Citizen Participation and Public Petitions Committee

7th Meeting, 2022 (Session 6), Wednesday 4 May 2022

PE1845: Agency to advocate for the healthcare needs of rural Scotland

Note by the Clerk

Lodged on	23 November 2020
Petitioner	Gordon Baird on behalf of Galloway Community Hospital Action Group
Petition summary	Calling on the Scottish Parliament to urge the Scottish Government to create an agency to ensure that health boards offer 'fair' and 'reasonable' management of rural and remote healthcare issues.
Webpage	https://petitions.parliament.scot/petitions/PE1845

Introduction

1. The Committee last considered this petition at its meeting on 8 September 2021. At that meeting, the Committee agreed to write to the Scottish Government. The Committee also agreed to write to the Remote and Rural General Practice Short Life Working Group and to rural health boards.

2. The petition summary is included in **Annexe A** and the Official Report of the Committee's last consideration of this petition is at **Annexe B**.

3. The Committee has received new responses from Sir Lewis Ritchie, Chair Remote and Rural General Practice Working Group, NHS Orkney and Shetland, NHS Grampian, the Petitioner, and Claire Fleming which are set out in **Annexe C**.

4. Written submissions received prior to the Committee's last consideration can be found on the petition's webpage. All written submissions received on the

petition before May 2021 can be viewed on the petition on the archive webpage.

5. Further background information about this petition can be found in the SPICe briefing for this petition.

6. The Scottish Government's initial position on this petition can be found on the petition's webpage.

Action

The Committee is invited to consider what action it wishes to take.

Clerk to the Committee

Annexe A

PE1845: Agency to advocate for the healthcare needs of rural Scotland

Petitioner

Gordon Baird on behalf of Galloway Community Hospital Action Group

Date lodged

23 November 2020

Petition summary

Calling on the Scottish Parliament to urge the Scottish Government to create an agency to ensure that health boards offer ‘fair’ and ‘reasonable’ management of rural and remote healthcare issues.

Previous action

I have been working to improve health care policies for rural and remote communities for several years.

During that time, I have met with MSPs, including Aileen McLeod, Emma Harper, Finlay Carson and Colin Smyth.

I have also met with a Senior Medical Officer (Oncology) for the Department of Health and Wellbeing.

Background information

We are experienced clinicians and medical managers, with a history of working with patients in rural and remote communities and 2 councillors.

We have submitted and published papers showing the effects of unnecessary travel for cancer patients; and showing that **travelling negatively affects access to inpatient care**. We have also met repeatedly with senior health officials, to raise these issues and obtained numerous undertakings to address the inequalities.
It seems that there is a gap between government agencies, who quite properly state a reluctance to interfere with operational matters, and

health boards who often see matters from a provider perspective. There is therefore not an agency or body to advocate for remote communities with adverse consequences for patients. Whether unrecognised or ignored the effect is negative, and the processes and procedures for resolution unsatisfactory, and certainly ineffectual.

This petition proposes that an agency is created, which will ensure that policy implementation by health boards is both “fair” and “reasonable” (both of which are statutory requirements) for rural and remote communities, as well as for those who live in more urban areas.

The role of the agency could be advisory whereby the facts of a policy and its possible impact are established, to ensure that parties understand the nature of the compromise and have clarity about the consequences.

The agency should have an ability to influence management thinking, a responsibility to ensure facts are relevant and valid, and best evidence considered within the management process.

It could also disseminate examples of best practice to ensure equity on a national scale, and to give comfort to boards facing the uncertainty of change. In the longer term this could encourage a better and more constructive dialogue, through context-specific management processes with rural and remote communities. The process would therefore focus on engendering mutual respect, rather than as now, confrontation.

The centralisation of complex services such as cardiology, neurology, oncology, obstetrics, paediatrics and others are essential to support a structure that will deliver consistent high quality and cost-effective care. Inevitably and appropriately, these are based in areas of high-density population. Being focussed on specific conditions and outcomes they require highly structured team management to perform as well as they do.

However, structural inequality can occur when the fabric of organisations, institutions, governments or social networks contain an embedded bias which provides advantages for some members and marginalises or produces disadvantages for other members.

