



Evaluation of Healthcare Service Provision on the Isle of Lismore

Final Report

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Glossary

CHP –Community Health Partnership

CRH – Centre for Rural Health

GP – General Practitioner

OOH – Out of Hours

SAS – Scottish Ambulance Service

Executive Summary

Background

Prior to 2009 the Argyll and Bute CHP sought to engage with the community on the Isle of Lismore regarding the model of future healthcare provision on the island. Discussions led to the proposal of a new Model which sought to: better coordinate and enhance current mainstream services; introduce anticipatory care plans for more vulnerable patient groups; encourage and support self care and to provide a coordinated and appropriate mechanism for accessing OOH, unscheduled and emergency care. Importantly, the Argyll & Bute CHP put in place a mechanism to ensure that the emergency care response for Lismore delivers the same outcomes as elsewhere across Argyll & Bute. In addition, it was the intention of the Argyll & Bute CHP that the model developed with the community on Lismore would inform service developments in other small remote and island communities.

The main elements of the proposed new model of healthcare provision for Lismore are listed below:

1. Anticipatory/Self Care
2. Mainstream Services
 - (i) GP provision
 - (ii) Community Nursing Provision from Appin/Lismore/Connel/Taynuilt Team
 - (iii) Allied Health Professionals/Other Specialist Services
 - (iv) Generic Health and Social Care Worker
3. Out of Hours/ Emergency/ Unscheduled Care Services
 - (i) Use of NHS 24 by the community
 - (ii) Scottish Ambulance Service
 - (iii) Community First Responder Training by the Scottish Ambulance Staff
 - (iv) Transport to the island by boat
4. Utilisation of combined resource currently spent on island services

Each part of the model was to be either implemented or the feasibility of its development discussed with the relevant stakeholders before the evaluation of the new model could take place (details of each part of the model can be found in the main body of the report).

The aim for the Argyll & Bute CHP was to provide a better quality, safe and sustainable model of healthcare provision on the Isle of Lismore that would reduce the need for unscheduled or emergency care OOH through better management of patient needs within normal working hours.

Aims and Objectives of the Evaluation

This evaluation sought to gain the views of both the community and their service providers on the implementation of this new model of healthcare provision on the Isle of Lismore. Views were sought from the community and the service providers in 2009 prior to the implementation of the new model. The evaluation of the new model took place in 2011 after ***all*** of the elements of the model had been in place for 6 months. The evaluation did not aim to evaluate the safety or quality of the new model, rather its focus is on the acceptance and appropriateness/suitability of the introduction of a new package of healthcare provision and its delivery to the Isle of Lismore and its community.

Methods

The study design adopted mixed qualitative and quantitative methods to evaluate the new model of Healthcare Service Provision on the Isle of Lismore including public meetings, interviews and a community questionnaire. Phase 1 work in 2009 sought to gather baseline data on the understanding of the new model to be implemented from both the citizens and service providers' perspectives. It was agreed that all parts of the new model would be in place for a period six months before the phase 2 work would proceed. Phase 2 work was undertaken in 2011 and sought to gather data on the experience of the new model from both the citizens and service providers' perspectives.

Topics covered in the data collection phases were negotiated with community council representatives and the Argyll & Bute CHP and included the following:

- Views on current services, challenges, needs
- Views on future services, hopes, expectations
- Views on community capacity, resilience, responsibility, rights, priorities, capacity to deal with illness and injuries
- Views on security, confidence, previous experiences
- Views on the way people use health services and will use health services

Findings

- **Views on current services, challenges, needs**

All of the elements of the new model of healthcare provision on the Isle of Lismore had been in place for six months before the evaluation of the service was completed. Although the majority of the community knew that a new model had been proposed, fewer knew that it had been implemented and there is much confusion as to what the model actually comprises.

There is much confusion over the different nursing roles. The community spoke about a Practice Nurse, Community Nurse and an Advanced Nurse Practitioner but were not clear on who was managed by whom or what skill sets each professional had. Many citizens were critical of and dissatisfied with the current nursing service, particularly those nursing services provided for the elderly and more vulnerable people in the community. Other services perceived to be led by nursing staff such as the prescription pick up service and health care promotion activities were also criticised. The Community Nursing Team was not utilised as anticipated in the model and therefore the benefits of team work were not realised.

The community and some service providers were very dissatisfied with the social care provision on the Island. This was very much seen as a retrograde step within a service that was previously seen as excellent.

The new GP partnership in the Port Appin surgery has had a very positive impact on the community and the community feel supported by and support their GPs.

It was perceived that there has been a lack of communication between the community and the Argyll & Bute CHP/Social Services. On the whole only the minority of the community feel that they have been able to influence health and social care provision and that Argyll & Bute CHP are acting to implement these decisions.

- **Views on future services, hopes, expectations**

The community were still calling for 24/7 nursing cover on the island. There was also a plea for more services for the elderly and vulnerable people on Lismore, in particular home visits.

The community were concerned about the capacity of the Volunteer Fire Service members to deploy the landing lights for the Air Ambulance in potential future emergency situations.

Service providers were keen to see that the Community Nursing Team was utilised as anticipated in the new model in the future.

Service providers are willing to discuss the use and role of a generic health and social care worker in future service provision.

- **Views on community capacity, resilience, responsibility, rights, priorities, capacity to deal with illness and injuries**

Islanders see themselves as self-reliant and resilient but not all the service providers agree. This is largely due to the continued call for 24/7 nursing cover and the reluctance to adopt health support schemes such as the Community First responder Scheme.

The local GPs have had a very positive effect on the community and have empowered the community to look at health care provision in a different way. For example they have implemented and led community defibrillation training. The community are now requesting community first aid training to complement this. However, some service providers are cautious regarding the capacity that the GP surgery has in helping the community to maintain their skills and have suggested that the SAS may have a role here too.

Generally the majority of the community take part in community events and are willing to help their neighbours.

The community has taken the lead in developing a Community Transport Scheme which has been highly praised by both community members and service providers.

The community is unclear as to how their service compares with more urban or equivalent services on the mainland and some perceive that it is less equitable. The community feel they have a right, like any other Scottish citizen, to good health and social care provision.

- **Views on security, confidence, previous experiences**

The community fears the erosion of their health and social care services. It is perceived that this would make Lismore a less attractive community and place to live in. Good service provision is strongly linked with the future sustainability of the island community.

The community appear to have lost some confidence in their nursing service and in social services.

Interviewees had many examples, some good some bad, of previous experiences of health and social care service provision. Importantly, in a small, tight knitted community such as Lismore one person's experience can become a whole community's experience.

- **Views on the way people use health services and will use health services**

The community is changing how it currently uses and would use health services now and in the future. This is a gradual change, with more people willing to use NHS 24 for advice and to call 999 in a health emergency in 2011 compared with 2009. The community have been asked not to directly call the on-call nurse OOH and although there is not a significant difference seen between those who self report as having called the nurse out of hours in 2009 compared with 2011, there is a significant difference in the numbers of citizens who would anticipate calling the nurse OOH if they were experiencing chest pains. The need for a nurse OOH has been questioned by both community members and service providers.

The community are more receptive to the Community First Responders Scheme in 2011 and are more satisfied with the emergency OOH care arrangements.

Recommendations

- There is a mismatch between what the community expect from their health and social care providers and what the providers can actually provide. In particular, the role of the Nursing staff based on Lismore, the services that are provided by Social Services and the input of the Community Nursing Team has caused confusion. The community would benefit from some clarity on these issues. Discussion around these roles and services should be part of an on-going engagement process in which the community have the opportunity to feed into and shape the evolution of their services.
- A health information sheet containing basic local information such as clinic times, telephone numbers for NHS 24, who to call when, how emergency services operate and what the ambulance is for would be useful to remind the community of how and when to access particular health and social care services. With services evolving on an on-going basis, service providers should discuss with the community how to make up-to-date information accessible for all.
- Anticipatory care plans for those with complex health needs and self care for all, including health promotion/education activities, are an important part of helping citizens to proactively and positively manage their health and wellbeing. The Argyll & Bute CHP should ensure that anticipatory care plans are in place for all vulnerable members of the community. The community should continue to take an active role in maintaining and improving their own health and wellbeing, with support from the Argyll & Bute CHP where appropriate.
- Many citizens were critical of and dissatisfied with the current nursing service with some comments in the questionnaire relating specifically to the quality of this service. Although the *quality* of nursing services on Lismore was not the focus of this report we recommend that the issues raised be addressed by the Argyll & Bute CHP.
- While the majority of citizens who were either interviewed or attended a public meeting called for continued 24/7 nursing provision the anticipated use of the nurse OOH by the wider community has dropped since the implementation of the new model. In the new model the community have been asked to contact NHS 24 in the first instance for OOH assistance or to call 999 in an emergency. Moreover, the GPs have publically stated that they would be unlikely to deploy a nurse OOH. Therefore, the role for a nurse OOH is unclear and we would recommend that the use of nursing staff to provide OOH cover be re-examined by the Argyll & Bute CHP in partnership with the community.
- The role of the wider Community Nursing Team should be implemented as was anticipated in the new model so that the benefits of team working can be realised for both the service providers and the community.
- Specific problems have been highlighted regarding access to some basic health care services. Procedures for the picking up/ dropping off of prescriptions should be put in place. The community have highlighted the difficulties in accessing GP services outwith normal working hours for those in full time employment. The GPs might consider either running a later clinic on Lismore or in the Port Appin Surgery.

- The proposed new role of a generic health and social care practitioner might be an appropriate role for remote, rural and island locations and may help to better integrate health and social care services. The specific details of this multidisciplinary role would merit further discussions between health and social care providers and the communities that they might serve.
- The apparent deterioration of social care on the island since 2009 is a major anxiety and frustration for the residents, particularly given the relatively high proportion of older people on Lismore. It is strongly recommended that social services engage with the community regarding recent and future changes in the delivery of social care. Engagement on these issues should involve a 2-way dialogue between the community and Social Services. Social Services should outline what their priorities are and discuss potential opportunities for community involvement with regard to future services delivery.
- The health and social care providers must continue to engage with the community on Lismore in a proactive and constructive way. They must demonstrate a joined up approach to future planning related to evolving health and social care services.
- The community has already successfully coordinated a community transport scheme and may have a role in developing and delivering community based services, not seen as a core priority to either the Argyll & Bute CHP or Argyll & Bute Social Services, but related to health and social care. This may be via a community trust, community enterprise, social enterprise or similar. It would be useful for the community to explore these opportunities with the Argyll & Bute CHP and/or Social Services. Further support and advice relating to how this could be organised should be sought from other agencies such as Highlands & Islands Enterprise and Highlands and Islands Enterprise Zone.

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1. Background

1.1 Context

Historically, the community on the Isle of Lismore had been provided with access to locally based nursing care 24/7 with GP provision being provided from the Port Appin surgery. Of note is that the nursing provision was provided by individuals who lived and worked on the island. Prior to the current new model of service delivery being implemented, medical assistance for emergency, unscheduled or out of hours care within the community was sought in the first instance from either/or both the GP and the Nurse Practitioner. They would be contacted directly by the patient or the patient's family and would attend in person or give advice over the telephone regarding any further action to be taken.

In 2004 a new GP practice contract was introduced across the UK, including Scotland. This allowed GP Practices to opt out of providing out-of-hours (OOH) services. The possibility and the potential consequences, should it transpire that the Port Appin surgery GPs wanted to opt out, were raised at a Community Council meeting on the Isle of Lismore in 2004¹ and the Argyll & Bute CHP were engaged in a dialogue with the community regarding this. Since this time discussions on OOH services on the Isle of Lismore has been a standing item on the Community Council meeting agenda. Consequently, the community council formed a health sub-group through which continued discussions with the Argyll & Bute CHP and the local community have been maintained. Importantly, since this time there has been a firm commitment from the GPs in the Port Appin Surgery to continue to provide OOH cover to the local population including those on the Isle of Lismore.

In addition, in 2009, changes to the European Working Time Directive, which applies to all health and social care staff, meant that staff were required to comply with a 48 hour working week. If 24/7 nursing cover was to continue on the Isle of Lismore the Argyll & Bute CHP stated that they would need to employ 4.5FTEs to comply with the change in regulations². However, it was also stated that the regulations differ for on-call staff versus on-duty staff. Around this time, whilst core daytime nursing services have always continued, with the team working 9-5, Monday to Friday, OOH nursing cover was withdrawn briefly from the Isle of Lismore.

1.2 Development of a new model of Health care provision for the Isle of Lismore

The Scottish Government's *Better Health, Better Care: Action Plan (2007)*³ sets out a vision for the NHS in which the Scottish people and NHS staff are partners in the NHS. Under this policy, Community Health Partnerships, with established Public Partnership forums, are utilised to involve communities in the design of health services.

In 2008, the Argyll & Bute Community Health Partnership (CHP) held a 'road-show' on the island, the aim of which was to identify and explain the various component parts of the service and to gather back from the islanders their thoughts, considerations and ideas regarding the future service

¹ Minutes of Meeting held at Lismore Public Hall

http://www.isleoflismore.com/lismore_groups/community_council/2004/2004-05-26.htm

² Note of meeting held between Argyll and Bute CHP and Lismore Community representatives at 7pm on Tuesday 9th December 2008, at the Manse.

³ Scottish Government. *Better Health Better Care: Action Plan*. Edinburgh: Scottish Government, 2007.

configuration on the Isle of Lismore. Responses from this consultation exercise⁴ were analysed and used to develop a proposed new model of healthcare provision to put to the residents of Lismore.

The new Model sought to: better coordinate and enhance current mainstream services; introduce anticipatory care plans for more vulnerable patient groups; encourage and support self care and to provide a coordinated and appropriate mechanism for accessing OOH, unscheduled and emergency care. Importantly the Argyll & Bute CHP put in place a mechanism to ensure that the emergency care response for Lismore delivers the same outcomes as elsewhere across Argyll & Bute including in other remote, rural and island locations⁵. In addition, it was the intention of the Argyll & Bute CHP that the model developed with the community on Lismore would inform service developments in other small remote and island communities.

The aim for the Argyll & Bute CHP was to provide a better quality, safe and sustainable model of healthcare provision on the Isle of Lismore that would reduce the need for unscheduled or emergency care OOH through better management of patient needs within normal working hours. The main elements of the proposed new model of healthcare provision for Lismore is summarised in Box1 below. For a more detailed version see the 'Draft proposed plans for future healthcare provision to the population of the Isle of Lismore' document.⁶

Box 1: Summary of 2009 draft proposed plan for future healthcare provision to the population of the Isle of Lismore.

Anticipatory/Self Care

There is a growing recognition within all health services in Scotland that the focus needs to change; from providing reactive and crisis care to anticipating health problems and delivering care aimed at preventing the development of crisis, which often results in emergency situations where people are admitted to hospital.⁷

There is now considerable evidence which shows that many crisis situations can be predicted and measures can be taken in advance of the crisis occurring which will successfully avert an emergency situation arising.

(i) Anticipatory Care

This involves both GPs and the community nursing team working with patients to ensure that health needs are met through planning, delivery and review of care for people with specific complex health needs (including palliative care and long term conditions). The health care professionals will identify patients with increased risk factors. Through developing an anticipatory care plan for each of these patients they will identify potential problems that may arise and take appropriate action for dealing with them. The anticipatory care plan will also outline early warning signs of deterioration in their condition and individual plans of care for acute episodes of illness. Anticipatory care planning should result in an improvement in health for the community of those on Lismore with complex healthcare needs; earlier intervention by healthcare professionals and/or the individual themselves will ensure that crises are kept to a minimum.

