PE1845/EE Petitioner submission of 30 December 2022

On behalf of the Galloway Community Hospital Action group and supported by Caithness Health Action Team

Thank you to the Health Committee for further considering petition 1845 to develop an agency that will provide independent advocacy for rural patients.

We welcome that Borders and Highland boards accept the need for the profile of rural issues to be raised. We are glad boards acknowledge that discrepancies exist. Current advocacy through board executive and non-executive, politicians, RRHEAL, and NES (not to mention local engagement with patient participation and action groups) has failed to deal with the issues highlighted in the many submissions supporting the 1845 Petition as well as PE1890 and PE1924.

This lack of success is due to their dual responsibility being both providers and agency. Service providers who are well-represented can engage easily with accessible urban patient advocacy groups. For rural communities, geographically disparate and remote from all "centres of excellence", the service provider view dominates. This imbalance is recognised as structural inequality. Management favours a "one size fits all", inevitably urban model. Such a proscriptive approach was challenged in a petition submission from The Dispensing Doctors Association, The Remote Practitioners Association of Scotland, The Scottish Countryside Alliance, Douglas Deans, Professor Philip Wilson (Director, Centre for Rural Health, Aberdeen University), Caithness Health Action Team and Galloway Community Hospital Action Group. For all of these well-informed groups, the provision of effective advocacy is essential and overdue.

Advocacy is not another layer of bureaucracy. On the contrary, it will inform the current, often disconnected, bureaucratic structures. Current bureaucracy has created and sustained the 20+ year 7-hour Wigtownshire referral pathway to Edinburgh (passing within a mile or so of the Beatson) for cancer. The gradual deterioration over 10 years to the now non-existent Wigtownshire intrapartum and out-of-hours community midwifery care (150-mile round trip), is below any minimum standard. Maternity services in Caithness by Highland are following the same path. Multiple reports of labouring and roadside delivery unattended in private transport predict a major adverse event. All of these and others, from opposite corners of the country, impose physical, emotional and financial harm. Worse, cancer "survival disadvantage" is described,[1] a situation that could not be ignored in urban settings. During the Covid epidemic, Professor Whitty prioritised Health in Coastal communities through NHS England's Annual report noting a "lack of reliable data" and "long neglected and overlooked" association with health disadvantages.[2] Scotland has similar and even greater problems, also overlooked as described in the petition 1845 submissions.

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[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5537495/

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005217/cmo-annual_report-2021-health-in-coastal-communities-summary-and-recommendations-accessible.pdf

We propose a proven system to cut through the contributory silo mentality. Silos were highlighted by the Sturrock Report. National and international experience supports our proposal. The role of the Remote and Rural Commissioner in Australia and the Children and Young Person commissioner for Scotland have cut through bureaucracy. Key decision-makers are not blindsided or hi-jacked by the press for predictable and avoidable adverse events. Such advocacy would ensure critical information is not overlooked. If boards are beyond reproach in this matter, an agency would seek ways to congratulate, disseminate and promote their working practices. Why should anyone object to such transparency? Why do virtually all current structures reject an advocacy process that is based on "fair and reasonable" principles that bind both parties? Presently, there is no doubt that many informal agencies are based on a narrow and less than a perfectly informed view. There is a place for a commissioner as a mediator in such circumstances. Credibility depends on being independent of either party.

This systematic failure of all the current structures to address these gross inequities causes negative outcomes including associated excess mortality. The evidence in our petition submissions is based on sound peer-reviewed evidence and common sense. It has so far been persistently and systemically overlooked by some boards.

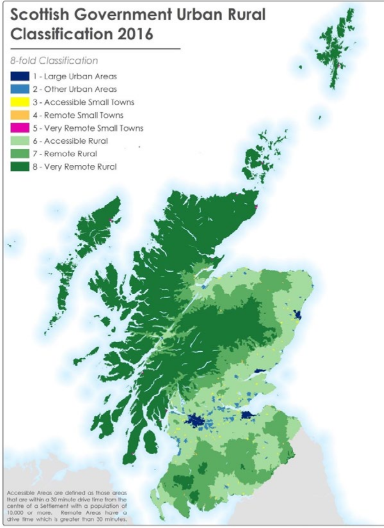
Advocacy would reduce bureaucracy by sharing best practices nationally while ensuring a fair and reasonable balance between clinical effectiveness and cost. A better-informed legislature will deliver healthcare gains with reduced costs by avoiding inappropriate or unworkable solutions. The latest GP contract is an example. These could be used as key performance indicators for the process.

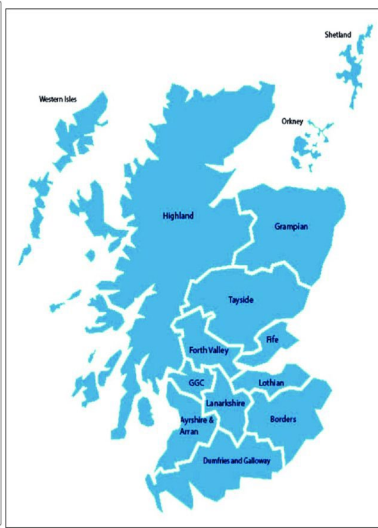
It is not clear why 3 of 8 boards failed to respond. Using parameters from page 12 of The National Framework for Service Change in NHS Scotland,[3] Lanarkshire (describing itself as serving a population .. "across rural and urban communities") was not approached. Of other boards that were not asked for a response, Forth Valley and Ayrshire and Arran are equally rural (from a healthcare perspective), and Tayside is similar to Borders. Although much better in Scotland than elsewhere in the UK, this is further evidence of systemic misunderstandings of rural and remote health and deprivation. An agency could eliminate inconsistency and develop and share realistic, sustainable, equitable solutions with better outcomes and lower costs.

The Sturrock report[4] into Highland Health Board recommended mediation in disputes. An advocacy/agency process will address, perhaps resolve, the issues arising from PE1890 and PE1924 by ensuring that both parties benefit from an agreed well-informed view. The objective of PE1845 works towards political and management decisions driven by independent, well-informed, accountable, fair and reasonable, principles and processes. CHAT supports petition 1845.

[3] https://www.sehd.scot.nhs.uk/nationalframework/documents/remoterural/final%20draft170505.pdf

[4] https://www.tsh.scot.nhs.uk/Safe/Docs/Learning%20from%20External%20Inquiry%20Reports/Sturrock%20Report%20-%20Apr%2019.pdf


Scottish Government Urban Rural Classification 2016
8-fold Classification
1 - Large Urban Areas
2 - Other Urban Areas
3 - Accessible Small Towns
4 - Remote Small Towns
5 - Very Remote Small Towns
6 - Accessible Rural
7 - Remote Rural
8 - Very Remote Rural
Accessible Areas are defined as those areas that are within a 30 minute drive time from the centre of a Settlement with a population of 10,000 or more. Remote Areas have a drive time which is greater than 30 minutes.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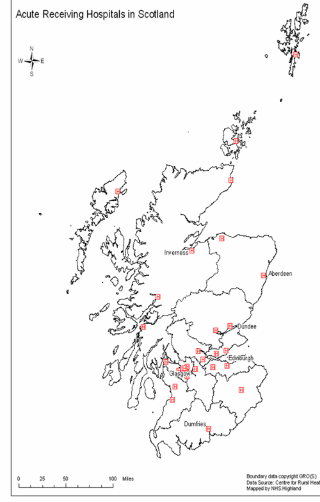
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