crucial element in evaluating the sustainability of any new model of service.

Thus, there are two elements to consider with service redesign under constraint. The first are the costs and outcomes that the proposed model of care can achieve given the alternative of the deteriorating service under the current circumstances. The second is the ability to sustain that new model of care. If an acceptable level of service in terms of clinical outcomes can be identified through a new model of care, whether that is an alternative mix of skilled staff within the general practice, or a rationalisation of practices to ensure a critical mass, then ultimately the ability to deliver that service into the future through the ability to staff it appropriately, is a vital outcome.

v) Time-frame for evaluation: The underlying reasoning behind the need to develop new models of service is the issue of the sustainability of service. Therefore, the timeframe that would be required to accurately address the issue of sustainability would need to be long enough to incorporate medium to long-term effects. Thus, while short-term effects may indicate direction of movement in outcomes, it may be that short-term costs are higher than might be needed longer term in the need to alter patterns of recruitment and retention where reputation/misconceptions on service support etc may be an issue while some outcomes may only materialise longer-term.

9.2 Financial Flows Review

9.2.1 Introduction

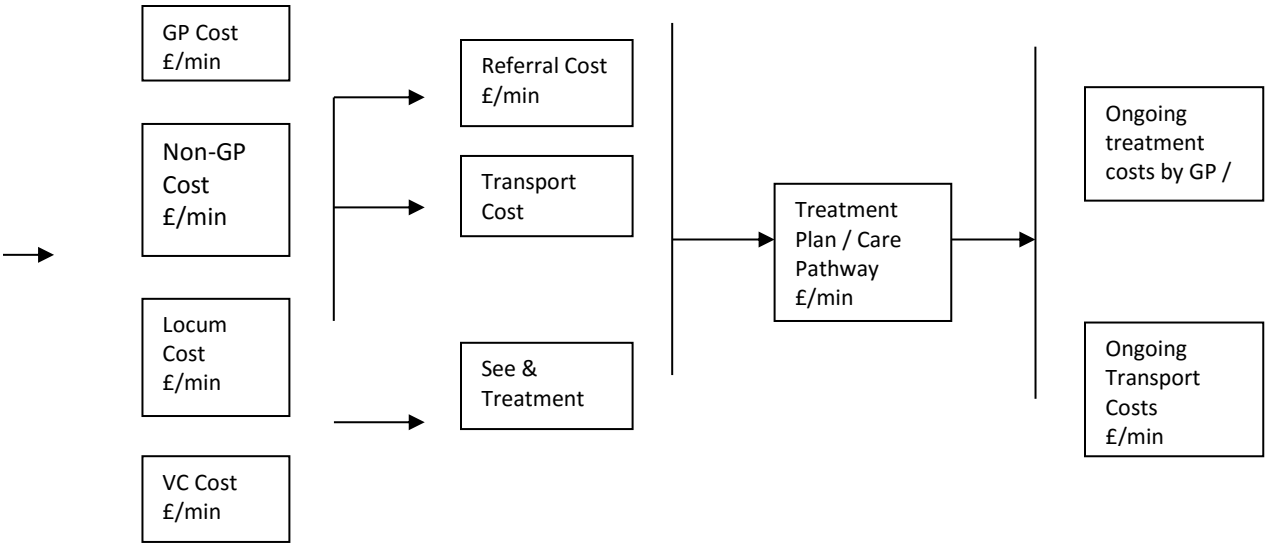
Following consultation with expert input, it was considered that a health economic review would not be feasible or even desirable within the context of the Being Here programme evaluation. With advice from HERU, it was decided to attempt to complete a much simpler analysis of the financial expenditure flows to see if any patterns or trends were possible and whether any financial impact of remoteness and rurality could be determined. The financial flows analysis aimed to provide a set of simple calculations based on available data that indicated where costs had decreased or increased over the period of the Being Here programme. It did not in any way pretend to provide a health economics analysis of the programme.

9.2.2 Aims

The aims of this financial flows exercise were to:

- Identify an algorithm or set of algorithms that allowed a methodology to be executed that could track changes in financial transactions before and during the implementation of the Being Here programme (as shown below)
- Execute the methodology and integrate the results with the Being Here evaluation process
- Provide an analysis of the financial changes that have occurred

Together these aims sought to contribute towards an overall aim of understanding what the financial implications of decisions made throughout the Being Here programme were and to provide some commentary to those findings. Clearly such an approach was acknowledged to be limited and was entirely dependent on the availability of data.



9.2.3 Methodology

Following the decision to consider financial flows it was agreed between the Being Here programme manager and the Research, Development and Innovation Manager of NHS Highland to seek to identify certain markers or criteria that would enable some degree of tracing of change and associated expenditure.

Certain boundaries were decided on for the approach before the process of data collection was started. These were to aim to capture:

- Data from two years before the start of the Being Here Programme where that was possible
- NHS Highland data that was specific to the Health Board and to the CHPs, and even, where possible, and not confidential, to the locality
- Published data as proxies or as validated evidence where available

The overall aim was to ensure that data was comparable across the whole exercise i.e. to use a consistent measure throughout in financial terms, and where that was not available to convert that to the most commonly used measure.

9.3 Conclusions and Recommendations

The process of trying to obtain accurate, complete and comparable data to address the aims of this aspect of the Being Here programme evaluation was extremely challenging and did not result in any full set of data that could be analysed to provide a clear answer, or comprehensive financial model. The data that was obtained and some limited points of analysis are contained within a short separate report that is available on request from the Research, Development and Innovation Manager of NHS Highland.

It was noted, however, that data was so difficult to obtain, patchy and in so many different formats that it was impossible to use it effectively to address the objectives set for the financial impact exercise.

The key recommendation that has emerged from the whole exercise is that the inconsistent, dispersed, different format, different time period and even different unit cost of data needs to be completely reviewed and made much more efficient.

While there have already been some changes in the processes used for some of the departments involved in the collection, processing and use of data, for example, improvements in the processes used by Employment Services and Medical Staffing, there is much more to be done in this area and others. Any organisation that aims to work efficiently is entirely dependent on the consistency and quality of its data, and without such data it is difficult to provide evidence of the financial, and wider cost-benefit of any activity. While the Being Here programme has undoubtedly resulted in benefits, especially in Northern Highland, the inability of the research team to reach a fully evidenced financial impact analysis, let alone a health economics evaluation has been a weakness of the evaluation, but one that has pointed out the need to address data management across the whole organisation (and associated organisations) as a matter of urgency.

10.0 Conclusions: Being Here for Remote and Rural Primary Care in Scotland

10.1 Introduction

The Being Here Programme set out to develop and test new models of sustainable primary care provision within four areas of remote and rural Scotland (Acharacle, the Small Isles, Mid-Kintyre and Argyll). A review of programme documentation, carried out by UHI Rural Health and Wellbeing researchers, identified the key changes that the Programme aimed to achieve. These were used to develop a set of indicators for monitoring progress towards Programme aims over a three-year time period. During this time, researchers carried out three rounds of fieldwork across the programme area and conducted 364 semi-structured interviews with over 200 community residents, third sector workers and healthcare professionals. Our indicators showed progress towards the achievement of aims in all areas. Thematic analysis of the data collected during the interviews allowed identification of the general changes that had occurred in each test site from the perspectives of both the community and healthcare professionals. This allowed the evaluation to meet its aims of obtaining stakeholder views on Programme change; verify what types of service innovations took place in each test site; and to monitor and analyse responses to feedback.

10.2 Summary of key themes

Although interview data analysis revealed the breadth and diversity of individual experiences, key themes (e.g. service quality, communication/consultation, continuity of care, community capacity, technology) were shared across all the pilot areas and present in all rounds of fieldwork. Differences were largely evident in areas trialling innovative services and roles, where specific views were voiced about service delivery models. The following section summaries the key combined themes from all fieldwork cycles.

Service quality

Most interviewees were satisfied with service safety and standards. Patients tended to see a lack of continuity of care as the main threat to quality and tended to associate quality of service with having a personal relationship with a healthcare professional who was familiar with their background. Finding continuity was disrupted by the prolonged use of different locums, residents welcomed changes that

reduced reliance on temporary staff. The fear of losing continuity was the main driver behind concerns about practice mergers which meant becoming part of a larger, usually more town-based GP team.

Sustainability

Following implementation of Programme changes, most interviewees believed local services would be sustainable in their current form. Concerns remained, however, that long-term sustainability may be undermined in the future by any potential decreases in NHS budgets, turnover of staff or lack of engagement with technology. Some community residents associated the sustainability of a GP service with how much they felt it was required and used locally, i.e. it will be publicly funded and thereby be sustainable because there are people who need it.