⁴ Services to Lismore Public Drop in Event 061108 report v0.2

http://www.isleoflismore.com/lismore_groups/community_council/2008/2008-11-06.pdf

⁵ Your guide to local health services in Argyll & Bute Community Health Partnership

<http://www.nhshighland.scot.nhs.uk/Publications/Pages/YourGuidetoLocalHealthServicesinArgyllandButeCHP.aspx>

⁶ Argyll & Bute Community Health Partnership - Discussion document - Draft proposed plans for future healthcare provision to the population of the Isle of Lismore

http://www.isleoflismore.com/lismore_groups/community_council/2009/2009_draft_chp_plans.htm

⁷ Building a Health Service Fit for the Future Summary [Report]. Scottish Government 2005

<http://www.scotland.gov.uk/Publications/2005/05/23141307/13104>

Box 1: Summary of 2009 draft proposed plan for future healthcare provision to the population of the Isle of Lismore continued...

(ii) Self Care

With the right level of support many people take a more active role in their own care, living with and managing their own health conditions. The GPs and the community nursing team will continue to support, educate and contribute to community members ability to care for themselves and their families. They will share their skills

and knowledge with patients and their carers, acting as a key resource and providing a route to other services and professionals. Health promotion and prevention will form part of the individual care plan. For example, they will provide opportunities to people who live with long-term chronic conditions to develop new skills to manage their condition better on a day-to-day basis.

Community members will be encouraged to take some responsibility for their own health. For example, undertaking some simple measures to ensure appropriate management of everyday minor ailments, including keeping a small number of common medicines in the home (e.g. paracetamol and cough mixture) and contacting health care professionals and/or NHS 24 when early warning signs present to ensure a speedy response and prevent crises.

Mainstream Services

All communities in Argyll and Bute have access to the core services provided by doctors, nurses and allied health professionals. The CHP has been actively working to ensure that we no longer have health care professionals working in isolated, lone practitioner roles. The CHP are linking staff in the more remote and rural communities into teams; this will provide the necessary levels of support, supervision and guidance to ensure that each practitioner meets the clinical governance requirements of his/ her role. The following section describes the proposals for service provision to the Lismore community.

(i) GP provision

The GPs based in Port Appin currently visit Lismore 2 days per week to allow the community to consult them on the island. Community members can also travel to Port Appin and consult the GPs there. The practice have chosen to provide the emergency out of hours service for patients registered with the practice meaning that patients can phone out with the hours of 9-5pm Monday- Friday for advice and/or consultation. The benefits of continued GP provision in and out of hours are that the patients are known to the GPs, resulting in continuity of care and an understanding of wider family issues impacting on the individual patient.

(ii) Community Nursing Provision from Appin/Lismore/Connel/Taynuilt Team

One nurse cannot be a specialist in all aspects of care required in a community like Lismore or remain competent in all aspects of the role. The role of community nurse for Lismore should therefore be seen as a generalist role working as part of a wider team of colleagues, some of whom will have specialist interests in particular fields of nursing.

The benefits of "teamwork" across this wider team would address concerns about professional isolation, lone working, clinical governance, clinical supervision, succession planning, recruitment and retention. Rotating mainland staff to Lismore and Lismore staff to the mainland would reduce professional isolation and provide others with the opportunity to obtain an insight into island nursing. Reviewing the team structure would also provide an opportunity for better integration, ownership and operational working.

The CHP undertake to advertise a community nurse post to be based within the Connel/Taynuilt/Appin/Lismore community nursing team to contribute to the equitable delivery of nursing care across the area, as dictated by patient need. The post holder will also provide 3 nights a week of on-call cover, based on Lismore, from 5pm-9am. This will be in addition to the current day nurse provision and on call commitment of 4 nights. This will be done and work in parallel with the other sustainable solutions outlined in the paper and will be reviewed after six months. This will allow an evaluation of the overall model proposed to be undertaken and provide the community with a level of confidence in terms of the responsiveness of the solutions outlined.

Box 1: Summary of 2009 draft proposed plan for future healthcare provision to the population of the Isle of Lismore continued...

(iii) Allied Health Professionals/Other Specialist Services

Provision of services by a range of allied health professionals will continue to be delivered in the same way as at present. This will include the visiting podiatry service, physiotherapy service through Port Appin and access to other services such as Speech and Language Therapy, Occupational Therapy and Dietetics as required.

In addition a range of other specialist services to which the island community has access include Community Psychiatric Nursing; MacMillan Nursing; Community Children's Nurse; Respiratory Nurse Specialist; Stroke Nurse Specialist; Coronary Heart Disease Nurse Specialist & Diabetes Nurse Specialist.

(iv) Generic Health and Social Care Worker

As part of the wider primary health and social care team input, the CHP intend to work in partnership with Council colleagues to explore the possibility of developing a new role which would provide an agreed level of health and social care, enabling a timely response and a single identifiable point of contact for the community of Lismore.

The benefits of this role include flexibility and adaptability enabling the post to meet the needs of the service, including the provision of an out of hours service. Being part of the wider primary health and social care team would result in support and supervision from a designated community nurse and the development of a learning development plan for the post holder, ensuring the role is developed in a structured way that meets clinical governance requirements. As part of the wider team networking, peer support and further learning opportunities would be available as well as regulation of the role by a designated community nurse. This role would not replace access to existing services.

The CHP will work in partnership with other service providers in the island to explore the possibilities of developing this role.

Out of Hours/ Emergency/ Unscheduled Care Services

During the consultation period it was apparent that the issue that caused most concern for the islanders was the need for certainty that services could respond quickly whenever an emergency arose on the island. Islanders felt vulnerable and concerned that a diminished service provision on the island may lead to the inability to effectively manage emergencies.

The CHP propose the following to ensure that the provision of emergency care both within 9am-5pm hours and during the out of hours period will deliver the same outcomes for people on Lismore as for those living in all other parts of Argyll and Bute.

(i) Use of NHS 24 by the community

The community is encouraged to use NHS 24 as the first point of contact for non-emergency health care needs out of hours. This will provide the GPs with a triage service for out of hours calls and therefore potentially reduce the number of out of hours contacts. In addition, the Highland Hub would provide the co-ordinating point for arranging out of hours consultations with the local GP.

Anticipatory care plans for those patients with complex health needs will be shared between the GP and NHS 24 to provide essential information regarding vulnerable patients. These plans will then be used to make sure that correct decisions about individual patient care are made in emergency situations.

When phoning NHS 24, calls will be allocated to the health care professional appropriate to meet the identified need, be it a nurse, pharmacist or dental nurse. Treatment at home might be advised, a consultation with a local GP arranged or in some cases an ambulance may be arranged. If you believe the health care emergency you or your family member are presenting with places life in danger you then need an emergency ambulance response and should always phone 999.

Box 1: Summary of 2009 draft proposed plan for future healthcare provision to the population of the Isle of Lismore continued...

(ii) Scottish Ambulance Service

The Scottish Ambulance Service proposes the following developments as part of the emergency response:

1. Placing an ambulance-type vehicle on Lismore, possibly a Patient Transport Vehicle, with trolley cot facility.
2. Landing lights for 24hr helicopter access
3. Suitably trained local volunteers to look after the vehicle & landing lights.
4. Paramedics on the helicopters will drive the vehicle to the patient/casualty and arrange evacuation as appropriate.

Helicopter access will always be the most useful mode of transport when the retrieval of a critically ill person is required from Lismore. The Scottish Ambulance Service air ambulance requires the use of landing lights to ensure safe landing and take off. The use of local staff to position landing lights will ensure local knowledge of the island is utilised, thereby facilitating a safe and timely evacuation. The identified dedicated landing site is to be re-assessed & surveyed to confirm no problems have arisen since the original survey.

In the event of the Scottish Ambulance Service being unable to utilise their air ambulance due to bad weather or darkness, the Ministry of Defence's Sea King would be mobilised to evacuate a critically ill patient.

In addition the Emergency Medical Retrieval Service (EMRS) provides patients with life threatening conditions in rural areas of West Scotland, with rapid access to the skills of a consultant in emergency or intensive care medicine. The consultants are ready to respond to requests for help, by helicopter or plane, within minutes and can be requested by the GP, NHS 24 and the Scottish Ambulance Service.

(iii) Community First Responder Training by the Scottish Ambulance Staff

First responders have been established across Scotland where they have been found to be appropriate for remote communities. Training is provided by the SAS and this is followed by performance and clinical audit and refresher training as a matter of routine. Participants undergo the Disclosure Scotland check and successful first responders are covered by SAS insurance. First Responders are alerted by 999 Control after the ambulance has been activated. The type of incident that First Responders are called to will be appropriate to the training they have received. If the ambulance or ambulance helicopter is a distance away the GP can also be contacted by SAS Control.

The benefits of the first responder scheme include the availability of locally based community members to respond in a timely manner to emergency situations, irrespective of weather and the time of the day. On-going training and audit will ensure skills are maintained to the highest possible standard. The establishment of First Responders Scheme is complimentary and supplementary to core provision and not a substitute.

(iv) Transport to the island by boat

The CHP acknowledge the service provided by the ferrymen in transporting the GP to the island and/or evacuating a patient from the island during emergency situations. It is envisaged that this will continue. In addition it may be possible in extremis to access the Glen Sanda quarry boat to transport the GP to the island when weather conditions are poor.

Utilisation of combined resource currently spent on island services

Several agencies currently provide services on Lismore and similarly face the difficulties of recruitment and retention, lone working and fears of sustainability of service provision. Utilising all of the resources currently spent on Lismore, through discussion with partner agencies and joint working will allow the development of roles which cross the boundaries of agencies and can ensure the continued delivery of services which meet the needs of the community and are safe and sustainable. A community enterprise company might be one way of utilising the combined available resources and meeting the identified needs of the island and is therefore worth exploring further.

1.3 Aims and Objectives of the Evaluation

The evaluation sought to gain the views of both the community and their service providers on the implementation of a new model of healthcare provision on the Isle of Lismore. Views were sought from the community and the service providers in 2009 prior to the implementation of the new model. The evaluation of the new model took place in 2011 after ***all*** of the elements of the model had been in place for 6 months. The evaluation did not aim to evaluate the safety or quality of the new model, rather its focus is on the acceptance and appropriateness/suitability of the introduction of a new package of healthcare provision and its delivery to the Isle of Lismore and its community.

2. Evaluation Methods

The study design adopted mixed qualitative and quantitative methods to evaluate the new model of Healthcare Service Provision on the Isle of Lismore including public meetings, interviews and a community questionnaire (Fig.1). Phase 1 work in 2009 sought to gather baseline data on the understanding of the new model to be implemented from both the citizens and service providers' perspectives. It was agreed that all parts of the new model would be in place for a period six months before the phase 2 work would proceed. Phase 2 work was undertaken in 2011 and sought to gather data on the experience of the new model from both the citizens and service providers' perspectives.

Topics covered in the data collection phases were negotiated with community council representatives and the Argyll & Bute CHP and included the following:

- Views on current services, challenges, needs
- Views on future services, hopes, expectations
- Views on community capacity, resilience, responsibility, rights, priorities, capacity to deal with illness and injuries
- Views on security, confidence, previous experiences
- Views on the way people use health services and will use health services

Figure 1. Methods used in the evaluation



2.1 Public meetings

In 2009 three public meetings were held in total, 35 people attended these. In 2011 two public meetings were held, 15 people attended these. The public meetings were held at different times of the day to allow as many of the population of Lismore to attend as possible and have their views voiced. Public meetings in 2011 were not originally planned but the researchers suggested that, given the long period of time which had elapsed between the two phases of data collection, this would be appropriate. All public meetings were recorded and transcribed. Both sets of data from 2009 and 2011 were then analysed and compared.

2.2 Citizen interviews

Interviews in 2009 were held with six community members (as nominated by the community council). Four service providers who lived on Lismore were also interviewed (these are mentioned again in the section on service provider interviews). Interviews in 2011 were held with eight community members (as nominated by the community council); one of these individuals was previously interviewed in 2009 as a service provider. Where possible the same community members were invited to interview in both 2009 and 2011. An additional two community members, interviewed in 2011, were sought (as nominated by the community council) to get a wider range of experiences of the new model from the population of Lismore. Interviewees comprised young, middle-aged and older adults on Lismore, some of whom had younger or older dependants. Three service providers who lived on Lismore were also interviewed (these are mentioned again in the section on service provider interviews). All interviews were recorded and transcribed. Both sets of data from 2009 and 2011 were then analysed and compared.

2.3 Service provider interviews

In 2009 nine service providers were interviewed, including four that lived on Lismore. In 2011 ten service providers were interviewed, including three that lived on Lismore. These represented services including health care, social care, fire services, local councillors and ambulance services. Managers and front-line service providers were represented. Service providers were identified by the community council and the Argyll & Bute CHP. Where possible the same service providers were invited to interview in both 2009 and 2011. If this was not possible due to changes in personnel an appropriate alternative contact was provided either by the community council or Argyll & Bute CHP.

2.4 Community Questionnaire

A community questionnaire was developed collaboratively by Argyll & Bute CHP, the Centre for Rural Health (CRH) and the Lismore community (Community Council). This questionnaire was distributed in 2009 as detailed below. A minor number of modifications to the original questionnaire were requested by Argyll & Bute CHP prior to the questionnaire being distributed in 2011.

In 2009 the questionnaire was distributed to 162 Lismore citizens aged 16 and over, as identified by the community council. These were identified as permanent residents. The community council distributed the questionnaire and then a reminder leaflet. Responses were returned directly to the CRH. One hundred and twelve responses were received (69.1% overall response).

In 2011 the questionnaire was distributed to 159 Lismore citizens aged 16 and over, as identified by the community council. These were identified as permanent residents. The community council distributed the questionnaire. No reminder was sent. Responses were returned to Argyll & Bute CHP prior to being handed over unopened to CRH. One hundred and seven completed questionnaires were received (67.2% overall response).

The data was organised and analysed using a Statistical Package for the Social Sciences, (SPSS version 14) and comparisons were drawn between 2009 and 2011. Comments from the 2009 and 2011 questionnaires were also analysed and compared by theme.

3. Evaluation Findings

3.1 Public meetings and Citizen interviews

In July 2009 interviews were conducted with six community members (nominated by the community council). Three public meetings were also held with 35 people in total attending. In August / September 2011 the interviews were repeated and two public meetings were held with 15 people in total attending. Out of the original six community members, it was only possible to re-interview five. One of the interviewees chosen as a service provider in 2009 was re-interviewed as a community member in 2011, and two additional interviewees were contacted (nominated by the community council). Interviewees comprised young, middle-aged and older adults on Lismore, some of whom had younger or older dependants. Three service providers who lived on Lismore were also interviewed (these are mentioned again in the section on service provider interviews). All public meetings and interviews were recorded and transcribed. Both sets of data from 2009 and 2011 were then analysed and compared.

Topics discussed included the following:

- Views on current services, challenges, needs
- Views on future services, hopes, expectations
- Views on community capacity, resilience, responsibility, rights, priorities, capacity to deal with illness and injuries
- Views on security, confidence, previous experiences
- Views on the way people use health services and will use health services

The main themes that emerged from the public meetings and citizen interviews are discussed below.