When the structure is balanced, for example by someone or a body that is responsible for representing the end user (in this case the patient), inequalities lessen. The agent could be the clinician, traditionally the general practitioner, a Health Board or politicians. In 2004, however, Scotland placed NHS Trusts (primarily a structure status) within Health

Boards. The inevitable conflict between agency and structure fell more in favour of structures (as the managers had always been primarily providers). In the new set-up, the board non-executive is responsible for oversight, acting as an agent and being responsible to government.

In an urban setting, centralisation creates fewer conflicts; the benefits of travel (often a minor inconvenience) are clearer and the deficits smaller. Communications between professionals and user organisations are easier. Committees rarely have rural representatives, due to access issues: that includes agency organisations such as the British Medical Association, professional Colleges and Academics, as well as patient representatives.

Poor national data

Structures drive policy and management through available data. Deprivation is closely associated with health outcomes and current deprivation indices do not favour the rural deprived. For example, car ownership may be a rural necessity but is an indicator that reduces deprivation scores. The Scottish Office Department of Health Acute Services Review Report of 1998 highlighted a lack of rural research, a situation that still exists. These data issues were highlighted in the academic press such as the **British Journal of General Practice** The effect of “distance decay”, where the uptake of specialist services is reduced by the need to travel, is widely recognised. A further **Editorial** in the British Journal of General Practice hypothesised that the effects of distance decay should be regarded as deprivation in its own right. The lack of good rural data remains an issue.

Common sense and Compassion

However compelling the data, managers should be driven by common sense and compassion, a value that should above all underpin any public service. Both of these have a contextual element and a personal awareness, and data is usually heavily biased towards specific (in this case urban) groups. Even then, a healthy BMW owner lacks context for what a cancer patient’s 10-hour journey on hospital transport really means, and the victim of that policy, vulnerable through illness, deprivation and exhaustion, is unlikely to wish to confront the providing authority. An agency can inform this process, either independent or embedded within the management structure. The appendix reveals the lack of agency in a rural health board.

Poor local data

Even in the most rural boards, the primacy of managing for population centres is widespread. Rural middle management can be excluded from

decision making, often inadvertently. Confusion between consultation and engagement, underpinned by you “don’t understand the big picture”, and “must expect to travel” mean that rural provision is not critically examined, and lying at the edge of “outreach” services, rural becomes underserved.

Lack of agency

The board should serve a region equitably, but inevitably the urban majority dominates, and rural issues fall off the agenda. Advocates are frequently seen as troublesome and disruptive, while “groupthink” encourages a belief in the moral superiority of the group, and marginalisation of critical evaluation. This can be **demoralising to caring professionals** because—

“managers' approach could have been moderated by an understanding of frontline care work. However, on the whole, they had never worked in healthcare. This culture clash, coupled with the managers’ limited repertoire of (mostly technical) ‘hard skills’, meant that aspects of healthcare that are difficult to quantify – for example, providing care to people who are frightened, agitated or in their final moments of life – were overlooked. Over time, the differences between the two professional groups contributed to a deep divide, underpinned by mutual suspicion and labelling. This provided fertile ground for some managers to impose a top-down control regime in an attempt to gain the desired organisational results”.

The effects on staff and patients

Throughout Scotland, staff who raise issues encounter a number of barriers. Managers are people too; vulnerable to unconscious bias fuelled by lack of contact with periphery, pressures to deliver, and a focus on the immediate and local problems. The expeditious solution is to marginalise these minority issues, using tactics that may be construed as bullying, but may also be due to poor information (qualitative and quantitative), or poor interpretation which may be explained by a culture supporting structural inequality.

Summary

In a perfect world management would resolve this by creating an agency that would inform the board of unintended consequences of policy, but it is clear from issues in Galloway, Grampian, Argyll & Clyde and others that such issues cannot be raised centrally without resistance and inevitably confrontation. It is no coincidence that many of these issues arise in rural areas.

Annexe B

Extract from Official Report of last consideration of PE1845 on 8 September 2021

The Convener: The final continued petition that we are considering this morning is PE1845, on an agency to advocate for the healthcare needs of rural Scotland. For the petition, we are joined again by Emma Harper MSP and Rhoda Grant MSP. You are competing with each other this morning to ensure that you are with us for the same number of petitions, but we are glad to have both of you.