Breadth

Generally, the breadth of primary care services provided in the pilot areas was deemed satisfactory, but interviewees worried about any changes perceived to be eroding local hospital provision, such as the closure of wards. Community residents often called for more visiting consultants, although they did not expect the same level of provision as in an urban setting and accepted access to services was necessarily more difficult in a remote and rural area. Interviewees commonly felt primary care was better in a rural area because of the availability of appointments and having access to a regular, known GP. The lack of mental health services was a common concern across the pilot areas, particularly in communities where services and support groups were not available locally. Delivering services such as counselling was identified as a particular problem in small communities because of the difficulty of ensuring confidentiality. Primary care and online resources could potentially have a greater role where patients cannot regularly access any other mainstream services such as Community Psychiatric Nurses or support groups. Although travel to secondary care was not within the Programme remit, the impact of time-consuming, stressful and costly journeys was raised routinely by patients and staff across all areas especially when service breadth was discussed. Improved communication and integration with third sector organisations was suggested as a way of improving the breadth of service delivery and increasing the potential for social prescribing within the community and thereby building local capacity.

Practice model

Interviewees registered with larger team practices were, on the whole, satisfied with their primary care services. Although choice and continuity were valued, interviewees were generally willing to see any

available GP if they were suddenly very ill. In communities with a small local practice or resident single-handed GP, interviewees were less likely to perceive any advantages in becoming part of a wider GP team practice especially if they feared it would result in their local surgery closing. The retention of a local surgery space and, thereby, a visible GP presence was fundamental to reassuring patients about maintaining a local service and signifying that their perceived needs were considered in service planning. For residents, proximity, continuity and a personal relationship with the GP remained the key to safeguarding service safety and quality. Although some thought that a single-handed GP was no longer a desirable model for doctor or patient, there was still a feeling that a single GP got to know you and your family, establishing a relationship which enhanced patient care. Participants often expressed a strong desire to keep GPs in the local community, but at the same time they were generally in favour of a wider multi-disciplinary team approach and willing to see other professionals as appropriate. A team model comprising a Health Care Assistant and a Practice Nurse/Advanced Nurse Practitioner was widely accepted. However, more information on their training and responsibilities would facilitate a greater understanding of different roles, reducing levels of fear and reassuring patients about new service models.

GP recruitment

Although communities were aware of GP recruitment problems, the reasons were not necessarily understood by those who felt their rural community was an attractive location offering a good quality of life to professionals. Factors cited include lack of suitable employment for a spouse, professional isolation/de-skilling, the burden of out-of-hours work, rural lifestyle and lack of local support services/infrastructure. Although several practices have successfully attracted new GPs, recruitment remains a concern for patients and professionals who worry about future staff turnover. Reasons for successful recruitment included networking with universities, developing as a teaching practice, the Rural Fellow Scheme, increasing remuneration, promoting challenging and interesting work, local hospital facilities, fostering a multi-disciplinary team approach and the availability of training. Views were mixed over the impact of the Being Here advertising campaign with some indicating professional networking was more important in sourcing applicants; whilst others thought it had helped significantly by raising the profile of rural GP practice across the country. Some interviewees also highlighted the need to attract suitable candidates from rural areas to medicine via earlier promotion at secondary school and to promote rural primary care as an interesting, dynamic and flexible career path.

Professionals: MDT, support and training

The majority of professionals were very satisfied with the accessibility and quantity of training. Effective multi-disciplinary team working was viewed as central to preventing professional isolation.

Communication & consultation

This theme encompassed four distinct areas: **routine communication** from the GP practice; **strategic level GP engagement** in community development planning; **NHS consultation** with the community about wider service change; **communication between management and local staff** on the ground. A disparity was evident between community and professional views about the adequacy and role of consultation and the extent of patient involvement. Although communication was viewed to have improved in West Lochaber over the life of the evaluation, a lack of effective communication was commonly reported in other areas where community interviewees talked about their opposition to change being hardened because of frustration and disillusionment with the engagement process. Even where it was acknowledged consultation opportunities had been provided on service change, dissatisfaction and uncertainty were expressed routinely about the extent of community influence on policy decisions, which people often felt had already been made prior to public engagement events. Encouraging wider public participation in service planning and development could be difficult unless the community perceived an urgent 'threat' to service provision. Different communication methods are required to reach all parts of the community rather than just those residents generally characterised as the 'usual suspects' or 'same old faces'. Consultation events were often criticised by those who did not attend them as being inconvenient due to location, timing or lack of notice.

Technology

Increasing the use of both Video Conferencing (VC) and telehealthcare was identified by a majority of interviewees as a factor in promoting sustainability, but poor Broadband and mobile coverage remained apparent barriers to further expansion. Extending the VC use was a key suggestion to reduce lengthy, stressful and expensive patient journeys to secondary care, but there was little evidence of any significant expansion over the course of the evaluation, in spite of a widespread openness to greater use amongst staff and patients.

Out-of-hours/emergency care

In Fieldwork 1, interviewees often felt vulnerable when changes necessitated a greater distance to travel to access services, particularly given the lack of public transport and potential for severe weather in remote and rural areas. During subsequent visits patients reported fewer concerns about out-of-hours care, although there were still worries about a lack of home visits for older people and lack of public transport. When a GP or nurse no longer lived within the community, many interviewees missed the sense of reassurance and security embodied in this professional presence. Some patients worried about the responsibility of making the decision to call the emergency services themselves rather than asking the local GP. Although interviewees were generally confident about a timely and effective emergency response, cases were reported on the Small Isles where call handlers had not understood the island location and appropriate procedures. Views remained mixed over NHS24 with a range of experiences reported. Participants often felt happier to go straight to their local hospital out of hours if possible without calling NHS24.

Community resilience

Views were divided with some participants feeling resilience was strengthened by the community doing more for itself while others felt resilience was undermined by a loss of conventional local services. A large number saw no change in local community resilience over the course of the Programme, either because they judged their community to be highly responsible and resilient already, or because the level of change had not been significant enough to have an influence. A high value and sense of pride were attached to informal support networks operating in small rural communities. Although it was widely believed that residents already co-operate and look after one another, some interviewees thought communities could do more e.g. establish walking groups or First Responder Schemes. However, concerns were commonly expressed about the lack of community capacity where populations were low with only a small number of residents willing and/or able to take on multiple community roles.

Individual responsibility and reciprocity

A strong belief in taking individual responsibility for health was expressed by the vast majority of interviewees but views were divided about whether it this was actually happening or increasing. Although there was a tendency to think the relationship with healthcare professionals was now more of a partnership than in the past, a few thought there were patients who preferred to be told what to do rather than be given a choice. On the whole, greater responsibility and autonomy for the patient were judged

positively. Although a few associated the themes of reciprocity and partnership with having a close personal relationship with a GP who lived as part of the community, they tended to think this relationship was in decline. Others believed it was healthier for the GP's personal wellbeing to come from outside the community.

First and Emergency Responders

Attitudes to the First and Emergency Responder Schemes were in the main were positive, especially where residents had seen them in action. However, specific issues continued to arise at all stages during the evaluation about volunteer capacity, lack of adequate training and seeking permission to give pain relief which affected community confidence and volunteer morale. Paying First Responders a retainer in line with, for example, fire fighters, was raised frequently in the belief that this would make it more attractive for new volunteers and aid sustainability:

Service innovation in the Small Isles

Although widespread concern had been expressed about the charter boat cancellations from the beginning of the evaluation, reliability improved following the take-over by a new operator. On the whole, attitudes to the GP service were very positive and many interviewees across all the islands thought the service had improved. The new health centre was welcomed on Eigg but the lack of a community dental service, VC links and surgery spaces were highlighted on Canna, Muck and Rum. Residents were generally open to the idea of the new Health and Social Care Support Worker role and felt positive about it strengthening community resilience. As with the First Responders, uncertainty, however, was expressed over confidentiality, community capacity and the necessity of treating your own relatives or friends as well as skills maintenance as the workers had not been widely utilised at the time of interview.

10.3 New Models of Sustainable Primary Care Delivery

As detailed in earlier sections of this report, changes to primary care provision were made across each of the Being Here Programme pilot sites. The most visible changes in terms of new healthcare professional roles, and involvement of community members and volunteers, were seen in the Small Isles and Acharacle. The focus within the Mid-Argyll and Kintyre sites was much more on the merger of GP practices and revisions to the ways in which out-of-hours services are structured.