Nursing service

In 2009 there was widespread confusion about the roles and job titles within the nursing service. The lack of clarity and understanding had an impact on people's expectations of service provision on the island. Many compared the current situation with the historical nursing services on the island. In her 2009 interim report, Prof Jane Farmer suggested that this could be addressed by explaining to the community how and why nursing had changed; detailing the role of the nursing practitioner and the responsibilities of the team; providing practical information e.g. times of clinics. In 2011 people remain largely confused and this continues to have an impact on their expectations of the nursing service. There is a feeling that the nurse is or should be 'under the control' of the GP practice. A new community nurse has been temporarily employed to provide out of hours relief cover for the nurse practitioner. During the day she has other duties off the island as part of the Appin/Connel/Taynuilt team although she has been involved with certain Lismore health promotion activities like weight loss sessions. All this has fuelled confusion further. People do not understand why she is not more available on the island. As the nurses are no longer called directly by the public out of hours, the idea of providing cover for the nurse practitioner is seen by some people as pointless. People variously wonder why the community nurse is there, why she appears to do very little, why she is not permanent. Team-working outlined in the model does not appear to have happened. The community nurse post is temporary but people can readily identify this as a positive change and it has diverted attention from the team working which was one of the main measures of the new model. The fact that the whole process has taken two years rather than six months has led some people to think this post is part of the new organisation. Confusion over roles and services encourages a variety of expectations which when unfulfilled cause dissatisfaction with the health service provision on the island as a whole. Lack of understanding of the nursing service encourages

the belief that island residents may be worse off than the mainland and that they are not getting services that everyone else receives.

Several believe such a highly qualified nurse practitioner is not required on the island. People are generally satisfied with GP service, particularly out of hours, and see a nurse practitioner as unnecessary. Many want to see the current community nurse post kept in place. Feeling remains strong that a nurse should be resident but a 'community nurse' or 'district nurse' is seen as more appropriate. Views are heavily influenced by the traditional idea of a nurse who is part of the community, making home visits and getting to know everyone personally. This is to some extent embedded in their sense of island identity.

Home visits

Many people want a health professional or nurse who will make home visits to fulfil a range of tasks e.g. to deliver prescriptions, check on people following hospital discharge, change dressings and make regular contact with older or vulnerable people to prevent emergencies arising. Currently home visits are made following a medical needs assessment. However, residents want someone who will call in regularly to provide a vital source of social contact, particularly with isolated older people, and identify potential problems to ensure early intervention. Establishing a relationship with older people is key to allowing them to feel more comfortable about discussing their problems. Many view this as a nursing role, feeling this was something that happened traditionally on the island. Some recognise they may already get more personal contact with doctors and nurses on the island than the mainland or particularly a city. For this reason some think health care is better than on the mainland, whereas others feel that it is worse. The call for someone to carry out home visits has increased since 2009.

Residents think there is a very good neighbourly culture on the island, which is key to its identity. They believe strongly that neighbours do check on each other but many live at some distance away and often neighbours are older themselves. Neighbours are anxious about interfering too much and feel there is a limit on what it is appropriate for them to say or do, whereas a professional is more independent and objective. Generally people believe very strongly the island is helping itself as much as it can with neighbours being able to rely on each other. However, neighbours are there to support but not interfere or pry. Issues involving people's specific health issues and sense of independence are not necessarily seen as appropriate for a neighbour to deal with but are seen as more suitable for a health professional. Neighbourliness is intrinsic to community identity but it has boundaries as also seen in the attitude to first responders discussed below.

Generic Health and Social Care Worker

On the whole there is little understanding of what this worker could be as health and social services are seen as separate roles. People feel it would be difficult to bridge the gap and that there is no obvious and suitably qualified person to step into that post. This view has not changed since 2009.

24/7 cover

Although there is some recognition that a nurse may not be able to treat a patient in an emergency situation, the demand for a resident nurse(s) to cover the island 24 hours a day seven days a week remains as strong as in 2009. Residents generally want a medical professional available on the island '24/7' in case the island does get cut off by severe stormy weather. However rare this is, people remain anxious about being unwell or injured and trapped on the island. It is perceived that the presence of an island nurse is a way of establishing a sense of equity with the mainland. Although much of the focus has been on emergency care, people also want reassurance that less serious problems arising during the day can be dealt with speedily if the doctor cannot get there or they cannot travel to the clinic or surgery because of the weather or other practical reasons. This is

viewed as particularly important for families with young children and the island's increasing older population. A few thought that if health services were seen as poorer than the mainland then it would discourage younger people and families returning or moving to the island. On the whole people are satisfied with the GP out of hours service and are relieved it has been retained, having voiced fears in 2009 that it would be lost. The influx of tourists is noted as an additional pressure on services during the summer.

Out of hours service

Since 2009 people have been encouraged to use NHS 24 rather than phone the nurse or doctor directly as they did before. Generally this is viewed as working well and people are satisfied that the GPs are willing to come out to the island as required.

Since 2009 there has been a slight change in attitude to NHS 24 as a few more people express willingness to use it and report a satisfactory service. Although some fears have been overcome, there are still criticisms that the response rate is too slow or that NHS 24 staff are not familiar with the geography and do not realise Lismore is an island. Concerns about a telephone diagnosis include not making yourself fully understood if you are ill or confused, that older people have particular problems using the phone or simply that you need to be seen to be assessed adequately.

Emergency service

The SAS helicopter can land at the fire station where an ambulance is left ready for the paramedics to use. The ambulance is maintained by the fire service. There is some confusion over why the ambulance is there and not at the ferry where the GP can use it. Some people wonder what it is for and why it does not seem to be used. The GPs appear to have their own vehicle ready at the ferry for use.

Many complain that sick or injured people cannot be transferred comfortably onto the ferry and it is unsuitable for stretchers or wheelchairs. There is no sheltered area to wait and people complain that casualties had been left in the rain. However there is general praise for the ferry service and staff and its availability for emergencies.

People are aware that the fire service volunteers put out the landing lights for the helicopter but they are concerned that there is no rota and that, as many of the volunteers work on the mainland, it may be difficult to find them when needed. There is a misunderstanding of the way the fire volunteers work – they do not operate a rota but have pagers to call them in an emergency. As it is difficult to recruit volunteers at the moment on the island, people are concerned that this service may not work adequately when required. One person believed the island needed its own helicopter.

Community First responders Scheme

In 2009 there was a considerable opposition to the proposed First Responders Scheme. In 2011 there has been a slight change with some saying it would be a good idea as long as proper professional medical backup is ensured. Some of the same concerns are still expressed – the fear that accepting first responders means they will lose professional services, general lack of trust and confidence in the scheme, not wanting a stranger or fire fighter turning up on the doorstep. Equally if a friend or neighbour tried to help and something went wrong, then it would make it very difficult for them in the community on such a small island. People still feel it could be too much responsibility for a volunteer and they would rather have a medical professional attend them. In 2011 it is evident that people remain reluctant to join a formal scheme under the label of first responders. However, attitudes to the defibrillator training are much more positive. It is generally seen as a good measure but people are anxious that the equipment is not readily available for use.

It is kept locked in the ambulance or community hall. There is also more positive feeling towards extending first aid training while recognising that skills and knowledge need regular updating.

Social care

Most people think that social care has deteriorated or broken down completely since 2009. Two years ago people were generally very satisfied with provision on the island but in the intervening years home care has been re-organised and the so-called 'granny bus' withdrawn. Although the transport has been taken over successfully by the community, there was dissatisfaction with the home carers coming over from the mainland – concerns include what if they cannot get to the island, they are not part of the community and do not know people well.

Prescription service

Complaints about the prescription service have increased since 2009. People think they have to wait too long and the system is inefficient and inadequate.

Community resilience

It is widely agreed that Lismore is a resilient and self-reliant community willing to do things for itself e.g. check on neighbours, run community transport, attend/run self-help groups for depression, fitness, etc.

Self Care and Health promotion

The series of talks given on selfcare and health promotion by the service providers on the Isle of Lismore were poorly attended. Some negative attitudes were expressed about how the talks were organised and the 'top-down' approach criticised. However, there seemed to be general support for the idea of health promotion and people wanted to see more done on the island. People were more positive about the weight loss and depression groups. One person said it was difficult to attend anything like this if you worked.

Anticipatory Care plans

People were not very aware about this measure and it was not talked of much. However a few said it was not adequate and that there needed to be more care plans arranged.

Lack of communication/consultation

Some confusion was still evident about the specific measures in the model. Many did not believe the community had been listened to, particularly over its demand for 24/7 cover on the island. It was felt that consultation meetings had been held at the beginning of the process but not during implementation to explain what was going on during the two years.

3.2 Service provider interviews

In July 2009 nine service providers were interviewed, including four that lived on Lismore. In August/September 2011 ten service providers were interviewed, including three that lived on Lismore. These represented services including health care, social care, fire services, local councillors and ambulance services. Managers and front-line service providers were represented. Service providers were identified by the community council and the CHP. Where possible the same service providers were invited to interview in both 2009 and 2011. If this was not possible due to changes in personnel an appropriate alternative contact was provided either by the community council or Argyll & Bute CHP. Interviews were both recorded and transcribed or detailed notes were taken by the

researcher at the time of interview. Both sets of data from 2009 and 2011 were then analysed and compared.

Topics discussed included the following:

- Views on current services, challenges, needs
- Views on future services, hopes, expectations
- Views on community capacity, resilience, responsibility, rights, priorities, capacity to deal with illness and injuries
- Views on security, confidence, previous experiences
- Views on the way people use health services and will use health services

The main themes that emerged from the service provider interviews are discussed below.

New model

In 2009 the aim of a new model was seen as ensuring the services work together to provide a seamless and sustainable service. Two years later health service providers were on the whole optimistic and positive about the new model although there was some confusion over the organisation of the nursing team on and off the island. Four felt that a sustainable model had now been achieved. Two of these service providers thought that the model developed for Lismore was transferable to other island communities. One service provider felt that Lismore was a catalyst for the provision of local ambulances being placed on other islands and that the changes to the service provision deployed on Lismore had paved the way to help other island communities e.g. development of a Fire & Rescue and Ambulance Service memorandum of agreement.

Nursing service

In 2009 one service provider said the nursing provision was too half-hearted, suggesting the island should have two well trained nurses with back up from the mainland or nothing. If the latter, the islanders should be told that they cannot have a resident nurse. In 2011 some are confused about how the nursing team is working and one interviewee was unsure if the nurses on call were part of the new model. Two interviewees agreed that the development of an integrated nursing team did not happen as anticipated in the model. Nursing services were instead provided by one individual.

In both 2009 and 2011 the health professionals were concerned about maintaining their skills (e.g. obstetrics, emergency care) with a relatively small caseload. One person cannot be all things to all people anymore as was the traditional nursing model on the island. One interviewee believed residents were starting to understand that modern medicine and health care have to be delivered differently and felt they were moving away from asking for a nurse on call to wanting a more effective district nursing service. However, there are others who still hold on to the 'comfort zone' of keeping an island nurse. People resist schemes such as the first responders because of the fear that the nurse will be taken away if they develop other ways of coping.

It is recognised that living on a small island can be difficult for a professional because boundaries can get blurred when people are on first name terms. Patients can bring up professional matters during social occasions, etc.

Home visits and 24/7 cover

In both years two service providers (not health) also wanted 24/7 cover on the island for reassurance. Three believed there should be someone who could make home visits especially given the ageing population. One felt that residents are calling for a traditional district nurse role which

does not exist on the mainland any more. Three service providers in 2011 believed that nursing cover 24/7 on Lismore was not needed or appropriate for the population.

Out of Hours Service

In 2011 most service providers seemed very satisfied with the new system and believed the response is adequate and quick and that the GPs and NHS 24 services work well together. NHS 24 now holds a list of vulnerable people resident on the island. Call outs were said to be a monthly rather than daily or weekly event. One thought most people still phone the GP directly rather than NHS 24. It is also seen as a waste of money if the on call nurses are not used either by the public or the GPs. Another interviewee (not health) was very critical of NHS24 and had no confidence in it.

Emergency care

In 2009 it was noted that no agreement had been reached concerning who put out the landing lights for the SAS helicopter. By 2011 a memorandum of agreement was finally in place and a process whereby the Volunteer Fire Fighters on Lismore deployed the landing lights was in place. It was noted by a number of service providers that this part of the model took the longest to implement. In 2011 service providers say people are still anxious about transport and emergencies particularly in stormy weather when they can feel abandoned and isolated. There are rare occasions when even the Sea King helicopter cannot get in because of poor visibility.

Community First responders Scheme

In 2009 one interviewee expressed understanding of people's reluctance to get involved. On the island residents are inter-related and worried about the repercussions of making a mistake. It was suggested the fire crew had withdrawn from first responders because it appeared it might be blamed for the loss of health services. In 2011 there is a feeling that attitudes are more positive and that residents recognise they need first aid skills.

Social care

As with the community interviewees, several service providers believe social care services on the Isle of Lismore has deteriorated since 2009. Social services explained that the outreach service and 'Granny bus' was provided through ring-fenced, time limited funding from the Scottish Government. Argyll & Bute Council could not sustain these activities out with this funding scheme but instead donated a vehicle to the community which is being used by the Lismore community transport group to provide volunteer led community transport. Across the Argyll & Bute Council area a public consultation exercise is underway regarding the delivery of social services including those provided to older adults. Care will be prioritised for those older adults who are at a significant risk of harm and that need extensive care and support. Across Argyll & Bute home care and personal care services for these groups is to be delivered by preferred providers from the private sector.

Community resilience

In 2011 all but one of the service providers found island residents to be hardy people who do not call the doctor out unless it is a real emergency. Generally they see the island as a very self-sufficient community, where people help each other out. One person was concerned volunteers cannot provide the same service as professionals and believes having medical staff on the island helps build community resilience by encouraging people to move there and build up the community. In 2009 one interviewee said if the island lost its services, it would de-populate because it was such a fragile community.

Self Care and Health promotion

Health promotion talks were poorly attended.

Anticipatory Care plans

Service providers believe that anticipated care models have helped to reduce emergencies and helicopter evacuations. Treatment plans ensure better preventative care and chronic disease management. Families are trained to deal with problems when they arise. One interviewee thought more care plans were needed and that amongst a largely healthy population, few people were aware of them.

3.3 Community Questionnaire

A community questionnaire was developed collaboratively by Argyll & Bute CHP, the Centre for Rural Health and the Lismore community (Community Council). The questionnaire asked citizens about them and their community, their general health, how they use or would use health services available to them, their satisfaction with health and social care services available to them, their views on community first responder and first aid training and their views on consultations with the Argyll & Bute CHP. An additional free text comment box was provided at the end of the questionnaire for citizens to add additional comments that were important to them. Both sets of comments from 2009 and 2011 were then analysed and compared.

The questionnaire was distributed to Lismore citizens aged 16 and over, as identified by the community council. These were identified as permanent residents. The community council distributed the questionnaire. In 2009 of 162 questionnaires that were distributed 112 responses were received (69.1% overall response). In 2011 of 159 questionnaires that were distributed 107 completed questionnaires were received (67.2% overall response). Throughout this section where numbers of respondents do not add to the number of responses received (112 in 2009, 107 in 2011) this is due to missing responses for particular questions.

All data is represented in tabular form with percentage figures shown on the right hand side of the data by the year of questionnaire, where appropriate. Where data is also represented in a graphical format, percentage values are used. Where percentage values shown do not add to 100, this is due to the effect of rounding.

3.3.1. About you and your Community

Demographics

In 2009, 58 women (52%) and 54 men (48%) responded. In 2011, 55 women (51%) and 52 men (49%) responded. Table 1 below shows age and other demographic data.