The petition was lodged by Gordon Baird on behalf of Galloway community hospital action group and it calls on the Scottish Government to create an agency to ensure that health boards offer fair and reasonable management of rural and remote healthcare issues. The petition was first considered in January 2021 and the clerk's note outlines the work that the session 5 committee carried out on the petition.

The written submissions on the petition highlight some of the issues experienced by rural and remote communities as they try to access medical care, including patients being required to take long, often awkward journeys for not only critical care but routine out-patient appointments, of which I think we have all heard examples from colleagues in the chamber at various question times; outreach clinics to rural communities being dependent on individual consultants rather than organised programmes; and a failure by key organisations to understand the importance of dispensing GPs to rural and remote communities.

In alphabetical order, I will take Rhoda Grant first.

Rhoda Grant: The petition is not from people in my constituency, but the committee will have seen that the Caithness health action team made a submission to the committee in support of it. Their concerns are similar to those of others in that people in that area have huge distances to travel to access medical treatment. Some funding is available, but it is not adequate and does not remove the financial disadvantage. There is also a social disadvantage for people with caring responsibilities—for example, children have to be looked after while they are away—all of which creates huge problems for people. That is a consistent problem throughout the Highlands and Islands area that I represent and it has been an issue for me for all the time that I have been a member of the Scottish Parliament.

I understand that the training for medics, nurses and all those involved in healthcare is geared towards teamwork so that people can collaborate when working together to provide healthcare. In remote rural areas, however, we ask people to work very much on their own without any back-up and to depend on their own skills and knowledge, but the training does not equip people to do that.

We also see that the NHS values specialisation. If a person specialises in a subject, their grading goes up, and that is true for doctors and nurses. However, at one point, I was speaking to nurses who work in the area that I cover who have a huge range of skills because they need to cope with anything that comes through the door and what is happening there and then, but they are on a basic banding. The breadth of their knowledge was not recognised; only the depth of their knowledge was recognised.

There are therefore huge disincentives for people who are generalists to become involved. One is from a training point of view, and the other is from a financial and career progression point of view. I therefore agree with the petitioners. We need an agency to take up the issue and work with it by looking at training and remuneration to make sure that we have health services in those remote and rural communities. It gets to the point where people are maybe not getting the health interventions that they need as quickly as they can, because it becomes very difficult for them. We do not need an A and E around every corner, but we do need to provide those kinds of services to people, without the same in-depth specialisms that there are elsewhere. People should have the same access to health services, regardless of where they live.

Emma Harper: I thank the convener for having me here, and the committee for considering the petition. I am aware of the petition, as I know Dr Gordon Baird very well. He lodged it on behalf of himself and the Galloway community hospital action group, and another retired GP, Dr Angela Armstrong.

The petition calls on the Scottish Parliament to urge the Scottish Government to create an agency to ensure that health boards offer fair and reasonable management of rural and remote healthcare issues. Dumfries and Galloway is part of my South Scotland region and Stranraer is the town where I was born and lived until moving to the Dumfries area when I was 12. I am very familiar with the rurality of the south-west part of my constituency. I often hear from constituents that they feel forgotten, as many people automatically look to places north of the central belt, and even to the islands, when providing examples of remote and rural places in Scotland.

I will share a couple of examples, one of which the convener has already touched on. NHS Dumfries and Galloway is part of the south-east Scotland cancer network, meaning that people who live in Wigtownshire, Dumfries, Canonbie and Lockerbie are included in cancer pathways and treatment plans such that they sometimes have to go to Edinburgh for some types of cancer care, such as radiotherapy. That is a 266-mile round trip for folk living in Stranraer.

Based on the response to questions raised with the previous health secretary about the cancer pathway issue, my understanding is that patients in Dumfries and Galloway are offered a choice of place to attend as part of their treatment. If their

treatment choice is Glasgow, that would therefore be the place to attend. However, nowhere in Dumfries and Galloway is closer to Edinburgh by travel time than Glasgow and the Beatson, for instance.

A second example to highlight regarding fairness is that persons in other health board areas such as Ayrshire and Arran and Highlands and Islands are offered travel reimbursement for journeys of more than 30 miles. That is not the case in Dumfries and Galloway, where people are means tested for any travel costs to be reimbursed. Those are only two examples.