Although we observed progress towards the achievement of indicators in each of the pilot sites; overall, three of the four sites achieved the majority of the aims identified at the start of the programme:

- **Mid-Argyll:** achieved what local team wanted in terms of out-of-hours provision; training and some recruitment of doctors.
- **Small Isles:** goals of the Being Here programme were achieved in the main; new roles are up and running and fairly well received by the community interviewees; the GPs' boat and rota is now considered acceptable by most community members; there is a tangible community spirit and buy-in (although this has faced several challenges along the way and not all community members view the service changes positively).
- **Acharacle:** the aims of the Being Here programme were achieved in the main; there is a multidisciplinary team; new cover for out-of-hours; less reliance on locum staff; the community largely accept changes to the GP practice; and there is a perceived prevention of professional isolation amongst staff.
- The **Kintyre** pilot site area, by the end of our evaluation period, had not achieved the locally-established Being Here programme goal of practice mergers that were accepted by the community. This is shown through five of the community indicators remaining red at the end of the evaluation period. All of the indicators relating specifically to the perceptions of health and social care professionals were, however, met fully or to a substantial degree.
- **Islay:** although not part of the Being Here Programme in funding terms, Islay can also be seen to have made substantial progress towards achievement of their own local goals in terms of practice merger, sustainability and community acceptability. They attribute this to individual drive and culture within the practices, training, teaching, integration, consistency and joint working.

In terms of sustainability, evaluation indicators show that by the end of the Programme period, the perceptions of both community members and staff had shifted towards considering their local service to be sustainable in most of the pilot sites but some doubts persisted in Kintyre. The main threats to future sustainability were seen to be potential reductions in NHS budgets and turnover of healthcare professional staff in the future. Community members, and sometimes healthcare professionals, were not always convinced that the recruitment to GP and other new posts through the Being Here Programme would necessarily lead to the retention of people within these roles over the mid- to long- term. There was also concern expressed about the burden of volunteering within a First Responder Scheme – it was

suggested that this, over time, could lead to a drop off, and potential shortage of, volunteers in these roles.

In the Small Isles and Acharacle in particular, we saw the introduction of new multi-disciplinary teams and models of providing services – thus meeting one of the key aims of the Being Here Programme. In these two West Lochaber test sites, it has been shown that a broadening of teams and introduction of new roles can work to provide a service that is viewed by the community as safe, appropriate and relatively sustainable (albeit with some challenges and suggestions for further improvement noted within our sample of interviewees).

The evaluation found no particular evidence of increased usage of technology as a result of the Being Here Programme's activities but there is a desire amongst communities to increase utilisation, and, therefore potential for VC appointments – this may bode well for the introduction of the Attend Anywhere system for outpatients' appointments.

10.4 Shifting Perceptions of Acceptable Primary Care Models

From the very early days of our fieldwork, the majority of community residents considered their primary care models to be safe, of an acceptable standard and covering the breadth of rural primary care needs. Most were also open to the idea of a team-based, rather than single-handed GP, approach to service delivery. It was also apparent that the majority of healthcare professionals already viewed the primary care models as meeting several of the Being Here Programme evaluation indicators; including arrangements for out-of-hours and unscheduled care being acceptable; being open to the concept of practice mergers and feeling that local clinical leads were participating in the service developments. This indicates that there was a high level of satisfaction within the healthcare professional groups in each case study site that the new services were meeting the Being Here Programme objectives from early in the Programme period. By the end of the evaluation period there were few examples of healthcare professional specific indicators not being fully achieved; with "reduced feeling of isolation and/or over-burden" remaining partially achieved in the Small Isles and perceptions of the acceptability of out-of-hours and unscheduled care remaining mixed in Acharacle. In all the pilot sites, healthcare professionals felt that a reciprocal relationship with the community had been partly achieved.

When considered over time, the evaluation data revealed shifts in community perceptions of how closely they were involved in processes of services design and delivery in Islay, the Small Isles and Acharacle (with

perceptions of degree of involvement increasing over time). However, in Mid-Argyll and Kintyre this trend did not occur and residents in these areas tended towards lower levels of satisfaction with the Being Here Programme (as shown through the evaluation indicators relating to aspects of 'community engagement'). In addition, fear of service change remained more common within our Mid-Argyll and Kintyre community interviews, in comparison to other pilot sties. Practice mergers seemed to be a sticking point in Mid-Argyll and Kintyre for many of the residents that we spoke to – the threat of what they perceived to be 'closures' and a complete loss of service riled the community. According to many of our interviewees, they experienced a succession of 'negative' experiences with community engagement that did nothing to alleviate their concerns.

Nowhere did the overall perception within the community become one in which they saw themselves as active agents of change – only in some areas, did some people feel this, to a certain extent. Consideration of the qualitative data in our thematic analysis suggests that to engender such feelings it will require a greater degree of decision-making power to be given to community members; a greater transparency of how community views are taken into account and a greater degree of feeling within the community that they received adequate levels of feedback and opportunities for dialogue.

The Being Here Programme aimed to develop new models of primary care for remote and rural areas that would be considered by healthcare professionals and community members as contributing positively to local community resilience. We analysed how residents and healthcare professionals spoke about and conceptualised community resilience over time. For many community members, the link between health care service provision and community resilience was not apparent or easily understood. They most commonly talked about negative impacts on the economic sustainability of their families and communities that travel to secondary care appointments caused. Opinions that new service models *did* link to community resilience increased over time as communities witnessed first-hand that, for example, their new model could cope with something like an emergency or accident.

Community views on the acceptability of reciprocity were very mixed – these diverse views are not easily attributable to the Programme changes. When people talked about this topic, they tended to relate it more to their existing, personal views on doctor-patient roles, rather than any aspect of the Being Here service changes.

Our evaluation indicators and thematic analysis show that Being Here achieved particular success in shifting community opinions away from associating the quality of primary care provision with the full-time

presence of a GP within their local community; and towards an acceptance that quality provision can come from a team approach (that may involve GPs working with other types of healthcare professional, when appropriate). In Islay (although not part of the funded Being Here Programme), it was seen that the community responded positively to the retention of a GP presence within each of its main geographical communities – this was achieved through the retention of three surgery spaces, although not all open full-time for GP appointments. This may be one reason why the community indicators suggest attitudes to practice mergers are more positive in Islay than in the other two Being Here sites where mergers were proposed. If surgery space is reassuring, even without the physical presence of doctors on a full-time basis; this may be a way to reassure people facing practice mergers in other remote and rural areas. Having an identifiable 'health' or 'surgery' space within the community appears to aid the acceptance of new models of primary care delivery that are team based and cover wider geographical areas than previous un-amalgamated practices. An identifiable 'health' or 'surgery' surgery space could be, for example, in a community hall or other type of hub, and be used as a physical surgery and/or virtual surgery and health communication space, e.g. somewhere people could go to link up with virtual clinics or telephone consultations. This recreates the act of 'going to the doctor' which is the thing that a lot of people want to hang on to for reasons of reassurance – if we want people to be reassured then there may be other ways of engendering that reassurance that are more financially sustainable than small or single-handed practices. However, in Kintyre, where many community interviewees remained persistently unconvinced and fearful of practice mergers there was also a continuance of the idea that distance from a GP is linked to the quality of primary care service received (i.e. that those living further away are in receipt of a lower quality service). In areas where the feeling of a GP presence was maintained (Islay and Small Isles) even though this did not mean a GP was resident within the community or even in a surgery there full time, the notion that distance and quality are not necessarily linked became widespread over the duration of the programme – community members in the Small Isles and Islay could see first-hand that the model was working.

10.5 Implications for Remote and Rural Primary Care Delivery in Scotland

The Being Here Programme responded to the need for change within remote and rural primary care service delivery in Scotland. For various reasons, outlined earlier in this report, 'traditional' models of single-handed GP practices are often no longer seen as fit for purpose by healthcare professionals, service managers or community members. This is linked to a myriad of underlying reasons including healthcare

workers' professional and personal aspirations, communities' shifting care needs and service providers' financial constraints. However, within this shifting context, 'real' people live, work and play and often hold in high esteem traditional models of service delivery. Underlying much community 'dissatisfaction' with service change are fears of not being cared for, or cared about – of losing the reassurance that the NHS is 'there for them whenever needed' as represented by the presence of a healthcare professional within their local community; of losing reassurance that their community is valuable enough and sustainable enough in outsiders' eyes to warrant a health care professional residing within it. In this context, the Being Here Programme aimed to develop and test new ways of delivering remote and rural primary care that would be acceptable to, and accepted by, healthcare professionals and community members. We have seen, through this qualitative evaluation, that this has been achieved through practice mergers; new forms of 'distance' GP provision and new community roles such as Health and Social Care Workers and First Responders. However, our evaluation work has also highlighted the aspects of remote and rural care that community workers and healthcare professionals are still worried about. In this concluding section of the report, we pick out key learning points that may usefully inform the evolution of primary care service provision within other remote and rural areas of Scotland.

Retaining a GP presence within remote and rural communities is no longer necessarily tied to the physical presence of permanent doctor within a practice.