Table 1 Demographics data for Lismore citizens who responded in 2009 and 2011.

| | | Number | | % | |
|--------------------------------------|---------------------|--------|------|------|------|
| | | 2009 | 2011 | 2009 | 2011 |
| Gender | Male | 54 | 52 | 48 | 49 |
| | Female | 58 | 55 | 52 | 51 |
| Age | 16-30 | 9 | 7 | 8 | 7 |
| | 31-50 | 18 | 20 | 16 | 19 |
| | 51-64 | 33 | 33 | 30 | 31 |
| | 65-74 | 27 | 25 | 25 | 23 |
| | 75+ | 23 | 22 | 21 | 21 |
| Employment | Fulltime | 28 | 30 | 26 | 31 |
| | Part-time | 19 | 13 | 18 | 13 |
| | Retired | 51 | 47 | 48 | 48 |
| | In education | 6 | 5 | 6 | 5 |
| | Unemployed | 3 | 3 | 3 | 3 |
| Born in Oban & Lorne area | Yes | 31 | 32 | 28 | 30 |
| | No | 80 | 74 | 72 | 70 |
| Lived locally | <5 years | 21 | 23 | 19 | 21 |
| | 6-20 years | 43 | 34 | 38 | 32 |
| | >20 years | 48 | 50 | 43 | 47 |
| No. in house | 1 | 21 | 18 | 19 | 17 |
| | 2 | 50 | 51 | 45 | 48 |
| | 3+ | 40 | 38 | 36 | 36 |

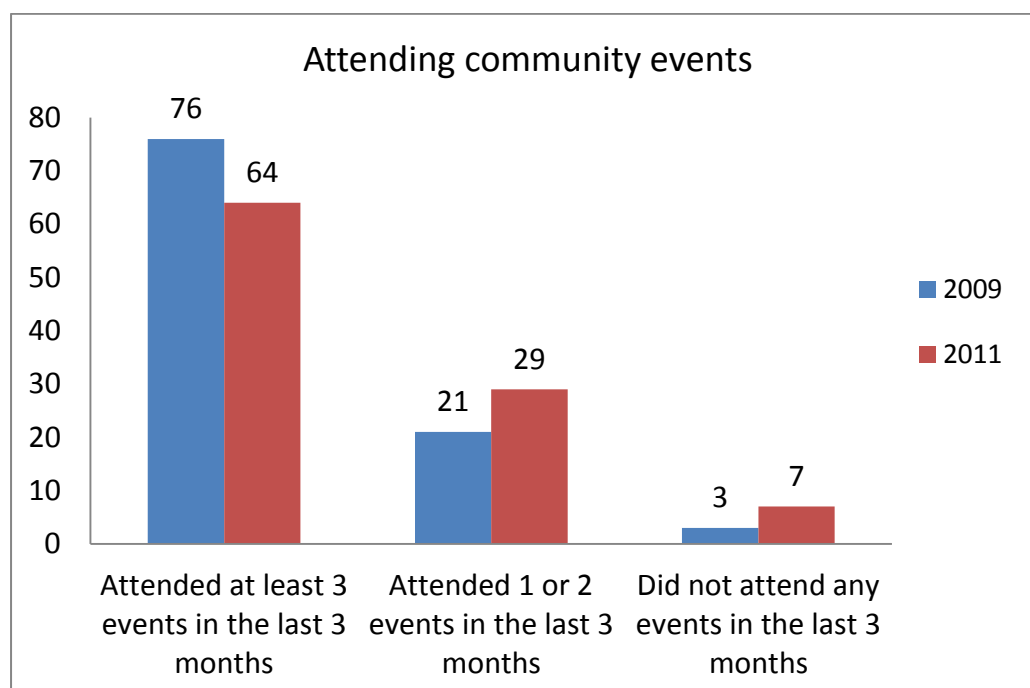
Attending Community Events

With regard to the level of community participation of Lismore citizens in their community, in 2009, 76% had attended community events at least three times in the last three month, compared with 64% in 2011. Twenty one percent had attended one or two events in 2009 compared with 29% in 2011, while 3% did not attend any events in 2009 compared with 8% in 2011.

Table 2 Attendance at community events

| | Number | | % | |
|---|--------|-------|------|------|
| | 2009 | 2011 | 2009 | 2011 |
| | n=112 | n=105 | | |
| Attended at least 3 events in the last 3 months | 85 | 67 | 76 | 64 |
| Attended 1 or 2 events in the last 3 months | 24 | 30 | 21 | 29 |
| Did not attend any events in the last 3 months | 3 | 8 | 3 | 8 |

Figure 2 Attendance at community events



Providing informal help to neighbours

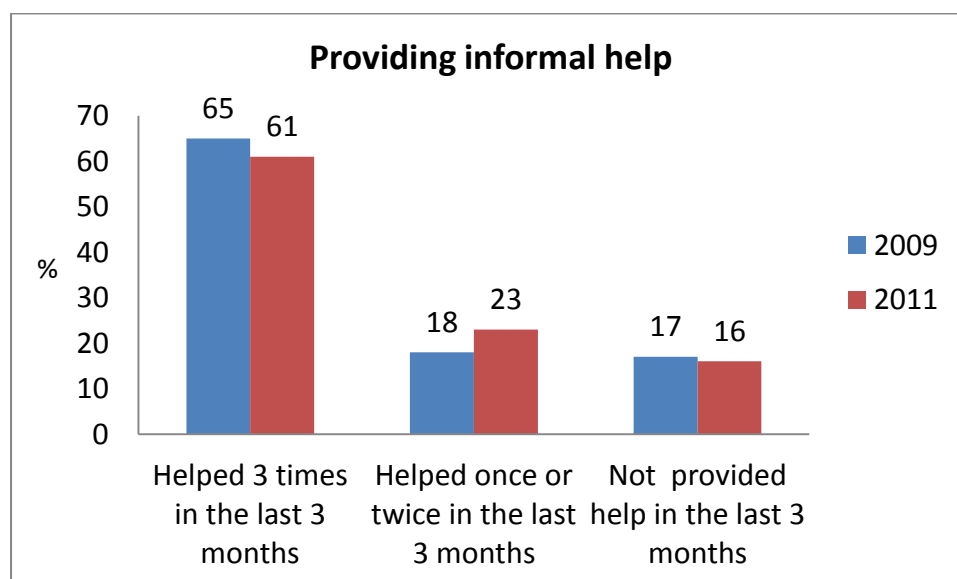
Table 3 and Figure 3 show the findings on provision of informal help to neighbours.

In 2009 65% of citizens who responded had helped at least 3 times in the last 3 months, compared with 61% in 2011. Eighteen percent had helped once or twice in 2009 compared with 23% in 2011, while in 2009 17% had not provided informal help to a neighbour recently compared with 16% in 2011.

Table 3 Providing informal help to neighbours

| | Number | | % | |
|---|--------|-------|------|------|
| | 2009 | 2011 | 2009 | 2011 |
| | n=112 | n=107 | | |
| Helped 3 times in the last 3 months | 73 | 65 | 65 | 61 |
| Helped once or twice in the last 3 months | 20 | 25 | 18 | 23 |
| Not provided help in the last 3 months | 19 | 17 | 17 | 16 |

Figure 3 Providing informal help



3.3.2. General Health and Health Services

Self-reported Health

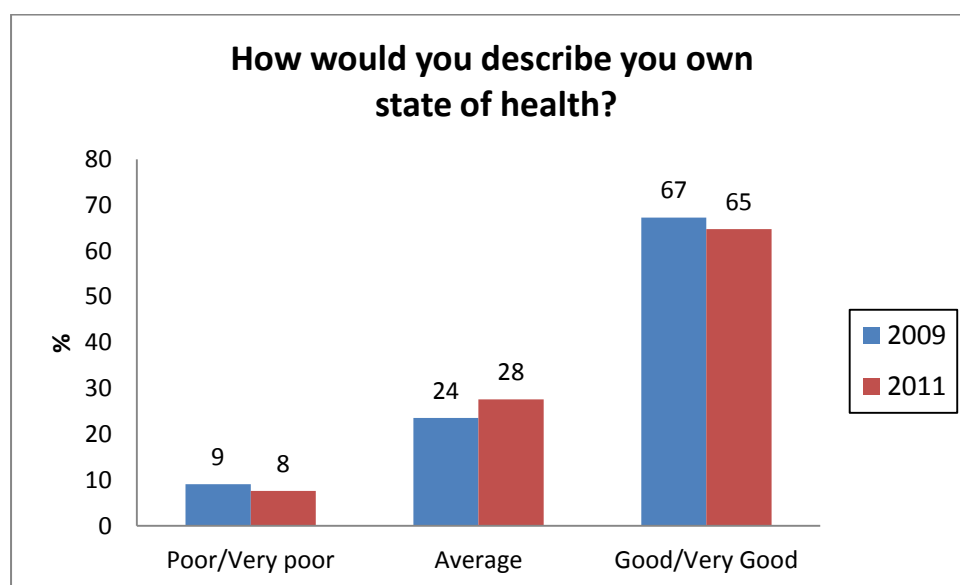
Findings for self-reported health are shown in Table 4 and Figure 4.

In 2009, 67% of respondents described their health as very good or good, compared with 65% in 2011. Twenty four percent described their health as average in 2009 compared with 28% in 2011, while in 2009 9% described their health as poor or very poor compared with 8% in 2011.

Table 4 Self-reported health

| | Number | | % | |
|-------------------|--------|------|------|------|
| | 2009 | 2011 | 2009 | 2011 |
| Very good or good | 74 | 68 | 67 | 65 |
| Average | 26 | 29 | 24 | 28 |
| Poor or very poor | 10 | 8 | 9 | 8 |

Figure 4 Self-reported health



Use of Services

Table 5 and Figure 5 show how services were used in the previous 12 months by respondents in 2009 compared with 2011.

Sixty nine per cent had visited or been visited by a GP in 2011 compared with 2009 (73%).

Thirty two per cent had visited or been visited by a nurse/nurse practitioner in 2011 and 47% in 2009.

Fourteen per cent of respondents had called NHS24 in 2011 while the figure in 2009 was 10%.

Three per cent of respondents in 2011 had called 999 while nobody had called 999 in 2009.

Forty per cent of respondents in 2011 had been an out-patient in hospital compared with 42% in 2009.

Ten per cent of respondents in 2011 had been an in-patient in hospital in 2011 compared with 13% in 2009.

Fourteen per cent of respondents in 2011 had called the local GP out-of-hours compared with 19% in 2009.

Eight per cent of respondents in 2011 had called the nurse/nurse practitioner out-of-hours in 2011 compared with 15% in 2009.

Thirty seven per cent of respondents in 2011 said that they had used the drop-in community nursing clinic.

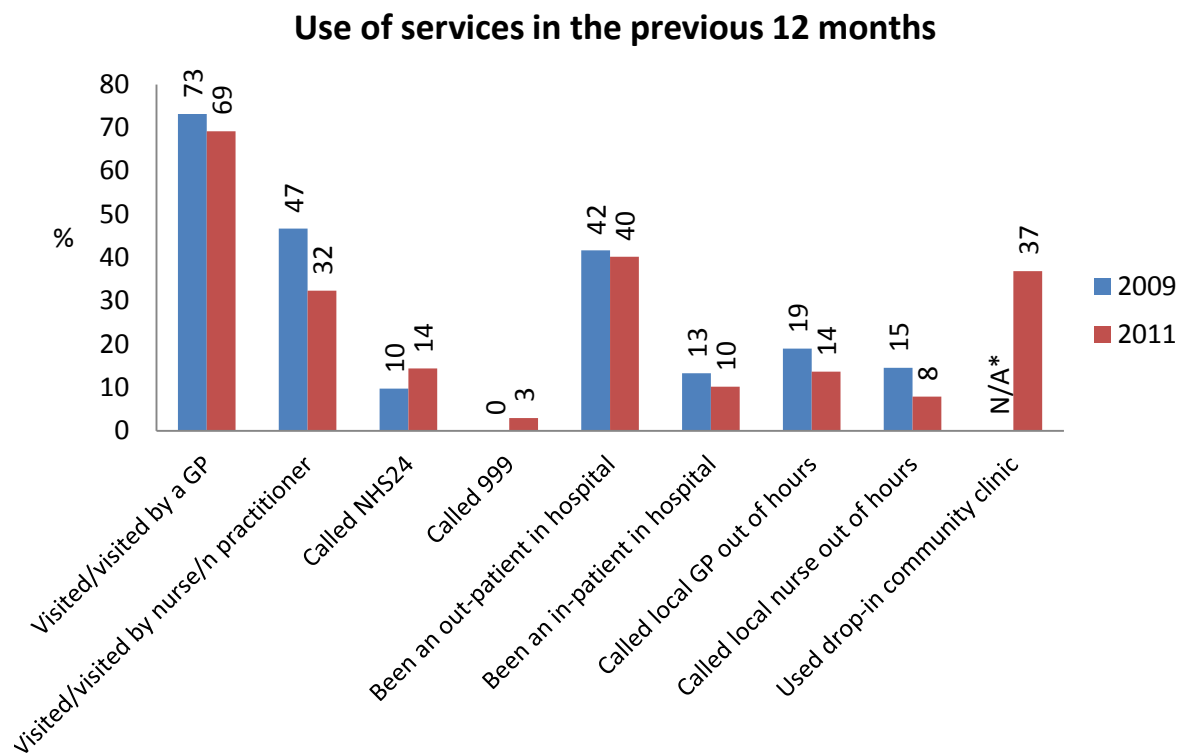
Table 5 Use of services over the last 12 months

| | Number | | % | |
|---|--------|------|------|------|
| | 2009 | 2011 | 2009 | 2011 |
| <i>Visited, or been visited by GP?</i> | 82 | 72 | 73 | 69 |
| <i>Visited or been visited by nurse/nurse practitioner?</i> | 50 | 33 | 47 | 32 |
| <i>Called NHS 24?</i> | 10 | 15 | 10 | 14 |
| <i>Called 999?</i> | 0 | 3 | 0 | 3 |
| <i>Been an out-patient in hospital?</i> | 43 | 41 | 42 | 40 |
| <i>Been an in-patient in hospital?</i> | 14 | 10 | 13 | 10 |
| <i>Called the local GP out-of- hours?</i> | 20 | 14 | 19 | 14 |
| <i>Called the nurse/nurse practitioner out-of-hours?</i> | 15 | 8 | 15 | 8 |
| <i>Used the drop-in community nursing clinic?</i> | N/A* | 38 | N/A* | 37 |

*use of the drop-in community nursing clinic was only asked in the community questionnaire in 2011.

Figure 5 Use of services in the previous 12 months

*use of the drop-in community nursing clinic was only asked in the community questionnaire in 2011.



Anticipated use of services following chest pain

Table 6 outlines findings around what citizens of Lismore said they would do if they were experiencing chest pain, during the day and during the night, in 2009 compared with 2011.