The Being Here Programme has shown that there are other models of service delivery that can be efficient, sustainable and acceptable, such as those implemented on Islay and the Small Isles. In both of these sites, the new models were introduced in a way that was cognisant of the importance of a physical 'health' or 'surgery' space within the community.

Recruitment to current vacancies does not necessarily dispel community fears over service sustainability.

Our qualitative work has shown that community members' perceptions of the sustainability of their services are not only linked to whether current posts are filled – community members consider much longer time scales when making their assessment of service sustainability. Recruitment to a post does not necessarily dispel community and health professionals' fears that 'one day our healthcare professionals will leave' – retention is seen as key to sustainability. Although Being Here has filled posts,

there is not enough evidence to say whether its activities, such as its advertising campaign, have had or will have an effect on longer term recruitment and retention issues – this still plays on the minds of remote and rural community members and healthcare professionals. Several of the healthcare professionals interviewed as part of the evaluation had already made the decision that they wanted to move to a rural area regardless of the Being Here advertising campaign – with some describing how they were actively seeking to move to a rural practice that would allow them the freedom and opportunities to work in a patient-centred manner. For community members to feel more reassured about long-term service sustainability, they will need to see that there is a 'back up' plan for continuing to attract replacements on an on-going basis should people leave their posts (this applied to both paid and voluntary roles).

To allay community members' fears of service change, the community must perceive there to be open and transparent communication channels, alongside information sharing.

As has been seen in other studies and service evaluations, the Being Here Programme suggested that purposeful, appropriate and meaningful community engagement activities lie at the heart of whether a community will feel satisfied with change, take part in any change process and feel comfortable and reassured throughout its course. Within the Being Here pilot site where fear of change remained higher (Kintyre), it was associated with greater feelings of the 'unknown', i.e. community members described not being able to understand what changes were taking place and a conceptualisation of the NHS as an organisational body that did not communicate frequently or adequately enough with them. The use of the National Standards for Community Engagement, at all organisational levels[4], might help improve community members' experiences of communication with the NHS.

Something that was repeatedly raised within our community interviews was a desire to better understand the roles of different kinds of healthcare professionals. Our thematic analysis identified that to let those healthcare professionals who are 'on the ground' have, and know that they have, greater autonomy to do community engagement activities may go part way towards addressing this. Within the Being Here pilot sites we met local front line staff, with valuable local knowledge and contacts, who described feeling as if they were not permitted to undertake even simple community engagement and awareness-raising activities, e.g. nurses and community members alike reported a desire to have a simple information sheet on the different roles undertaken by staff within the primary health care team. This is something that

[4] Not all health and care professionals interviewed were aware of and/or had utilised these.

should not be costly to achieve and could go a long way to dispelling fears and promoting acceptance of any new model/multi-disciplinary team in other remote and rural areas.

The community engagement issues that emerged in Mid-Argyll and Kintyre are not unique to these areas, or to the Being Here Programme; rather, they have often been reported elsewhere in the academic, evaluation and practitioner literature. They are reflective of wider challenges relating to community engagement that would benefit from being tackled on a strategic level. It is testament to the commitment of particular individuals in Acharacle and the Small Isles that the community engagement challenges were surmounted in these areas to a greater degree. Divergent views about the role and extent of consultation held by community and healthcare professional interviewees were evident and highlight a need for more creative engagement solutions to be tested. Employing a wider range of methods could help to reach and involve a greater number and wider variety of community members; in particular an increased use of digital methods and other options for contributions that can remain anonymous such as post-boxes and participation booths. Differing expectations over the aim and outcome of consultation exercises should be taken into consideration in order to facilitate meaningful community involvement and develop future models for co-production. Further research could help to identify appropriate and effective models of community engagement in rural communities experiencing this type of service re-design as well as explore ways of broadening participation, facilitating co-production and building community resilience.

Service models that include new roles, particularly those that are voluntary, require tangible, visible, reliable support structures, training programmes and communication channels for those taking on the roles.

Creating remote and rural primary care services that are reciprocal, and viewed as reciprocal by community members, will take concerted effort to shift attitudes; this is something that cannot necessarily be 'designed in' to a service change. The Being Here Programme has demonstrated that reciprocal, community-embedded, team-based models can work; and be accepted by the community as adequate, safe, and as sustainable as they can be in the short- to medium- term. This acceptance and commitment are strongest when the volunteers and the wider community feel that they understand the new roles and that the people taking them on are suitably trained. We saw in the Small Isles, for example, a persistent anxiety related to First Responders' lack of a schedule of on-going training that they felt was appropriate in terms of content and frequency. Although central to the functioning of new remote and rural primary care models within the Being Here pilot areas, the issues of First Responder role definition,

training provision and scheduling rest with the Scottish Ambulance Service and not the Being Here Programme team within the NHS. This clearly demonstrates how important cross-agency working is to the sustainability of remote and rural service delivery models.

Our analysis of qualitative data collected from First Responders themselves suggests that remote and rural communities may feel safer and more comfortable if the role is seen to be tailored to their specific local context. The need to administer pain relief, for example, was seen as an essential requirement for First Responders by volunteers and community members in the Small Isles. However, this was outside the scope of a First Responders' role. Their lack of ability to administer pain relief was an emotive issue; with community members describing the decision to volunteer as a decision to accept the fact that they may be called to an emergency involving a friend, family member or acquaintance in a great deal of pain that they were not in a position to alleviate. The scheme can work as long as the people involved are clear about their roles, receive on-going support and can see a tangible schedule of training into, at least, the near future. It is not just the First Responders themselves that need reassurance about training – wider community acceptability could be engendered by making the training schedule and requirements available to the general public.

10.6 Additional Learning Opportunities

Technology

Being Here aimed to increase the use of technology as part of making services sustainable. However, many of the changes in Being Here have not been linked specifically to the use of technology, e.g. new Health and Social Care Worker roles and merger of GP practices. Implementation of these changes can be seen to be related to sustainability in several ways but have not yet been accompanied by increased use of video conferencing for patient consultation. This is regarded as one of the most important ways to further increase sustainability of remote and rural health services by many of the community members and NHS staff that were interviewed as part of the qualitative evaluation. In order to implement this, those working in remote and rural areas (both on the ground and in management) will need to be supported not least in terms of gaining access to specialist services in larger centres such as Inverness/Glasgow. Secondary care VC has been piecemeal in the past and an overall strategy could help facilitate sustainability alongside local initiatives such as the new roles and GP models tested in Being Here. A clear connection in people's minds is the link between having to travel for secondary care and

personal/community economic resilience. Initiatives could build on this link to encourage self-care and use of technology. During the evaluation workshop at the NHS Being Here Legacy Event (11 May 2017), the challenges of increasing technology usage, changing primary care practice models, consulting the public consultation and recruiting healthcare professional were discussed. Technology (combined with connectivity) was proposed by the participants as the top priority to be highlighted to Scottish Government.

Mental health services

Across all the pilot areas, concerns were expressed about access to mental health services, particularly where patients lived a long distance from dedicated services and support groups. Delivering services such as counselling was identified as a particular problem in small communities because of the difficulty of ensuring confidentiality. Primary care and online resources could potentially have a greater role where patients cannot regularly access any other mainstream services such as CPNs.

Local knowledge

The Being Here qualitative evaluation acted as a channel for feeding the local voice to managers and operational staff. It has highlighted the need to look at how we build such processes into everyday locality operations.

Recognition of the third sector

Improved communication and integration with local third sector organisations was thought by many interviewees to be a way to improve the breadth of service delivery. A more integrated approach could also increase the potential for social prescribing to be offered within the community and thereby build local capacity.

10.7 Concluding Remarks

This report is the result of three years of qualitative evaluation work carried out by the Rural Health and Wellbeing Research team based at the University of the Highlands and Islands. Through the development of Programme indicators and completion of three cycles of fieldwork in each of the Being Here pilot sites, we have been able to monitor the progress of the Programme towards its goals over time. These indicators showed progress towards the achievement of Programme aims in all pilot areas e.g. high level of service

quality, sustainability, service breadth, multi-disciplinary team working, introduction of new roles, out-of-hours provision, less reliance on locums, practice mergers (except Kintyre) and recruitment. Concerns remained, however, over the impact of recruitment, retention and NHS budgets on long-term sustainability as well as the burden of volunteering, lack of increase in technology usage and adequacy of community engagement. The perceived lack of transparency in both policy consultation and implementation was seen to have contributed to dissatisfaction, frustration and disillusionment with the engagement process compounding the difficulty of introducing change in some areas. Ensuring communities feel involved, confident and secure is key to fostering trust, strengthening local capacity and building community resilience.

As has been described in earlier sections of this report, new models of service delivery have been successfully implemented; although practice mergers had not taken place in Kintyre by the end of our evaluation period. Being Here has shown that multi-disciplinary teams and more 'dispersed' models of provision can be implemented in remote and rural areas in ways that both communities and healthcare professionals find safe, acceptable and consider to be sustainable in the short to medium term. It is not unsurprising that we encountered a desire within many communities to retain a sense of personal contact with their healthcare professionals, especially their GP, but the service changes within the Programme have demonstrated that this feeling can be retained in ways that do not necessarily require the full-time presence of a GP within the community.

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Appendix 1: Interview Schedules, Information Sheets and Consent Forms

Baseline Interview Schedule – Healthcare Professional

31/10/2014

1. How is primary care provided in X? What types of health professional role/ post operate in X?
    a. Can you describe your role within this?

2. If you work within a multi-disciplinary team, how do you feel about its coordination?

3. Do you use communications technology within your everyday work? How do you use it, e.g. connect with patients/other healthcare professionals to avoid travel? How do you feel about using digital technology?

4. Would you say you are well connected into networks of professional support and training?
    a. If so, how do you access and maintain these?
    b. If not, how would you like to be able to access and maintain these?
        i. Do you ever feel isolated?
        ii. Do you every feel over-burdened?
        iii. Do you ever feel dissatisfied with your work-life balance?

5. Do you have any experience of dealing with healthcare professional vacancies in X? What was your role in the recruitment? In your opinion, was the recruitment successful?

6. How do you feel about the use of locums in X? (high; expensive; necessary etc.)

7. Thinking about Primary Care in your local area, would you describe it as…? Can you explain why you think this?
    a. Of acceptable quality?
    b. Safe?
    c. Able to deal with the breadth of healthcare situations that may arise in X?
    d. Able to deal with a variety of types of need, e.g. emergency, management of long-term conditions, diagnosis and acute illness.
    e. Overall, how sustainable do you think primary care is in your local area? (fragile; under strain).

8. How much of a role do you think the community's opinions have in the running of local primary care services?

9. Do you feel that any improvements could be made to the ways in which primary care is organised and delivered within X?

a. In particular, I'm interested to know whether you think the way in which primary care is delivered needs to change in X and why?
b. Do you think change is necessary and could be positive for X?
c. Do you think change could be risky? Why? How do you feel about this?

10. If you think change is necessary – who do you think should be involved in that process, and how?
    a. Local clinical leads and NHS management
    b. Local health care staff
    c. Local community residents
    d. Others

11. Do you think that the quality of care a patient receives is linked to how far they live from a GP practice? Can you explain why you think this?
    a. Do you think the quality of care is linked to the presence of a GP in X?
    b. Do you think it is essential for a GP practice to be located within X? Can you explain why you think this?

12. Can you think of any ways in which primary care could be provided to X without a GP practice located in X? For example, through the use of digital technology?

13. Do you know who is currently involved in the provision of emergency/out-of-hours care in X?
    a. Do you think this is an appropriate model? What works well/less well?
    b. How would you like to see emergency/out or hours care provided in X in the future? Do you think change is necessary?
    c. How do you feel about an increased role for community-based provision of services, such as First Responder schemes?

Baseline Interview Schedule – Community Member

31/10/2014

1. How long have you lived in X?

2. Do you understand what is meant by the term 'primary healthcare'? Where do you receive primary healthcare? Who delivers your primary healthcare?

   Primary care refers to health care provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment. It includes the work of health professionals who act as a first point of consultation for patients. Such a professional would usually be a primary care physician, such as a GP or nurse practitioner.

3. Have you ever used communications technology to connect with a healthcare professional, e.g. telephone appointment; video conference consultation?

4. Are you aware of a turnover in staff within primary care in X? For example, do you generally get to see the same GP?
   a. How important to you is consistency in primary care staff?

5. Thinking about primary healthcare in your local area, would you describe it as…? Can you explain why you think this?
   a. Fragile (under strain; unsustainable)?
   b. Safe?
   c. Of acceptable quality?
   d. Able to deal with the breadth of healthcare situations that may arise in X?
   e. Able to deal with a variety of types of need, e.g. emergency, management of long-term conditions, diagnosis and acute illness.

6. How much of a role do you think the community's opinions have in shaping the running of local primary care services?
   a. Have you ever taken part in a consultation?
   b. How would you take forward a suggestion or complaint?

7. Do you feel that any improvements could be made to the ways in which primary healthcare is organised and delivered within X?
   a. In particular, I'm interested to know whether you think the way in which primary care is delivered needs to change in X and why?
   b. Do you think change is necessary and could be positive for X?
   c. Do you think change could be risky? Why? How do you feel about this?

8. If you think change is necessary – who do you think should be involved in that process, and how?
   a. Local clinical leads and NHS management

b. Local health care staff
c. Local community residents
d. Others

9. How far do you live from your GP practice?
    a. Do you think that the quality of care you receive is linked to how far you live from a GP practice? Can you explain why you think this?
    b. Do you think the quality of care you receive is linked to the presence of a GP in X?

10. Can you think of any ways in which primary care could be provided to X without a GP practice located in X? For example, through the use of digital technology?

11. Do you know who is currently involved in the provision of emergency/out-of-hours care in X?
    a. Do you think this is an appropriate model? What works well/less well?
    b. How would you like to see emergency/out or hours care provided in X in the future? Do you think change is necessary?
    c. How do you feel about an increased role for community-based provision of services, such as First Responder schemes?

Fieldwork 1 Interviews – Healthcare Professional

(29/7/15)

Role/how long? (if appropriate)

1. What changes have been made to primary care services/social care services since the last visit/in the last six months?

2. Do you feel that the service is:

   - Sustainable?
   - Safe?
   - Of an acceptable standard?
   - Cover the breadth of primary care/ the breadth of remote and rural healthcare scenarios?

3. Do you think the community has been involved in developing services?
   How has the community been consulted? What role should the community have?

4. Have there been changes to the way your MDT is working?
   Is there anything that could be improved? e.g breadth, co-ordination

5. What role has the clinical lead played in implementing these changes? *Have they given their support?*

6. What do you think about your work-life balance?

   Do you feel isolated? Do you feel over-burdened?

   Has there been any change in last 6 months?

7. What is the current situation with the out-of-hours service?
   Has it changed? What works well/doesn't work well?

8. Do you think there has been any impact on community resilience?
   Is the community taking more responsibility for health and services?
   Is the relationship between community and healthcare professional becoming more reciprocal?

9. Are you using technology more or less than you were since the last visit?
   With professionals, patients?
   To what extent is telehealthcare being used?

10. Are you getting the appropriate training?
    Is it sufficient? Any improvements necessary?

11. Have there been any changes to social care?

    What works well?
    What doesn't work well?

12. Do you have any further comments to add - about primary health care or social care?

Fieldwork 1 Interviews – Community Member

29/7/15

1. Are you aware of any changes to local primary health care and social care services that have taken place since the last interview/last six months?

   What has changed?

   What do you like? What don't you like?

2. What do you think of the team-based practice?

   Advantages/disadvantages?

   How does it compare to the former single-handed practice?

3. Do you think services are …?

   - Sustainable
   - Safe
   - Of an acceptable standard
   - Cover the breadth of remote and rural healthcare scenarios.
   - Cover the breadth of primary care

4. Do you feel the community has been involved in the development of services?

   Do you feel the community has been consulted on proposals?
   How would you like to be involved/consulted?

5. Do you think the changes have had an impact on the capacity and resilience of the community?

Do you think there has been any impact on the strength/sustainability of the community?

Do you think the community should be more responsible for its services?

Do you think the individual should take more responsibility for their health?

Do you think the relationship with healthcare professionals is becoming more reciprocal?

6. What do you think of the current system for out-of-hours and unscheduled care?

   What works well? What does not work well?

7. Would you be happy to be seen by other members of the healthcare team rather than the GP?

   Is a team-based approach to ongoing care acceptable?

8. How far do you live from the GP practice?

9. Do you ever have a telephone consultation with your GP? *VC consultation?*

10. What do you think of the social care service in the area?
    What works well?
    What doesn't work well?

11. Do you have any further comments about primary health care or social care?

Fieldwork 2 Interviews – Healthcare Professional

3/4/2016

Role/how long? (if appropriate)

1. What changes have been made to primary care services/social care services since the last visit/in the last six months?

   What has changed?
   What do you like? What don't you like?
   Overall do you think the changes have been positive or negative?
   Have the changes been easier/more difficult than you thought?
   Is further change necessary? What developments are planned?
   What do you think of the practices merging?

2. Do you feel that the service is:

   - Sustainable?
   - Safe?
   - Of an acceptable standard?
   - Cover the breadth of primary care/ the breadth of remote and rural healthcare scenarios?

3. Do you think the community has been involved in developing services?
   How has the community been consulted? What role should the community have?