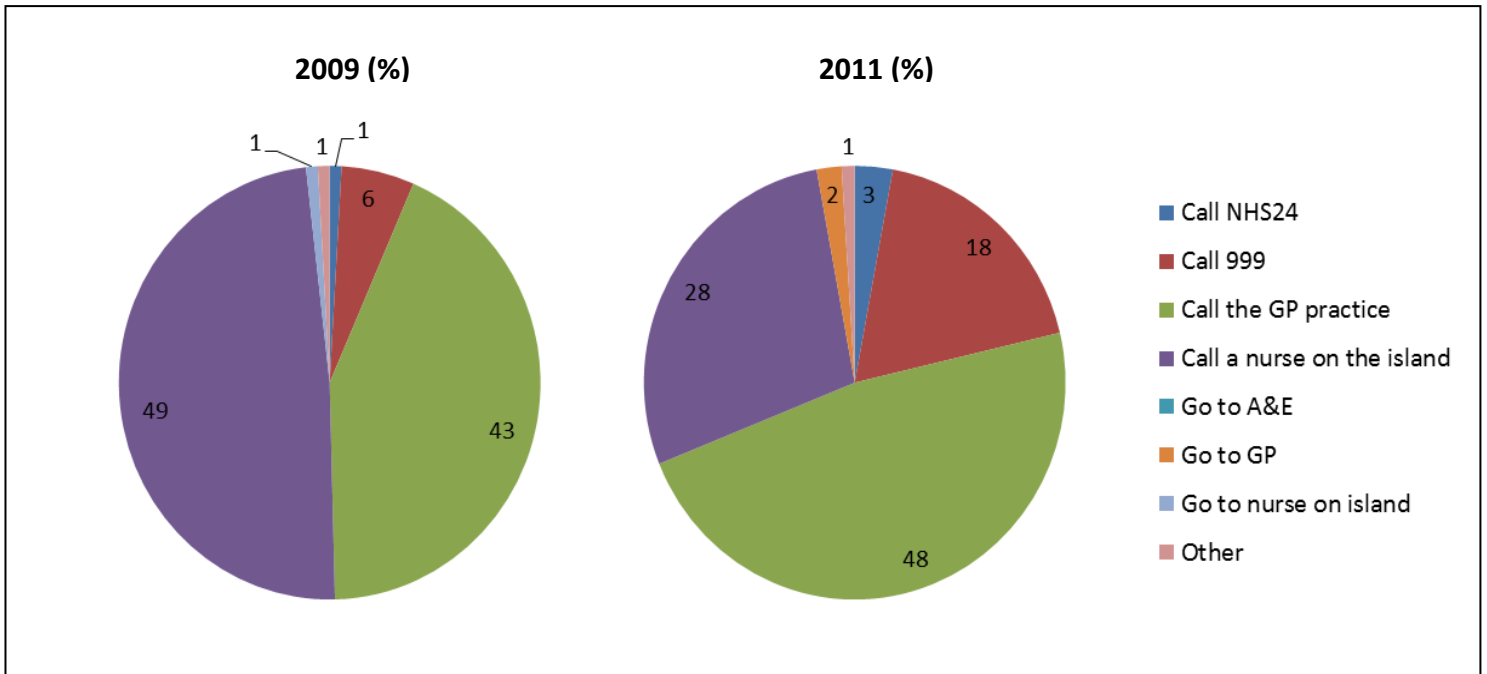
Table 6 Anticipated use of services following chest pain

| If you were with an adult experiencing chest pain on Lismore, which service would you contact first? | | | | | | | | |
|--|-------------------------------|----------------|------|------|----------------|----------------|------|------|
| | During the day, on a week day | | | | At night | | | |
| | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 |
| | Number (n=107) | Number (n=103) | % | % | Number (n=111) | Number (n=102) | % | % |
| Call NHS 24 | 1 | 3 | 1 | 3 | 7 | 11 | 6 | 11 |
| Call 999 | 6 | 19 | 6 | 18 | 13 | 25 | 12 | 25 |
| Call GP practice | 46 | 49 | 43 | 48 | 36 | 41 | 32 | 40 |
| Call a nurse on the island | 52 | 29 | 49 | 28 | 49 | 23 | 44 | 23 |
| Go to A&E | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Attend GP | 0 | 2 | 0 | 2 | 0 | 0 | 1 | 0 |
| Attend nurse on island | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 0 |
| Wait until morning, then call GP | N/A | N/A | N/A | N/A | 0 | 0 | 0 | 0 |
| Wait until morning, then call nurse | N/A | N/A | N/A | N/A | 4 | 0 | 4 | 0 |
| Other | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 2 |

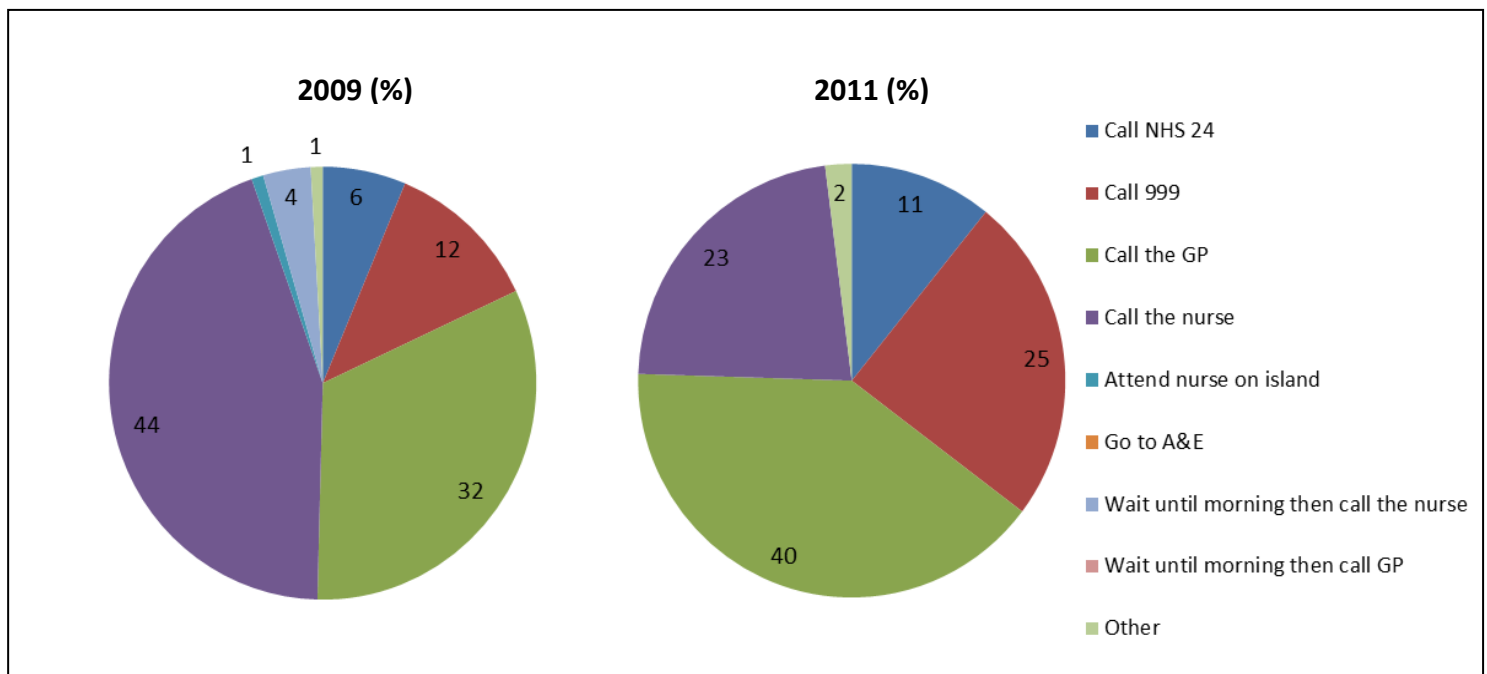
Figure 6 shows a breakdown of what citizens of Lismore said they would do if they were experiencing pain during the day (A) and at night (B) in 2009 compared with 2011.

Figure 6 Anticipated use of services following chest pain

A. During the day, on a week day



B. At night



Anticipated use of services for a cold

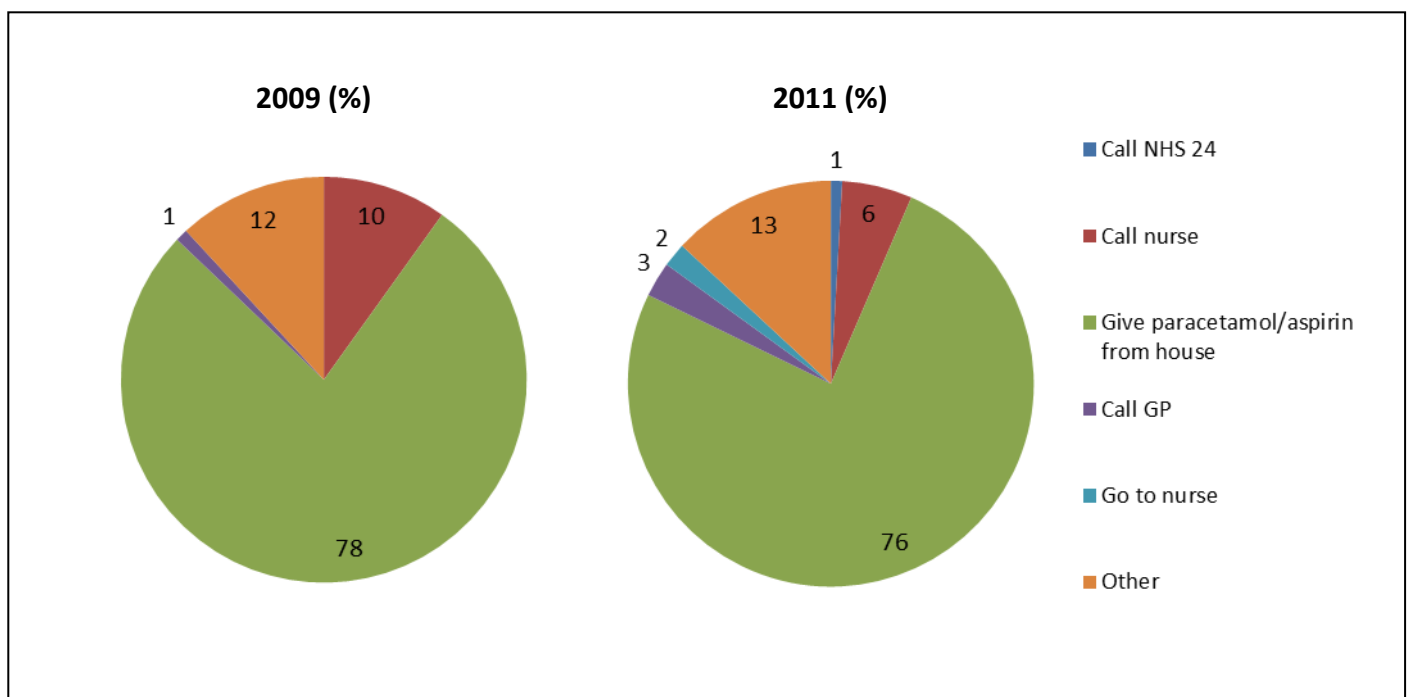
Table 7 outlines what citizens of Lismore said they would do if an adult staying with them had symptoms of a cold in 2009 compared with 2011.

Table 7 Anticipated use of services for a cold

| If an adult who was staying with you had symptoms of a cold during the night on Lismore what would you do first? | | | | |
|--|----------------|----------------|------|------|
| | 2009 | 2011 | 2009 | 2011 |
| | Number (n=112) | Number (n=107) | % | % |
| Call NHS 24 | 0 | 1 | 0 | 1 |
| Call a nurse on the island | 11 | 6 | 10 | 6 |
| Give them some paracetamol/aspirin you have in the house | 87 | 81 | 78 | 76 |
| Call GP practice | 1 | 3 | 1 | 3 |
| Go to a nurse on island | 0 | 2 | 0 | 2 |
| Other | 13 | 14 | 12 | 13 |

Figure 7 shows a breakdown of what citizens of Lismore said they would do if an adult with staying with them had symptoms of a cold in 2009 compared with 2011.

Figure 7 Anticipated use of services for cold symptoms



3.3.3 Health and Social Care Services in Lismore

Satisfaction with services

Respondents were asked their opinion on a range of services. Table 8 shows the responses in 2009 compared with those in 2011. The findings are shown graphically in Figure 8.

Table 8 Satisfaction with services

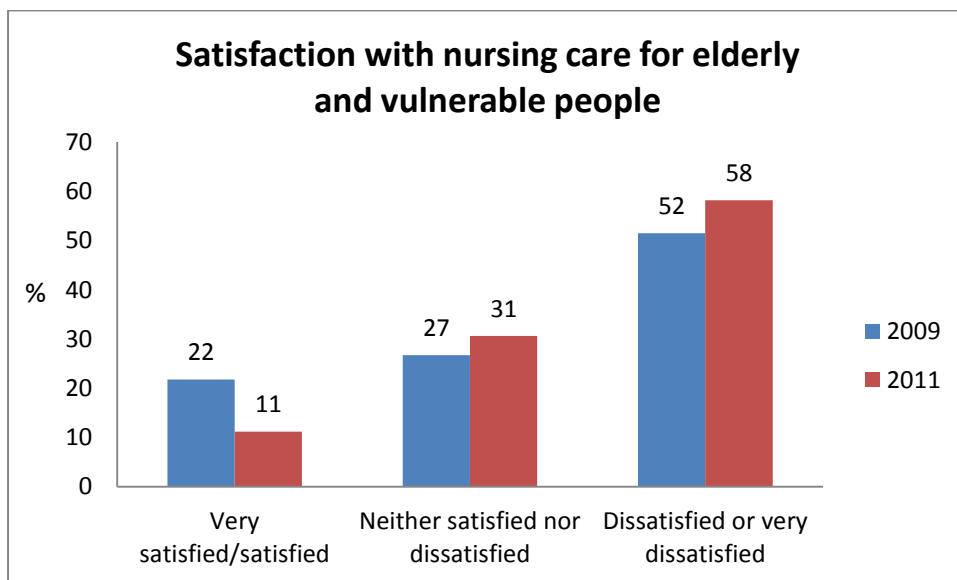
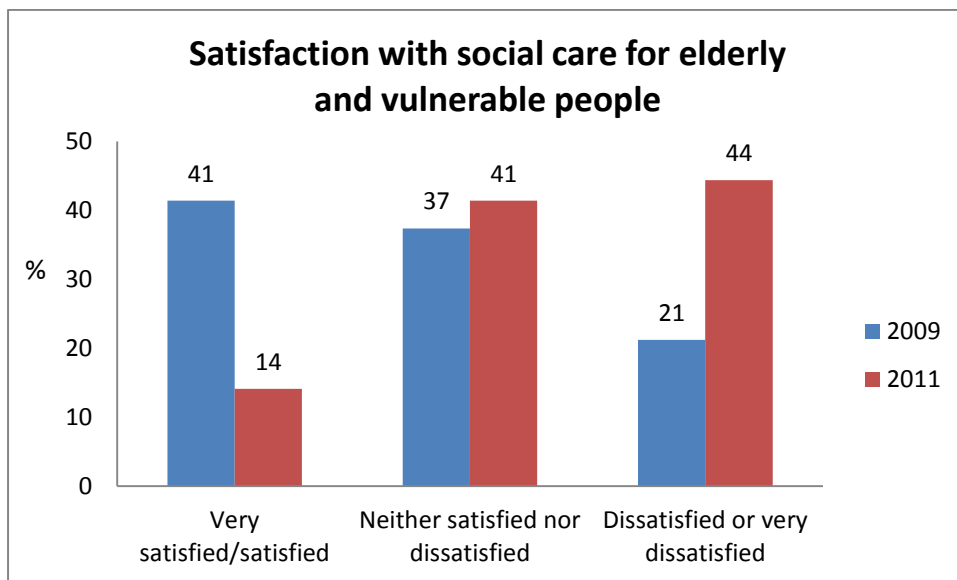
| <i>Social care for elderly and vulnerable people</i> | | | | | | | | | | | |
|--|------|------|------|------------------------------------|------|------|------|-----------------------------------|------|------|------|
| Very satisfied or satisfied | | | | Neither satisfied nor dissatisfied | | | | Dissatisfied or very dissatisfied | | | |
| Number | | % | | Number | | % | | Number | | % | |
| 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 |
| 41 | 14 | 41 | 14 | 37 | 41 | 37 | 41 | 21 | 44 | 21 | 44 |