4. Have there been changes to the way your MDT is working?
   Is there anything that could be improved? e.g breadth, co-ordination

5. What role has the clinical lead played in implementing these changes? *Have they given their support?*

6. What do you think about your work-life balance?

   Do you feel isolated? Do you feel over-burdened?
   Has there been any change in last 6 months?

7. What is the current situation with the out-of-hours service?
   Has it changed? What works well/doesn't work well?

8. Do you think there has been any impact on community resilience?
   Is the community taking more responsibility for health and services?
   Is the relationship between community and healthcare professional becoming more reciprocal?

9. Are you using technology more or less than you were since the last visit?
   With professionals, patients?
   To what extent is telehealthcare being used?

10. Are you getting the appropriate training?
    Is it sufficient? Any improvements necessary?

11. Have there been any changes to social care?

    What works well?
    What doesn't work well?

12. Do you have any further comments to add - about primary health care or social care?

Fieldwork 2 – Healthcare professional (Small Isles)

10/6/16

Role/how long? (if appropriate)

1. What *changes have taken place with primary health care and social care since the last interview?*

   GP service
   Health and Social Care Support Workers
   First Responder
   Visiting services
   Boat
   New surgery – surgery space
   Health Fair

   What do you like? What don't you like?
   Overall do you think the changes have been positive or negative? What has changed?

2. Do you feel that the service is:

   - Sustainable? Factors/threats
   - Safe?
   - Of an acceptable standard?
   - Cover the breadth of primary care/ the breadth of remote and rural healthcare scenarios?

3. Do you think the community has been involved in developing services?
   How has the community been consulted? What role should the community have?

4. Have there been changes to the way your MDT is working?
   Is there anything that could be improved? e.g breadth, co-ordination

5. What role has the clinical lead played in implementing these changes? *Have they given their support?*

6. What do you think about your work-life balance?

   Happy or unhappy with work life balance?
   Do you feel isolated? Do you feel over-burdened?
   Has there been any change in last 6 months?

7. What is the current situation with the out-of-hours service?
   Has it changed? What works well/doesn't work well?

8. Do you think there has been any impact on community resilience?
   Is the community taking more responsibility for health and services?
   Is the relationship between community and healthcare professional becoming more reciprocal?

9. Are you using technology more or less than you were since the last visit?
   With professionals, patients?
   To what extent is telehealthcare being used?

10. Are you getting the appropriate training?
    Is it sufficient? Any improvements necessary?

11. Have there been any changes to social care?

    What works well?
    What doesn't work well?

12. Do you have any further comments to add - about primary health care or social care?

Fieldwork 2 - Healthcare Professional (Argyll & Bute)

September 2016

1. How long have you worked in the area?

2. What changes have been made to primary care services/social care services since the last visit?

   What works well?
   What doesn't work well?

   Current situation with GP cover – what are the hours?

   Why do you think it is difficult to recruit? What do you think can be done?

   Advertising campaign?

   Proposed merger?
   Advantages
   Disadvantages

3. Do you feel that the service is sustainable? Factors in sustainability?

4. Do you think the community has been involved in developing services?
   How has the community been consulted? What role should the community have?

5. What do you think about your work-life balance? Is this a factor in r & r?

   Do you feel isolated? Do you feel over-burdened?

6. How is the out-of-hours service now it's taken over?
   What works well/doesn't work well?

7. Do you think there has been any impact on community resilience?
   Is the community taking more responsibility for health and services?
   Is the relationship between community and healthcare professional becoming more reciprocal?
   Meetings with CC or LPG – what is the role of GP?

8. Are you using technology more or less than you were since the last visit?
   With professionals, patients?
   To what extent is telehealthcare being used?

9. Are you getting the appropriate training and professional support?
   Is it sufficient? Any improvements necessary?

10. Do you have any further comments to add?

Fieldwork 2 Interviews – Non-clinical/management

6/5/16

Role/how long?

1. What changes have been made to primary care services in the last six months?

What has changed?

What works well? What is not working so well?

Advantages/disadvantages?

Have the changes been easier/more difficult to implement than you expected?

Barriers to change?

Is further change necessary? What developments are planned?

2. Do you feel that the service is sustainable?

Factors/threats?

3. Do you think the community has been involved in developing services?

How has the community been consulted? What role should the community have?

4. Do you think there has been any impact on community resilience?

Is the community taking more responsibility for health and services?

Is the relationship between community and healthcare professional becoming more reciprocal?

5. Is technology being used more or less since the last visit/last six months?

With professionals, patients?

To what extent is telehealthcare being used?

6. What training is available to health & social care professionals?

Is it sufficient? Accessible? Barriers? Any improvements necessary?

7. Have there been an impact/change to social care?

What works well?

What doesn't work well?

8. Do you have any further comments to add?

Fieldwork 2 – Community Member

3/4/2016

1. Are you aware of any changes to local primary health care and social care services that have taken place since the last interview/last six months?

   What has changed?
   What do you like? What don't you like?
   Overall do you think the changes have been positive or negative?

2. What do you think of the team-based practice?

   Advantages/disadvantages?
   How does it compare to the former single-handed practice?

3. Do you think services are …?

   - Sustainable
   - Safe
   - Of an acceptable standard
   - Cover the breadth of remote and rural healthcare scenarios.
   - Cover the breadth of primary care

4. Do you feel the community has been involved in the development of services?

   Do you feel the community has been consulted on proposals?
   How would you like to be involved/consulted?

5. Do you think the changes have had an impact on the capacity and resilience of the community?

Do you think there has been any impact on the strength/sustainability of the community?
Do you think the community should be more responsible for its services?
Do you think the individual should take more responsibility for their health?
Do you think the relationship with healthcare professionals is becoming more reciprocal?

6. What do you think of the current system for OOH and unscheduled care?

   What works well? What does not work well?
   Do you always expect to see a GP out-of-hours?

7. Would you be happy to be seen by other members of the healthcare team rather than the GP?

   Is a team-based approach to ongoing care acceptable?

8. How far do you live from the GP practice?
   How does this affect you? Does the distance have an impact on the quality of care you receive?

9. Do you ever have a telephone consultation with your GP? *VC consultation?*

10. What do you think of the social care service in the area?
    What works well?
    What doesn't work well?

11. Do you have any further comments about primary health care or social care?

Fieldwork 2 - Community Member (Small Isles)

10/6/2016

1. What changes have taken place with primary health care and social care since the last interview?

   GP service
   Health and Social Care Support Workers
   First Responder
   Visiting services
   Boat
   New surgery – **surgery space**
   Health Fair

   What do you like? What don't you like?
   Overall do you think the changes have been positive or negative?

2. What do you think of the new model?

   Advantages/disadvantages?
   How does it compare to the former single-handed practice?

3. Would you be happy to be seen by other members of the healthcare team rather than the GP?

   Visiting services?
   Is a team based approach to ongoing care acceptable?

4. Do you think services are …?

   - Sustainable – factors/threats
   - Safe
   - Of an acceptable standard
   - Cover the breadth of remote and rural healthcare scenarios.
   - Cover the breadth of primary care

5. Do you feel the community has been involved in the development of services?

   Has this changed?
   Do you feel the community has been consulted on proposals?
   How would you like to be involved/consulted?
   Benefits?

6. Do you think the changes have had an impact on the capacity and resilience of the community?

Do you think there has been any impact on the strength/sustainability of the community?
Do you think the community should be more responsible for its services?
Do you think the individual should take more responsibility for their health? Is this changing? Are there opportunities?
Do you think the relationship with healthcare professionals is becoming more reciprocal?

7. What do you think of the current system for OOH and unscheduled care?

   What works well? What does not work well?
   Do you always expect to see a GP out-of-hours?

8. Do you ever have a telephone consultation with your GP? *VC consultation?*

Technology?

9. How far do you live from the GP practice?
   How does this affect you? Does the distance have an impact on the quality of care you receive?

10. What do you think of the social care service in the area?
    What works well?
    What doesn't work well?

11. Do you have any further comments about primary health care or social care?

Fieldwork 3 – Community Member and Healthcare Professional

31/3/17

1. Quality of primary care

Finding: Satisfaction with safety, standard & breadth of primary care.

Agree/disagree

2. GP service model

Finding: - Generally single-handed GP is no longer considered a viable model. Small team preferred to offer choice and continuity for patient and professional support for the GP. Value placed on local surgery, even if GP visiting rather than resident.

Agree/disagree - why

Finding: Practice mergers – accepted in Small Isles/Acharacle/Islay but less so in mid-Argyll/Kintyre
More acceptable going from single-handed/locums to small permanent team – less acceptable going from small team to larger town based practice.