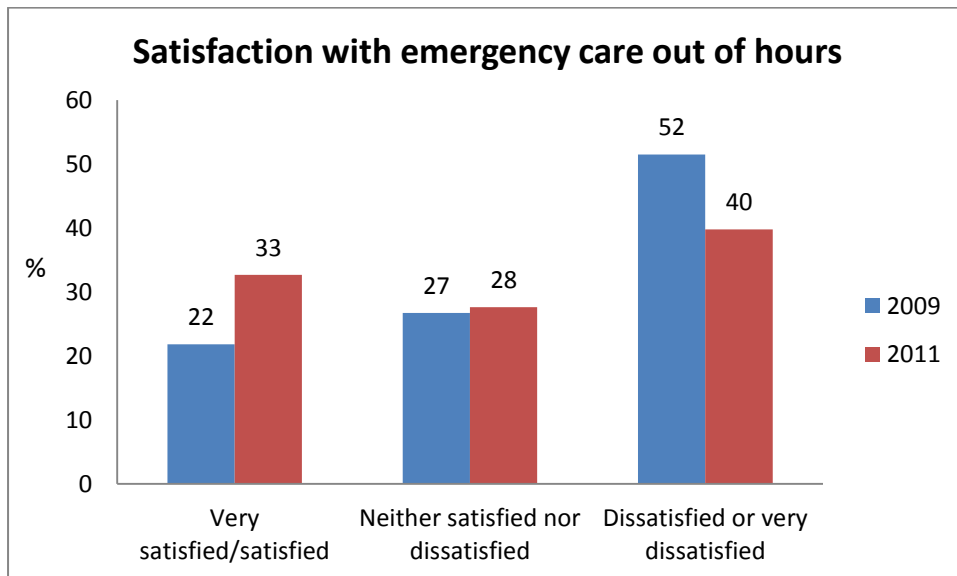
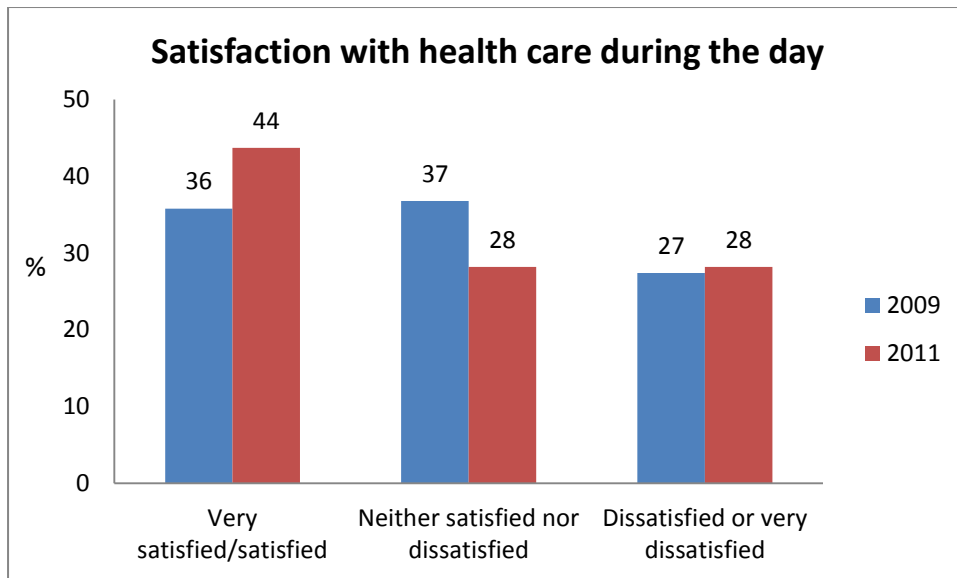
| <i>Nursing care for elderly and vulnerable people</i> | | | | | | | | | | | |
|---|------|------|------|------------------------------------|------|------|------|-----------------------------------|------|------|------|
| Very satisfied or satisfied | | | | Neither satisfied nor dissatisfied | | | | Dissatisfied or very dissatisfied | | | |
| Number | | % | | Number | | % | | Number | | % | |
| 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 |
| 22 | 11 | 22 | 11 | 17 | 30 | 27 | 31 | 52 | 57 | 52 | 58 |

| <i>Health care during the day</i> | | | | | | | | | | | |
|-----------------------------------|------|------|------|------------------------------------|------|------|------|-----------------------------------|------|------|------|
| Very satisfied or satisfied | | | | Neither satisfied nor dissatisfied | | | | Dissatisfied or very dissatisfied | | | |
| Number | | % | | Number | | % | | Number | | % | |
| 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 |
| 38 | 45 | 36 | 44 | 39 | 27 | 37 | 28 | 29 | 29 | 27 | 28 |

| <i>Emergency care out of hours</i> | | | | | | | | | | | |
|------------------------------------|------|------|------|------------------------------------|------|------|------|-----------------------------------|------|------|------|
| Very satisfied or satisfied | | | | Neither satisfied nor dissatisfied | | | | Dissatisfied or very dissatisfied | | | |
| Number | | % | | Number | | % | | Number | | % | |
| 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 |
| 22 | 32 | 22 | 33 | 27 | 27 | 27 | 28 | 52 | 39 | 52 | 40 |

Figure 8 Satisfaction with services





New service model

In 2009, 70% of people had heard that a new model of health and social care services had been proposed for Lismore, while 30% had not. In 2011, 39% had heard that a new model of health and social care services had been implemented for Lismore, while 61% had not.

In 2009, 72% of people thought they did not know, more or less, what the proposed new model was, compared with 83% in 2011.

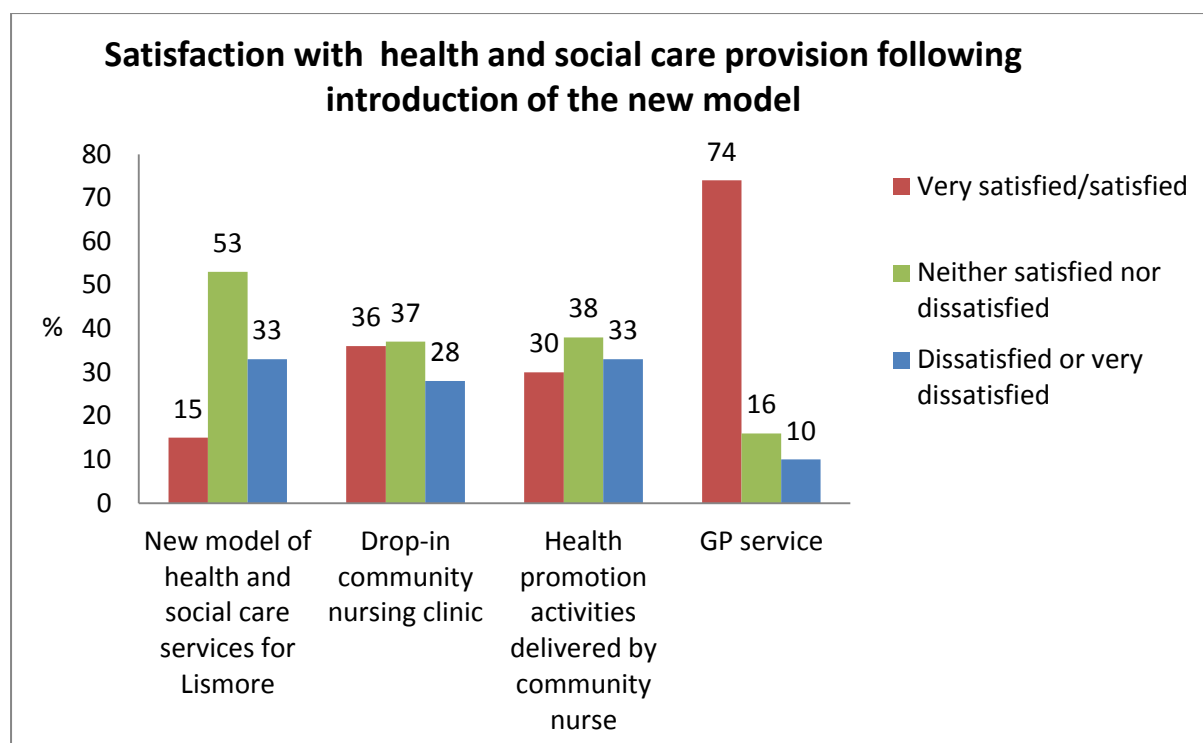
In 2009 28% of people thought that they knew more or less what the proposed new model was, compared with 17% in 2011.

Respondents were asked their opinion on health and care provision following introduction of the new model. The findings are shown in Table 9. The findings are shown graphically in Figure 9.

Table 9 Satisfaction with health and social care provision following introduction of the new model.

| Satisfaction with | Very satisfied or satisfied | | Neither satisfied nor dissatisfied | | Dissatisfied or very dissatisfied | |
|---|-----------------------------|----|------------------------------------|----|-----------------------------------|----|
| | 2011 | | 2011 | | 2011 | |
| | Number | % | Number | % | Number | % |
| <i>New model of health and social care services for Lismore (n=89)</i> | 13 | 15 | 47 | 53 | 29 | 33 |
| <i>Drop-in community nursing clinic (n=101)</i> | 36 | 36 | 37 | 37 | 28 | 28 |
| <i>Health promotion activities delivered by community nurse (n=101)</i> | 30 | 30 | 38 | 38 | 33 | 33 |
| <i>GP service (n=105)</i> | 78 | 74 | 17 | 16 | 10 | 10 |

Figure 9 Satisfaction with health and social care provision following introduction of the new model.



3.3.4 Your Views

In relation to first response aspects of the new model and process of engagement a short list of questions were asked. Responses are summarised in Table 10 and shown graphically in Figure 10.

Table 10 Citizens' views

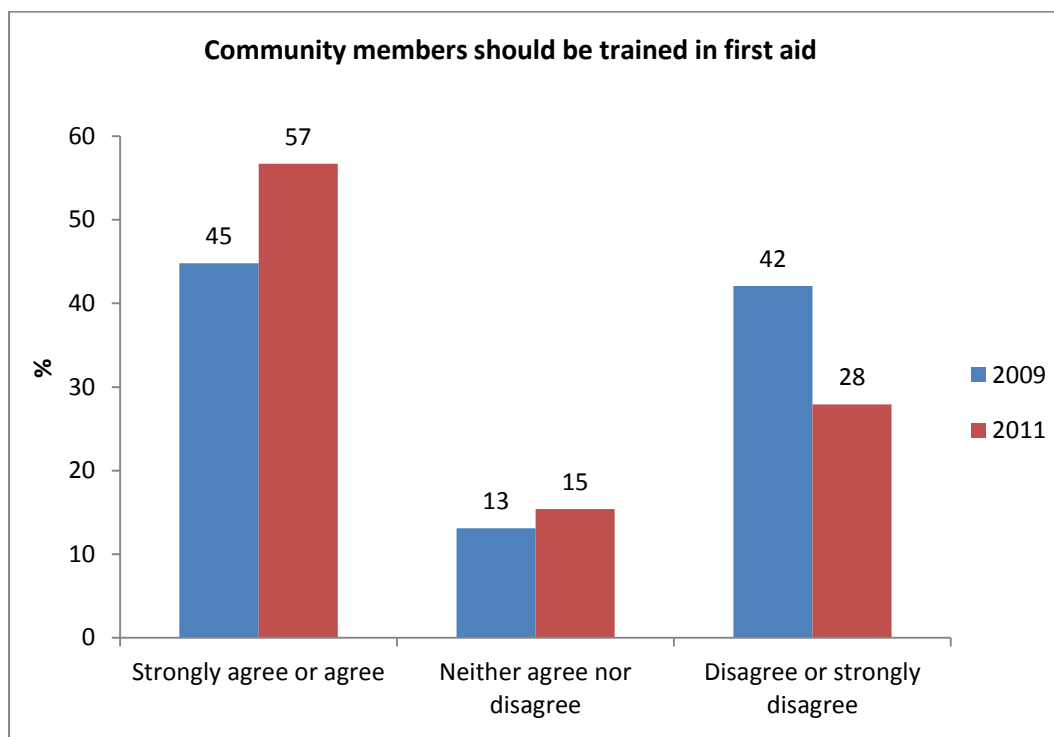
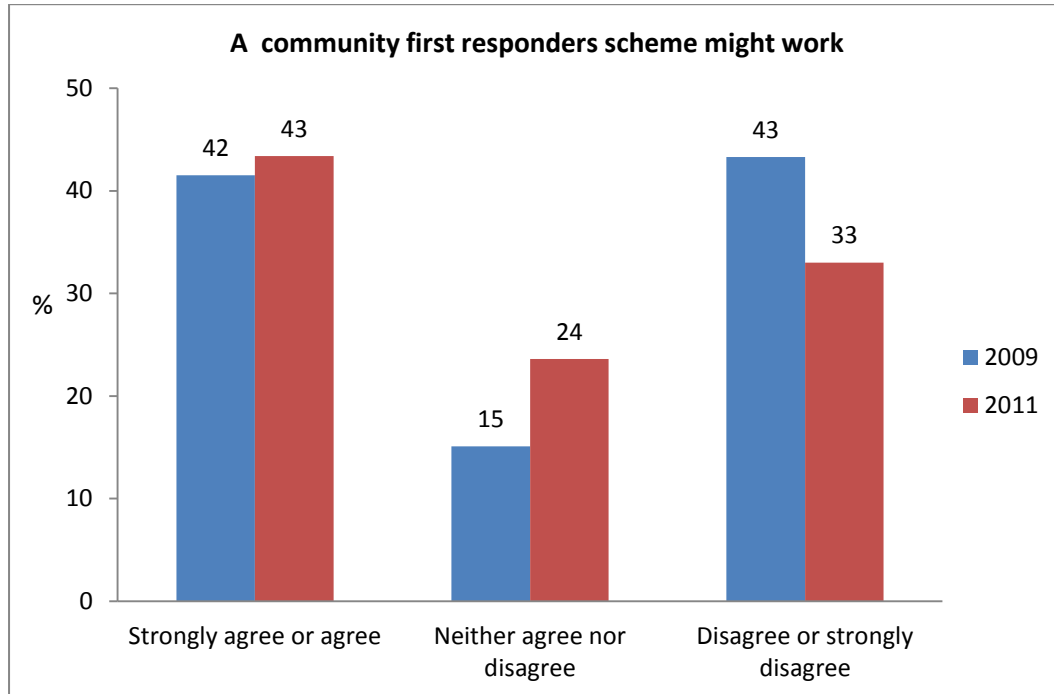
| <i>As an <u>addition</u> to the current emergency response service, a community first responder scheme might work</i> | | | | | | | | | | | |
|---|------|------|------|----------------------------|------|------|------|-------------------------------|------|------|------|
| Strongly agree or agree | | | | Neither agree nor disagree | | | | Disagree or strongly disagree | | | |
| Number | | % | | Number | | % | | Number | | % | |
| 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 |
| 44 | 46 | 42 | 43 | 16 | 25 | 15 | 24 | 46 | 35 | 43 | 33 |

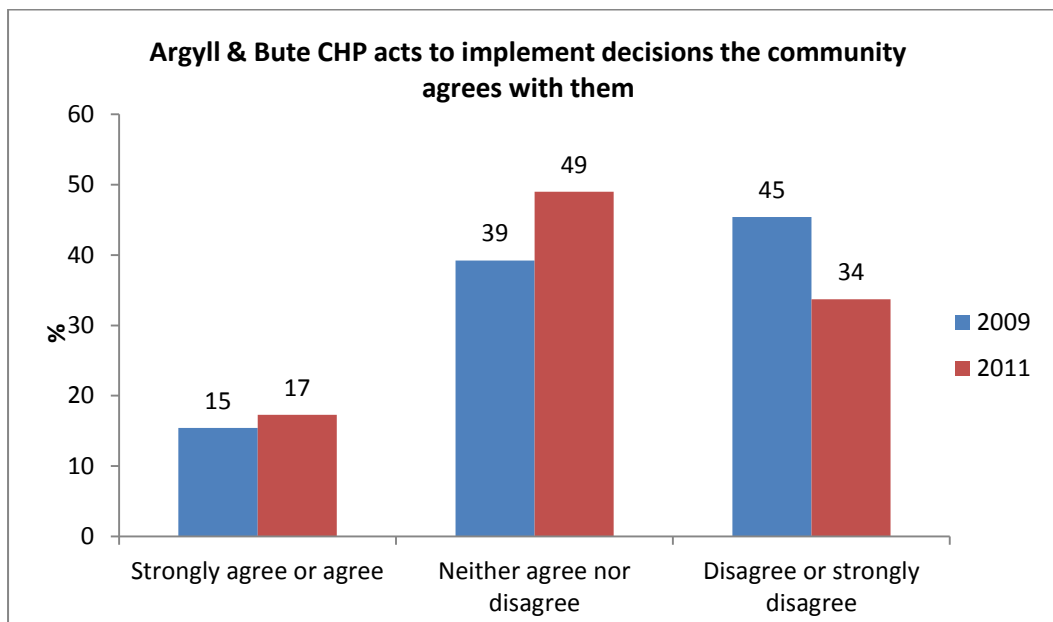
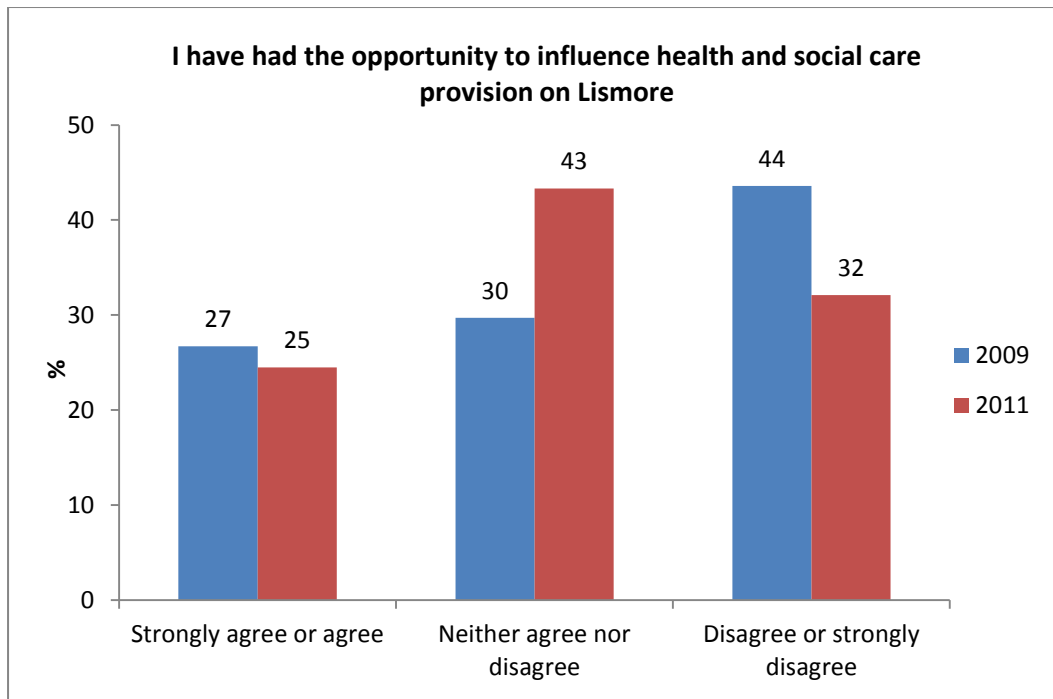
| <i>Community members should be trained in first aid</i> | | | | | | | | | | | |
|---|------|------|------|----------------------------|------|------|------|-------------------------------|------|------|------|
| Strongly agree or agree | | | | Neither agree nor disagree | | | | Disagree or strongly disagree | | | |
| Number | | % | | Number | | % | | Number | | % | |
| 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 |
| 48 | 59 | 45 | 57 | 14 | 16 | 13 | 15 | 45 | 29 | 42 | 28 |

| <i>I have had the opportunity to influence health and social care provision for Lismore</i> | | | | | | | | | | | |
|---|------|------|------|----------------------------|------|------|------|-------------------------------|------|------|------|
| Strongly agree or agree | | | | Neither agree nor disagree | | | | Disagree or strongly disagree | | | |
| Number | | % | | Number | | % | | Number | | % | |
| 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 |
| 27 | 26 | 27 | 25 | 30 | 46 | 30 | 43 | 44 | 34 | 44 | 32 |

| <i>Argyll & Bute CHP act to implement the decisions our community agrees with them</i> | | | | | | | | | | | |
|--|------|------|------|----------------------------|------|------|------|-------------------------------|------|------|------|
| Strongly agree or agree | | | | Neither agree nor disagree | | | | Disagree or strongly disagree | | | |
| Number | | % | | Number | | % | | Number | | % | |
| 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 | 2009 | 2011 |
| 15 | 18 | 15 | 17 | 38 | 51 | 39 | 49 | 44 | 35 | 45 | 34 |

Figure 10 First response and processes of engagement aspects of the new model





Additional comments from Questionnaire

Respondents were able to add additional comments on their completed questionnaires in 2009 and 2011. The range of comments reflected the themes in the interviews and public meetings and highlighted the following:

Nursing service

In 2009 comments were critical of the nursing services, particularly the “erratic” clinics, and people were unclear about the role of the nurse practitioner. Several said a nurse practitioner was unnecessary in both years:

“I do not think the presence of a nurse practitioner has helped the island. Better to have a plain NURSE who is available for everyday duties.” (2009)

“We don't also need an expensive nurse practitioner who is only available in social hours, when the GP is easily accessible anyway. This is a frightening place to live when a storm is blowing and there is NO access to any healthcare. This happens for several days at a time during winter. There is no acceptable alternative to resident nurses on the island. Anything else is unsafe in this geographical location.” (2011)

More proactive nursing was called for e.g. information on diet and exercise. In 2011 complaints about the nursing service had increased and there was still confusion over the roles of the nurse practitioner and the community nurse. Many comments called for a permanent community nurse. A great deal of dissatisfaction was expressed and a feeling that health service provision on the island has deteriorated in the last two years. Generally people feel they should have the same right to health provision as the mainland because they pay the same taxes and are entitled to equal treatment. However, there is some recognition that service provision is more difficult and expensive.

“Not been on the island very long ... I accept that living on a small island means that health provision CANT be as good as in a town or city. This is part of the price we pay for living somewhere pleasant.” (2011)

Home visits

The call for home visits for older people has more than doubled.

“Community nursing implies a nurse available out and about in the community, visiting the older and more vulnerable members of the community who may be reserved about asking for a doctor or nurse visit for consultation or reassurance about their condition.” (2011)

24/7 cover

As in 2009 there were calls for 24/7 medical cover (27 in 2009 and 11 in 2011), with only one person disagreeing with having a nurse resident on the island and saying it was a misunderstanding of what a nurse can do.

Out of hours cover/emergency cover

The distinction between the GP out of hours service and the emergency ambulance/helicopter is sometimes blurred. In 2009 several comments expressed fear that someone would die on the island due to poor emergency provision. In 2011 people are generally satisfied with the GP service, but some remain concerned emergency cover is inadequate and the arrangements for the helicopter would not work:

“I accept that standard NHS service is difficult to deliver on a rural island (ie expensive) BUT islanders are entitled to EXACTLY the same service as in a city, they pay the same taxes. Emergency cover for the island I regard as poor. Other island and peninsular services, practices on the west coast have provided a RIB (rigid inflatable boat) for the doctor's use. THERE MUST BE 24h 365 DAYS/YEAR” (2011)

One person was unclear who to phone in an emergency during the day.

First responders

Again comments on this issue mirror the interviews in both years. In 2009 seven out of eight comments were critical of the scheme with the more positive comments believing it was a good

scheme but only with the right professional back up. In 2011 people continue to have doubts about this scheme. There is a slight increase in those interested in more basic first aid and defibrillator training but not under the first responder umbrella or with these responsibilities.

Social care

A few comments referred to the deterioration of social care for older people. The perceived reduction of transport and social services for older people is linked to an increased demand for home visits as the increasing older population is seen as more isolated and vulnerable than before.

Prescription service

As in 2009 there were several complaints about the inadequate prescription service.

Community resilience

Lismore sees itself as a resilient self-reliant community:

“From personal observation, I would like to add that the most important factor in maintaining the system of care and if necessary improving on it, the greatest asset the island enjoys is its already existing tradition of mutual help and concern.” (2011)

Health promotion

In 2009 there were four comments asking for more sessions and opportunities to discuss diet and exercise with another wanting more information and advertising about what is available. Health promotion was not referred to in the 2011 comments.

Anticipatory Care plans

In 2009 a couple of people commented that there should be more care plans in place but there were no comments referring to this issue in 2011.

Lack of communication/consultation

In 2009 five comments said islanders were not being listened to and in 2011 there were three about lack of communication.

“I feel that Argyll and Bute and the health partnership are bulldozing a system on Lismore that is neither practical or wanted and is a retrograde step. Lismore could be a model for all small communities with an exceptional service. IT IS NOT at the moment.” (2011)

“The CHP have NOT been willing to try to UNDERSTAND OR BELIEVE the views of a small ISLAND COMMUNITY. This island should have full nursing cover day and night for emergencies” (2011)

“Why, why, why do we have to do this again when nothing looks as if it is changing for the better. YOU will obviously decide what we need not what the island requires. All to do with money I expect - but is this not a waste of money. Too many chiefs and not enough indians to make it work.” (2011)

One person suggested having regular meeting with health authority perhaps on a yearly basis to inform the community about changes in health service provision. Conversely one person wanted expert medical opinion to make an “informed decision” about services instead of consult the public.

4. Discussion & conclusions

In this section we discuss the changes observed, through the data collected during this evaluation, in citizens and service providers' views on a variety of aspects of the new model of healthcare provision on the Isle of Lismore. We have compared the 2009 data with that from 2011 and have attempted to explain what has driven these changes.

4.1 Public meetings and Citizen interviews

Although many residents are satisfied with general health provision on and off the island, they are often unsure of the new model and whether everything is in place. There is great confusion over the different nursing roles and a lot of criticism and dissatisfaction about the nursing service at the moment. The team-working measure does not seem to have been implemented and the appointment of the community nurse has caused confusion, although people want the post retained. Many of the same concerns remain: they want medical cover 24/7 on the island; desire home visits for vulnerable people; think that emergency cover is inadequate; feel there is a lack of communication with the service providers and that the service providers misunderstand the island community.

Islanders are firm in their belief that the community is self-reliant, resilient and willing to help itself. However, they do not want voluntary schemes to displace professional services and they want a sense of equity with the mainland. They do not want to feel marginalised and disadvantaged compared to the mainland. The demand for a resident nurse is still central to maintaining a sense of equity and security. It is also important for the future sustainability of the island community and encouraging younger people and families to return or stay. Residents fear the erosion of services not just as a loss of day to day provision but because of what this will mean for the viability of the community. The strong call for home visits is also influenced by the way the island sees itself as a rural community where people all know each other, neighbours matter and professionals are part of this network as they were traditionally – this is what makes up the community. There is no more understanding of what a generic worker role might consist of in 2011 than 2009. Islanders are very dissatisfied with the deterioration of social care, the prescription service, inadequate emergency cover and the nursing service. However, fears about the GP out of hours service are largely addressed and there are more positive attitudes to NHS 24, first responders and general first aid training.

On the whole citizen interviews, public meetings and questionnaire comments share these general themes.

4.2 Service provider interviews

The service providers do offer a slightly different view point, although there is a division between health care providers and other providers. The latter fall generally in line with community thinking and share many of the same ideas about a resident nurse and home visits. The health service providers remain distinct as in 2009, having generally a far more positive attitude to the new model and expressing greater satisfaction with the way it is working. They have their own specific concerns e.g. maintaining and updating skills, appropriate boundaries in a small community and the disjunction between the delivery of modern health care and traditional models.

4.3 Community Questionnaire

4.3.1 About you and your Community

The demographic profile of respondents in 2009 and 2011 were very similar except in two areas – employment and the length of time lived locally. More respondents (30%) were in full-time employment in 2011 than in 2009 (26%) and fewer respondents (13%) were in part-time employment in 2011 than in 2009 (18%). Fewer respondents (32%) had lived locally for 6-20 years in 2011 than in 2009, while more respondents (47%) had lived locally for >20 years in 2011 than in 2009 (43%). This may simply reflect a transition from one group (6-20 years) to another (>20 years) since the questionnaire was sent out in 2009. There was a small increase in the number of respondents who had lived locally for <5 years from 19% in 2009 to 21% in 2011.

Regarding community participation, there was a decline in the number of individuals who had attended at least 3 events in the last 3 months in 2011 (64%) compared with 2009 (76%). There was an increase in numbers attending 1 or 2 events in 2011 (29%) compared with 2009 (21%). More people in 2011 (8%) had not attended any events compared with 2009 (3%). This may be a reflection of transport changes on the island and the transition from a transport scheme that was led by social services to one that is now been taken forward by the community themselves.

Slightly fewer individuals had provided help 3 times to neighbours in the previous three months in 2011 (61%) than in 2009 (64%), while more had provided help once or twice – 23% in 2011 compared with 18% in 2009. The percentage of people who had not provided help in the previous 3 months was comparable for both years – 16% in 2011 and 17% in 2009.

4.3.2 General Health and Health Services

Little difference was observed in the community's self-reported health between 2009 and 2011. Twenty eight per cent of individuals described their health as average in 2011 compared with 24% in 2009, while 65% described their health as good/very good in 2011 compared with 67% in 2009. Poor/average health was reported by 8% in 2011 and 9% in 2009.

Regarding use of services in the previous 12 months, fewer had visited or been visited by a GP in 2011 (69%) compared with 2009 (73%). There was a drop from 47% in 2009 to 32% in 2011 in those who had visited or been visited by a nurse/nurse practitioner. There was an increase from 10% (2009) to 14% (2011) in those who call NHS24. In 2009, 19% of respondents had called the local GP out-of-hours, while only 14 % had done so in 2011. There was a drop from 15% (2009) to 8% (2011) in those who had called the nurse/nurse practitioner out-of-hours. With thirty seven per cent of respondents reporting that they had used the drop-in community nursing clinic. The new model encourages the community to contact NHS 24 or the GP Practice in Port Appin for medical advice OOH but not to contact the Nursing staff OOH directly. The changes in the use of health services between 2009 and 2011 as reported by the community indicate that the community are moving towards adopting the new process.

Anticipated use of services following chest pain

A scenario was described in which a patient was experiencing chest pain and individuals were asked which service provider they would contact for advice during the day or at night. Prior to the implementation of the new model the Nurse practitioner may have been called out, the patient assessed, care discussed with GP and if required the patient would be evacuated and transferred to hospital. The new model would propose that the patient would call NHS 24 for advice, NHS 24 might advise taking aspirin and if needed the air ambulance and a first responder would be mobilised.