Agree/disagree - why

Finding: Larger GP team model – professionals see a range of expertise/skills, more sustainable, easier to recruit

Agree/disagree - why

3. Sustainability

Finding: Services are largely sustainable but long-term viability is dependent on future NHS budgets & GP recruitment.

Agree/disagree – why

Other factors for sustainability? Impact of Being Here changes on sustainability?

4. GP communication/practice information

Finding: a range of views on whether practice communication is sufficient.

Are you satisfied with the level of information from the practice?
What kind of information do you want?
How do you want the information to be given to you?

5. Consultation & community engagement

Finding: consultation and community involvement are often perceived as inadequate.

What kind of issue do you want to be consulted on?
What is the best way to consult the community?
What is the extent of community influence on policy decisions?
How far do you think people's views can or should be taken on board by service planners?

6. Community participation

Finding: range of views on whether the community should do or can do any more and what type of role it should have.

e.g. helping neighbours, taking on voluntary roles, service provision

Agree/disagree – why

7. Technology

Finding – patients and professionals are open to further expansion particularly of VC but little increase in use found.

What technologies are being used?
What are the advantages?
What are the disadvantages?
What are the barriers? (Structural, strategic, cultural factors)
How can these be overcome?
What specific service would you like to access? E.g. secondary care, specialist advice.
How can specific technologies (e.g. VC facilities) contribute to wider community sustainability and resilience?

8. Service innovation (as appropriate to location)

Finding: positive attitudes to new roles but concerns over capacity and confidentiality

First Responders
Health & social care support workers
Non-GP out-of-hours cover

How do you feel this is now working? Working well/not working well?
Have your views changed since it was introduced? Positive/negative?

9. Third sector (as appropriate)

Finding: TS organisations used as service providers but not integrated with healthcare – opportunities for closer working/social prescribing

Agree/disagree – why

How could this be improved?
Opportunities? Barriers? Resources?

10. Mental health

Finding: commonly recorded service gap – access to services in R & R areas

Agree/disagree – why?

What are the problems specific to R & R?

11. Community resilience

Finding: Views are divided with resilience seen as dependent on community action or conventional services.

Agree/disagree – why?
What makes the community strong and sustainable?
Capacity

12. Impact of Being Here project (as appropriate)

Finding: different impacts across pilot areas

Fieldwork 3 – Community Member and Healthcare Professional (Small Isles)

June 2017

Interview question areas

1. Quality of primary care

Finding: Satisfaction with safety, standard & breadth of primary care.

Agree/disagree

2. Service elements

Practice model from Skye
Boat charter
Appointment system
Surgery space
Health and Social Care Support Worker
First Responders
Technology – VC, etc.
Pilot of 'Attend Anywhere'
Visiting services
Practice information
Consultation/community involvement – Health Panel
Sustainability
Resilience
Impact of Being Here project – advertising, etc.
Mental health
Third sector – social prescribing

Other comments

3. GP service model

Finding: - Generally single-handed GP is no longer considered a viable model. Small team preferred to offer choice and continuity for patient and professional support for the GP. Value placed on local surgery, even if GP visiting rather than resident.

Agree/disagree - why

Finding: Practice mergers – accepted in Small Isles/Acharacle/Islay but less so in mid-Argyll/Kintyre
More acceptable going from single-handed/locums to small permanent team – less acceptable going from small team to larger town-based practice.

Agree/disagree - why

Finding: Larger GP team model – professionals see a range of expertise/skills, more sustainable, easier to recruit

Agree/disagree - why

4. Sustainability

Finding: Services are largely sustainable but long-term viability is dependent on future NHS budgets & GP recruitment.

Agree/disagree – why

Other factors for sustainability? Impact of Being Here changes on sustainability?

5. GP communication/practice information

Finding: a range of views on whether practice communication is sufficient.

Are you satisfied with the level of information from the practice?
What kind of information do you want?
How do you want the information to be given to you?

6. Consultation & community engagement

Finding: consultation and community involvement are often perceived as inadequate.

What kind of issue do you want to be consulted on?
What is the best way to consult the community?
What is the extent of community influence on policy decisions?
How far do you think people's views can or should be taken on board by service planners?

7. Community participation

Finding: range of views on whether the community should do or can do any more and what type of role it should have.

e.g. helping neighbours, taking on voluntary roles, service provision

Agree/disagree – why

8. Technology

Finding – patients and professionals are open to further expansion particularly of VC but little increase in use found.

What technologies are being used?
What are the advantages?
What are the disadvantages?
What are the barriers? (Structural, strategic, cultural factors)
How can these be overcome?
What specific service would you like to access? E.g. secondary care, specialist advice.

How can specific technologies (e.g. VC facilities) contribute to wider community sustainability and resilience?

9. Service innovation (as appropriate to location)

Finding: positive attitudes to new roles but concerns over capacity and confidentiality

First Responders
Health & social care support workers
Non-GP out-of-hours cover

How do you feel this is now working? Working well/not working well?
Have your views changed since it was introduced? Positive/negative?

10. Third sector (as appropriate)

Finding: TS organisations used as service providers but not integrated with healthcare – opportunities for closer working/social prescribing

Agree/disagree – why

How could this be improved?
Opportunities? Barriers? Resources?

11. Mental health

Finding: commonly recorded service gap – access to services in R & R areas

Agree/disagree – why?

What are the problems specific to R & R?

12. Community resilience (include because part of impact assessment?)

Finding: Views are divided with resilience seen as dependent on community action or conventional services.

Agree/disagree – why?
Capacity

13. Impact of Being Here project (as appropriate)

Finding: different impacts across pilot areas

Baseline Project Information Sheet

31/10/2014

Being Here Project: Participant Information Sheet

This information sheet is designed for people who have been invited to take part in the Being Here Project baseline stakeholder review.

What is the Being Here Project?

The Being Here Project is an initiative to build the sustainability of health and care services in remote and rural areas. The Project is managed by NHS Highland and part-funded by the Scottish Government. In order to build sustainability, the Project aims to develop and test new models for remote and rural health and care services in Scotland. Part of the project comprises research and evaluation work – this is being managed by NHS Highland Research and Development Department, with UHI subcontracted to carry out some of the activities.

Why have I been asked to take part?

You have been identified as a project stakeholder. This means that you either work or live in a remote or rural area of Scotland that is part of the Being Here Project. You have either been identified through publically available records of healthcare staff or the electoral roll. The Project team want to include the opinions of stakeholders in the development and testing of new models of health and care.

If I agree to take part, what will I do?

A researcher from UHI will arrange a convenient time to speak with you on the telephone. You will be asked a series of questions designed to gather your opinions of health and social care services within your locality. This will last between 30 and 60 minutes.

How will my contributions be used?

The researcher will take notes during the telephone conversation. These notes will be anonymous and will not contain your name or any other identifying information. Several telephone interviews will be carried out with people working and/or living within your local area. UHI researchers will examine the notes from all of these interviews and pick out any common themes. These themes will be reported to the NHS Being Here Project team and will feed into the on-going development of the project.

Who is carrying out this research?

The research and evaluation work is managed by Dr. Sarah-Anne Munoz, Senior Research Fellow at the University of the Highlands and Islands. UHI Research Fellows Ann Clark, Sara Bradley and Issie MacPhail are assisting with the telephone interviews.

Contact: Sarah-Anne Munoz, UHI Rural Health and Wellbeing, Centre for Health Science, Old Perth Road, Inverness, IV2 3JH

E-Mail: sarah-anne.munoz@uhi.ac.uk Tel: +44 (0) 1463 279 568

If you have a query that you feel cannot be addressed by the research team, please contact the UHI Research Office Administrator: Tel 01463 279000, email: ro@uhi.ac.uk

Being Here Project Fieldwork: Participant Information Sheet

25/5/16

This information sheet is designed for people who have been invited to take part in the Being Here Project evaluation.

What is the Being Here Project?

The Being Here Project is an initiative to build the sustainability of health and care services in remote and rural areas. The Project is managed by NHS Highland and part-funded by the Scottish Government. In order to build sustainability, the Project aims to develop and test new models for remote and rural health and care services in Scotland. Part of the project comprises research and evaluation work – this is being managed by NHS Highland Research and Development Department, with UHI subcontracted to carry out some of the activities.

Why have I been asked to take part?

You have been identified as a project stakeholder. This means that you either work or live in a remote or rural area of Scotland that is part of the Being Here Project. The Project team want to include the opinions of stakeholders in the development and testing of new models of health and care.

If I agree to take part, what will I do?

A researcher from UHI will arrange a convenient time to speak with you in person or on the telephone. Alternatively the researcher may visit you in a community group setting organised in advance. You will be asked a series of questions designed to gather your opinions of health and social care services within your locality. This will last between 30 and 60 minutes.

How will my contributions be used?

The researcher will take notes during the interviews and group discussions. With prior consent the conversation may be recorded. These notes will be anonymous and will not contain your name or any other identifying information. Several interviews will be carried out with people working and/or living within your local area. UHI researchers will examine the notes and recordings from all of these interviews and pick out any common themes. These themes will be reported to the NHS Being Here Project team and will feed into the on-going development of the project.

Who is carrying out this research?

The research and evaluation work is managed by Dr. Sarah-Anne Munoz, Senior Research Fellow at the University of the Highlands and Islands. UHI Research Fellow Dr Sara Bradley will be carrying out the interviews and group discussions.

Contact: Dr Sarah-Anne Munoz (Project Lead), UHI Rural Health and Wellbeing, An Lochran, 10 Inverness Campus, IV2 5NA. E-Mail: sarah-anne.munoz@uhi.ac.uk Tel: +44 (0) 1463 279 000.

If you have a query that you feel cannot be addressed by the research team, please contact the UHI Research Office Administrator: Tel 01463 279000, email: ro@uhi.ac.uk

Baseline Participant Consent Form

31/10/14

Being Here Project: Participant Consent Form

This consent form is designed for people who have been invited to take part in the Being Here Project baseline stakeholder review. Please read our project information sheet before completing this form. Please discuss anything you are not sure about with one of the project researchers (contact details are given on the participant information sheet).

Please tick to confirm your agreement to each of the statements below:

I agree to take part in a baseline stakeholder interview by telephone ☐

I agree that a UHI researcher may take notes relating to the answers that I give in the telephone interview ☐

I agree that an anonymised version of the notes from my interview can be used in a thematic analysis ☐

I agree that anonymised quotes from my telephone interview can be used in project reports, academic papers and conference presentations. ☐

NAME……

SIGNATURE……..

DATE……..

Being Here Project Fieldwork Consent Form

29/7/15

Being Here Project: Participant Consent Form

This consent form is designed for people who have been invited to take part in the Being Here Project evaluation. Please read our project information sheet before completing this form. Please discuss anything you are not sure about with one of the project researchers (contact details are given on the participant information sheet).

Please tick to confirm your agreement to each of the statements below:

I agree to take part in an interview or group discussion. ☐

I agree that a UHI researcher may take notes relating to the answers that I give. ☐

I agree to being audio recorded. ☐

I agree that an anonymised version of the notes from my interview and recording can be used in a thematic analysis. ☐

I agree that anonymised quotes from the interview or discussion can be used in project reports, academic papers and conference presentations. ☐

NAME……

SIGNATURE……..

DATE……..

University of the Highlands and Islands Rural Health and Wellbeing

University of the Highlands and Islands Oilthigh na Gàidhealtachd agus nan Eilean

Appendix 2: Being Here Evaluation Indicators and Tables

Project Indicators

Revised following Workshop on Friday 22nd May, 2015.

Health and care professionals and community members feel that the new model is:

1. Inclusive of the community's voice
2. Sustainable
3. Safe
4. Of an acceptable standard
5. Cover the breadth of remote and rural healthcare scenarios
6. Cover the breadth of primary care
7. Building community resilience

COMMUNITY INDICATORS

8. Change is no longer feared
9. Out-of-hours and unscheduled care acceptable
10. Relationship with healthcare professionals becomes more reciprocal, with greater community and individual responsibility
11. Practice mergers are acceptable
12. View capability and capacity building and strengthening resilience as acceptable
13. Feel that they have been active agents in the change process
14. Value clinical standards over the maintenance of traditional health and care professional roles
15. No longer equate quality of service with geographical distance from service
16. No longer equate an appropriate emergency response with only the GP or Scottish Ambulance Service
17. 'See and treat' and ongoing care being done by non-GP/healthcare professional is acceptable
18. Team based approach to ongoing care acceptable

HEALTH AND CARE PROFESSIONAL INDICATORS

19. Reduced feelings of isolation and/or over-burden; they, and their families, are content with work-life balance
20. Out-of-hours and unscheduled care acceptable
21. Change is no longer feared
22. The relationship with the community becomes more reciprocal with greater community and individual responsibility
23. Practice mergers acceptable
24. Multi-disciplinary teams have clear lines of co-ordination and accountability that they understand
25. New roles/teams/practices are functioning with multi-disciplinary teams
26. Local clinical leads have participated in the change process and publicly support/demonstrate the model

OTHER INDICATORS

27. All new posts advertised and filled
    - Number and type of posts advertised
    - Whether and which posts were filled, and with same or different type of post?
    - How long took to fill?
28. Appropriate use of supplementary staff (locums, bank, agency)
    a. Reduced spend on supplementary staff
29. Increased use of technology
    a. Use logged - VC, text, phone, email, other
30. Increased 'see and treat' being done by non-GP/healthcare professional

Project indicator tables

NO	**PARTLY**	**YES**	**Not tested/applicable**

Note: Interviews were conducted in Gigha, Southend and Muasdale (Kintyre) and Inveraray and Furnace (mid-Argyll).

HEALTH AND CARE PROFESSIONALS AND COMMUNITY MEMBERS FEEL THAT THE NEW MODEL IS:				
	AREA	**Islay**	**Kintyre**	**Mid-Argyll**
1.	Inclusive of the community's voice			
2.	Sustainable			
3.	Safe			
4.	Of an acceptable standard			
5.	Cover the breadth of remote and rural healthcare scenarios			
6.	Cover the breadth of primary care			
7.	Building community resilience *(very dependent on type of community e.g. town or smaller)*			

COMMUNITY INDICATORS				
	AREA	**Islay**	**Kintyre**	**Mid-Argyll**
1.	The Change is no longer feared			
2.	Out-of-hours and unscheduled care acceptable			
3.	Relationship with healthcare professionals becomes more reciprocal, with greater community and individual responsibility			
4.	Practice mergers are acceptable			

5.	View capability and capacity building and strengthening resilience as acceptable			
6.	Feel that they have been active agents in the change process			
7.	Value clinical standards over the maintenance of traditional health and care professional roles			
8.	No longer equate quality of service with geographical distance from service			
9.	No longer equate an appropriate emergency response with only the GP or Scottish Ambulance Service			
10.	'See and treat' and ongoing care being done by non-GP/healthcare professional is acceptable			
11.	Team based approach to ongoing care acceptable			

HEALTH AND CARE PROFESSIONAL INDICATORS				
	AREA	**Islay**	**Kintyre**	**Mid-Argyll**
1.	Reduced feelings of isolation and/or over-burden; they, and their families, are content with work-life balance			
2.	Out-of-hours and unscheduled care acceptable			
3.	The change is no longer feared			
4.	The relationship with the community becomes more reciprocal with greater community and individual responsibility			
5.	Practice mergers acceptable			
6.	Multi-disciplinary teams have clear lines of co-ordination and accountability that they understand			
7.	New roles/teams/practices are functioning with multi-disciplinary teams			
8.	Local clinical leads have participated in the change process and publicly support/demonstrate the model			

HEALTH AND CARE PROFESSIONALS AND COMMUNITY MEMBERS FEEL THAT THE NEW MODEL IS:

	AREA	Small Isles	Acharacle
1.	Inclusive of the community's voice		
2.	Sustainable		
3.	Safe		
4.	Of an acceptable standard		
5.	Cover the breadth of remote and rural healthcare scenarios		
6.	Cover the breadth of primary care		
7.	Building community resilience		

COMMUNITY INDICATORS

	AREA	Small Isles	Acharacle
1.	The change is no longer feared		
2.	Out-of-hours and unscheduled care acceptable		
3.	Relationship with healthcare professionals becomes more reciprocal, with greater community and individual responsibility		
4.	Practice mergers are acceptable		
5.	View capability and capacity building and strengthening resilience as acceptable		
6.	Feel that they have been active agents in the change process		
7.	Value clinical standards over the maintenance of traditional health and care professional roles		
8.	No longer equate quality of service with geographical distance from service		
9.	No longer equate an appropriate emergency response with only the GP or Scottish Ambulance Service		
10.	'See and treat' and ongoing care being done by non-GP/healthcare professional is acceptable		
11.	Team based approach to ongoing care acceptable		

HEALTH AND CARE PROFESSIONAL INDICATORS			
	AREA	**Small Isles**	**Acharacle**
1.	Reduced feelings of isolation and/or over-burden; they, and their families, are content with work-life balance		
2.	Out-of-hours and unscheduled care acceptable		
3.	The change is no longer feared		
4.	The relationship with the community becomes more reciprocal with greater community and individual responsibility		
5.	Practice mergers acceptable		
6.	Multi-disciplinary teams have clear lines of co-ordination and accountability that they understand		
7.	New roles/teams/practices are functioning with multi-disciplinary teams		
8.	Local clinical leads have participated in the change process and publicly support/demonstrate the model		