During the day, 3% of respondents would now call NHS compared with 1% in 2009, while at night, 11% would now call NHS24 compared with 6% in 2009. During the day 18% of people would now call 999 compared with 6% in 2009, while at night 25% would now call 999 compared with 12% in 2009. 48% of respondents would now call their GP practice during the day compared with 43% in 2009, while at night 40% would now call their GP practice compared with 32% in 2009. Two per cent of people would now visit their GP during the day compared with 0% in 2009, while 0% would now attend the GP practice at night compared with 1% in 2009. No respondents said that they would wait until morning and then call their GP in either 2011 or 2009. During the day, 28% of respondents would now call a nurse on the island compared with 49% in 2009, while at night 23% would now call a nurse on the island compared with 44% in 2009. No respondents said that they would now visit a nurse on the island during the day compared with 1% in 2009. No respondents said that they would wait until morning and then call a nurse in either 2011 compared with 4% in 2009. No respondents said that they would go to A&E in either 2011 or 2009.

Within the community there is a move toward accessing services as described in the new model. As there was widespread unhappiness about using First Responders on Lismore no such scheme has been developed. If individuals were looking to have local medical expert advice, in this scenario, they would contact the GP practice in Port Appin.

Anticipated use of services for symptoms of a cold at night

A scenario was described in which a patient was experiencing symptoms of a cold at night and individuals were asked which service provider they would contact for advice. One per cent of respondents would now call NHS24, compared with 0% in 2009. Seventy six per cent of respondents would administer paracetamol/aspirin compared with 78% in 2009. Six per cent of respondents said that they would now call a nurse on the island compared with 10% in 2009. Thirteen per cent of respondents answered "other" to this question in 2011 compared with 12% in 2009. "Other" responses included doing nothing; keeping warm; give a hot toddy. A number of respondents in both years felt that it was a "daft" question to ask as it was only a cold.

4.3.3 Health and Social Care Services in Lismore

There was a large drop in the percentage of people who are very satisfied/satisfied with social care for elderly and vulnerable people, from 41% in 2009 to 14% in 2011. There was a corresponding increase in the percentage of people who are dissatisfied/very dissatisfied, from 21% in 2009 to 44% in 2011, and a small increase in those who are neither satisfied nor dissatisfied (37% in 2009 to 41% in 2011). It is clear that the change in delivery of home care and personal care services from locally based providers to providers based on the mainland has evoked a strong negative reaction among the community.

There was a decrease in the percentage of respondents who are very satisfied/satisfied with nursing care for the elderly and vulnerable people, from 22% in 2009 to 11% in 2011. There were increases in those who are neither satisfied nor dissatisfied (27% in 2009 to 31% in 2011) and in those who are dissatisfied or very dissatisfied (52% in 2009 to 58% in 2011). This probably reflects the strong community views on what services *should* be provided to this group in relation to the types of services that *are* being provided to this group as determined by the nursing role. It may also be a reflection on the quality of services being provided.

There has been an increase in the level of satisfaction with health care during the day with an increase in those who were very satisfied/satisfied from 36% in 2009 to 44% in 2011. There was a corresponding decrease in those who were neither satisfied nor dissatisfied (37% in 2009 to 28% in 2011). There has been little change in the percentage of people who are either dissatisfied or very dissatisfied.

There has been an increase in the level of satisfaction with emergency out of hours care with an increase in those who were very satisfied/satisfied from 22% in 2009 to 33% in 2011. There was a corresponding decrease in those who were dissatisfied/very dissatisfied from 52% in 2009 to 40% in 2011. The percentage of those who are neither satisfied nor dissatisfied was similar for both years (27% in 2009 and 28% in 2011). This change probably reflects the strong commitment from the GPs in the Port Appin surgery to cover OOH services for the island and the establishment of a process for the emergency evacuation off the island by helicopter.

In 2011 only thirty nine per cent of respondents were aware that a new model of health and social care services had been introduced to Lismore even though in 2009 70% of respondents had heard about the proposed new model. Eighty three per cent of respondents said that they did not know, more or less, what the new model was compared with 72% in 2009. Seventeen per cent of respondents thought that they knew more or less what the new model was compared with the 28% in 2009. Fifty three per cent of respondents are neither satisfied nor dissatisfied with the new model, with 15% being very satisfied/satisfied and 33% dissatisfied or very dissatisfied. The low number of people (89) who answered this question may reflect a lack of understanding of what the new model is. Together these findings indicate that although the majority of the community on Lismore knew that a new model of care provision had been introduced few knew the details of what it meant for local service delivery or to them. On the ground the community probably saw little change unless they actually used some of these services on a regular basis.

The Argyll & Bute CHP were interested in the community's views on the nursing services and GP services available to them. Additional questions asking about the use of the drop in nursing clinic, the health promotion activities and the GP led service were added to the questionnaire in 2011. A greater percentage of people (36%) are very satisfied/satisfied with the drop-in community nursing clinic than are dissatisfied/very dissatisfied, with 37% neither satisfied nor dissatisfied. Thirty eight per cent of respondents are neither satisfied nor dissatisfied with the health promotion activities delivered by the community nurse, with 30% very satisfied/satisfied and 33% dissatisfied/very dissatisfied. Seventy four per cent of respondents are very satisfied/satisfied with the GP service with 16% neither satisfied nor dissatisfied and 10% dissatisfied/very dissatisfied. Overall, the community were more satisfied with their GP services than they were with the nursing led services on Lismore.

4.3.4 Citizens Views

In 2011 33% of respondents disagree/strongly disagree on whether a community first responder scheme might work on Lismore compared with 43% in 2009. This has been accompanied by an increase in those who neither agree nor disagree that it might work (24% in 2011, compared with 15% in 2009). However the percentage of those who strongly agree or agree has remained similar (43% now compared with 42% in 2009). There has also been a shift in attitude on community members being trained in first aid. Fifty seven per cent think that this should now happen compared with 45% in 2009. This corresponds with a drop in those who disagree or strongly disagree, 28% now compared with 42% in 2009. These changes in attitude might be linked to the influence of the new team at the GP practice in Port Appin. The team here have been instrumental in taking forward defibrillation training with the community and have been proactive confirming their commitment to provide OOH services.

Fewer people disagree/strongly disagree that they have had the opportunity to influence health and social care provision on Lismore (32% now compared with 44% in 2009), however this is a shift to neither agreeing nor disagreeing (43% now compared with 30% in 2009). The percentage of those who strongly agree or agree remains similar (25% now compared with 27% in 2009).

There was similar trend in responses to the question relating to Argyll & Bute CHP acting to implement decisions agreed with the community. Thirty four per cent of respondents now disagree or strongly disagree compared with 45% in 2009, while 49% now neither agree nor disagree compared with 39% in 2009. The percentage of those who strongly agree or agree remains similar (17% now compared with 15% in 2009).

It is possible that the long time lag taken between developing the new model of healthcare provision in 2009 and evaluating it in 2011, along with the Argyll & Bute CHP disengaging somewhat with the community over that period relative to the level of engagement prior to 2009, has meant that some have forgotten that a new model had been proposed or implemented. Importantly, the majority of the community when asked in either 2009 or 2011 were not clear as to what the new model of healthcare comprises. The majority of the community feel that they have not had the opportunity to influence health and social care on the Island nor do they feel that the Argyll & Bute CHP has acted to implement decisions agreed by them and the community. This implies that the community engagement process was not a success.

4.4 Conclusion

Topics covered in the public meetings, interviews and the community questionnaire included the following:

- Views on current services, challenges, needs
- Views on future services, hopes, expectations
- Views on community capacity, resilience, responsibility, rights, priorities, capacity to deal with illness and injuries
- Views on security, confidence, previous experiences
- Views on the way people use health services and will use health services

In the concluding part of this report we summarise below the main findings in relation to these topics.

Views on current services, challenges, needs

All of the elements of the new model of healthcare provision on the Isle of Lismore had been in place for six months before the evaluation of the service was completed. Although the majority of the community knew that a new model had been proposed, fewer knew that it had been implemented and there is much confusion as to what the model actually comprises.

There is much confusion over the different nursing roles. The community spoke about a Practice Nurse, Community Nurse and an Advanced Nurse Practitioner but were not clear on who was managed by whom or what skill sets each professional had. Many citizens were critical of and dissatisfied with the current nursing service, particularly those nursing services provided for the elderly and more vulnerable people in the community. Other services perceived to be led by nursing staff such as the prescription pick up service and health care promotion activities were also criticised. The Community Nursing Team was not utilised as anticipated in the model and therefore the benefits of team work were not realised.

The community and some service providers were very dissatisfied with the social care provision on the Island. This was very much seen as a retrograde step within a service that was previously seen as excellent.

The new GP partnership in the Port Appin surgery has had a very positive impact on the community and the community feel supported by and support their GPs.

It was perceived that there has been a lack of communication between the community and the Argyll & Bute CHP/Social Services. On the whole only the minority of the community feel that they have been able to influence health and social care provision and that Argyll & Bute CHP are acting to implement these decisions.

Views on future services, hopes, expectations

The community were still calling for 24/7 nursing cover on the island. There was also a plea for more services for the elderly and vulnerable people on Lismore, in particular home visits.

The community were concerned about the capacity of the Volunteer Fire Service members to deploy the landing lights for the Air Ambulance in potential future emergency situations.

Service providers were keen to see that the Community Nursing Team was utilised as anticipated in the new model in the future.

Service providers are willing to discuss the use and role of a generic health and social care worker in future service provision.

Views on community capacity, resilience, responsibility, rights, priorities, capacity to deal with illness and injuries

Islanders see themselves as self-reliant and resilient but not all the service providers agree. This is largely due to the continued call for 24/7 nursing cover and the reluctance to adopt health support schemes such as the Community First responder Scheme.

The local GPs have had a very positive effect on the community and have empowered the community to look at health care provision in a different way. For example they have implemented and led community defibrillation training. The community are now requesting community first aid training to complement this. However, some service providers are cautious regarding the capacity that the GP surgery has in helping the community to maintain their skills and have suggested that the SAS may have a role here too.

Generally the majority of the community take part in community events and are willing to help their neighbours.

The community has taken the lead in developing a Community Transport Scheme which has been highly praised by both community members and service providers.

The community is unclear as to how their service compares with more urban or equivalent services on the mainland and some perceive that it is less equitable. The community feel they have a right, like any other Scottish citizen, to good health and social care provision.

Views on security, confidence, previous experiences

The community fears the erosion of their health and social care services. It is perceived that this would make Lismore a less attractive community and place to live in. Good service provision is strongly linked with the future sustainability of the island community.

The community appear to have lost some confidence in their nursing service and in social services.

Interviewees had many examples, some good some bad, of previous experiences of health and social care service provision. Importantly, in a small, tight knitted community such as Lismore one person's experience can become a whole community's experience.

Views on the way people use health services and will use health services

The community is changing how it currently uses and would use health services now and in the future. This is a gradual change, with more people willing to use NHS 24 for advice and to call 999 in a health emergency in 2011 compared with 2009. The community have been asked not to directly call the on-call nurse OOH and although there is not a significant difference seen between those who self report as having called the nurse out of hours in 2009 compared with 2011, there is a significant difference in the numbers of citizens who would anticipate calling the nurse OOH if they were experiencing chest pains.

The need for a nurse OOH has been questioned by both community members and service providers.

The community are more receptive to the Community First Responders Scheme in 2011 and are more satisfied with the emergency OOH care arrangements.

5. Recommendations

- There is a mismatch between what the community expect from their health and social care providers and what the providers can actually provide. In particular, the role of the Nursing staff based on Lismore, the services that are provided by Social Services and the input of the Community Nursing Team has caused confusion. The community would benefit from some clarity on these issues. Discussion around these roles and services should be part of an on-going engagement process in which the community have the opportunity to feed into and shape the evolution of their services.
- A health information sheet containing basic local information such as clinic times, telephone numbers for NHS 24, who to call when, how emergency services operate and what the ambulance is for would be useful to remind the community of how and when to access particular health and social care services. With services evolving on an on-going basis, service providers should discuss with the community how to make up-to-date information accessible for all.
- Anticipatory care plans for those with complex health needs and self care for all, including health promotion/education activities, are an important part of helping citizens to proactively and positively manage their health and wellbeing. The Argyll & Bute CHP should ensure that anticipatory care plans are in place for all vulnerable members of the community. The community should continue to take an active role in maintaining and improving their own health and wellbeing, with support from the Argyll & Bute CHP where appropriate.
- Many citizens were critical of and dissatisfied with the current nursing service with some comments in the questionnaire relating specifically to the quality of this service. Although the *quality* of nursing services on Lismore was not the focus of this report we recommend that the issues raised be addressed by the Argyll & Bute CHP.
- While the majority of citizens who were either interviewed or attended a public meeting called for continued 24/7 nursing provision the anticipated use of the nurse OOH by the wider community has dropped since the implementation of the new model. In the new model the community have been asked to contact NHS 24 in the first instance for OOH assistance or to call 999 in an emergency. Moreover, the GPs have publically stated that they would be unlikely to deploy a nurse OOH. Therefore, the role for a nurse OOH is unclear and we would recommend that the use of nursing staff to provide OOH cover be re-examined by the Argyll & Bute CHP in partnership with the community.
- The role of the wider Community Nursing Team should be implemented as was anticipated in the new model so that the benefits of team working can be realised for both the service providers and the community.
- Specific problems have been highlighted regarding access to some basic health care services. Procedures for the picking up/ dropping off of prescriptions should be put in place. The community have highlighted the difficulties in accessing GP services outwith normal working hours for those in full time employment. The GPs might consider either running a later clinic on Lismore or in the Port Appin Surgery.
- The proposed new role of a generic health and social care practitioner might be an appropriate role for remote, rural and island locations and may help to better integrate health and social care services. The specific details of this multidisciplinary role would merit further discussions between health and social care providers and the communities that they might serve.

- The apparent deterioration of social care on the island since 2009 is a major anxiety and frustration for the residents, particularly given the relatively high older population. It is strongly recommended that social services engage with the community regarding recent and future changes in the delivery of social care. Engagement on these issues should involve a 2-way dialogue between the community and Social Services. Social Services should outline what their priorities are and discuss potential opportunities for community involvement with regard to future services delivery.
- The health and social care providers must continue to engage with the community on Lismore in a proactive and constructive way. They must demonstrate a joined up approach to future planning related to evolving health and social care services.
- The CRH has previously worked with the Argyll & Bute CHP on a community engagement process for remote and island communities relating to service provision⁸. We would recommend that this process be utilised on Lismore and that a clear agreement is sought between the community and the Argyll & Bute CHP on what the outcomes of the process are and how they are progressed. Importantly, the Argyll & Bute CHP needs to recognise that how the community sees/identifies itself is key to its expectations of health care.
- The community has already successfully coordinated a community transport scheme and may have a role in developing and delivering community based services, not seen as a core to either the Argyll & Bute CHP or Argyll & Bute Social Services, but related to health and social care. This may be via a community trust, community enterprise, social enterprise or similar. It would be useful for the community to explore these opportunities with the Argyll & Bute CHP and/or Social Services. Further support and advice relating to how this could be organised should be sought from other agencies such as the Highlands and Islands Enterprise Zone⁹ and Highlands & Islands Enterprise¹⁰.

⁸ Remote Service Futures: Health Care Service Design with Communities- Final Report

<http://www.abdn.ac.uk/crh/uploads/files/remote-service-futures-project-final-report.pdf>

⁹HISEZ CIC, 81a Castle Street, Inverness, IV2 3EA T: 01463 715533 E: contactus@hisez.co.uk W: www.hisez.co.uk

¹⁰Highlands and Islands Enterprise, The Enterprise Centre, Kilmory Industrial Estate, Lochgilphead, PA31 8SH. <http://www.hie.co.uk>