The Scottish National Party's manifesto proposes a centre of excellence for remote and rural health and social care. I have already had a response from Cabinet Secretary for Health and Social Care, Humza Yousaf, regarding initial progress on that. I welcome the Government's introduction of the Scottish graduate entry to medicine programme. We also passed the University of St. Andrews (Degrees in Medicine and Dentistry) Bill in the most recent session of Parliament. ScotGEM has a focus on increasing the number of graduate doctors with a rural focus.

I would be grateful to the petitions committee for progressing this petition. I would seek to be proactive and objective and to have those proactive and objective measures taken forward. We need to highlight the health challenges in remote and rural areas. I would therefore welcome the petitions committee's continued progression of the petition.

The Convener: Thank you. Would colleagues like to comment on the evidence that we have heard?

David Torrance: I thank my colleagues for giving evidence. I would like to keep the petition open. We should write to the remote and rural general practice short-life working group, chaired by Sir Lewis Ritchie, and to the rural NHS boards to seek their views on the action called for in the petition. I would also like to write to Scottish Government to request an update on the establishment of a national centre for remote and rural health to see what progress has been made.

Paul Sweeney: The concerns raised by the petitioners are incredibly important and colleagues' submissions today have been enlightening. I am curious about the role of NHS health boards in those areas and how accountable they actually are. That is the elephant in the room here, is it not? They are meant to be the democratic voice of stakeholders in those regions, but it is clear that they are not performing that role effectively, given that this issue is now arising from groups that have been formed more organically underneath that structure. Consideration needs to be given to how effective health boards are in representing the interests of their areas. Should the committee write to ask the health boards how they can respond to the concerns raised by the petitioners and how they can redesign their services to respond to the issues raised by the petitioners?

How transparent are the appointments to those health boards? Is there an election process that is well known about? Should they not be considered to be as important as local council elections, for example, with regard to developing representation? That is therefore an element to consider: how democratic and accountable are health boards? They are quite opaque.

The Convener: I am happy to support all those suggestions. The issues that have been raised are important. I would like to write to the health boards and to Sir Lewis Ritchie, on the basis that it might be useful for the committee to take evidence on the back of the submissions that we receive in order to pursue the issues in more detail in an oral evidence session. In the first instance, I want to hear how they would respond to some of the arguments made in the petition, but, after that, we could drill down a bit further. We will keep the petition open and we will proceed on that basis. I hope that that meets with everybody's approval. Thank you.

Annexe C

Sir Lewis Ritchie, Chair Remote and Rural General Practice Working Group submission of 7 October 2021

PE1845/S – Agency to advocate for the healthcare needs of rural Scotland

Thank you for asking my views on the above petition, as Chair of the Remote and Rural General Practice Working Group (the Group).

The Group was established in April 2018 to facilitate the introduction of the 2018 General Medical Services Contract in remote and rural areas in Scotland. As part of the work of the Group, a report was published in January 2020 on the Scottish Government website: Shaping the Future Together. The report describes the workings and progress of the Group to end December 2019 and contains ten recommendations for future priorities. The recommendations were accepted in full by the previous Cabinet Secretary for Health and Sport and former MSP, Ms Jeane Freeman OBE.

One of the recommendations in the report was that the Scottish Government should establish a National Centre of Excellence for Remote and Rural Health and Social Care, to foster and promote innovation and excellence in Scotland and internationally. For your convenience, I attach an Annex which sets out the specific recommendation and its rationale.

This delivery of such a Centre was included in the Rural Section of the SNP 2021 Manifesto for Government: Scotland's Future, Scotland's Choice.

The work of the Group and deliberations about the desirability of a National Remote and Rural Centre of Excellence was also flagged in the National Plan for Scotland's Islands, published in December 2019.

Progress: I am aware that Scottish Government officials are presently working on defining the nature and scope of the Centre, in order to bring

this Scottish Government commitment to fruition, as soon as practicable. Part of this work will be examining the potential role of a Rural Health Commissioner which has been successfully established in Australia for some years.

Summary: In relation to Petition PE1845, there are potential synergies in relation to the planned National Centre of Excellence for Remote and Rural Health and Social Care, including consideration of the potential role of a Rural Health Commissioner. I hope that you and your committee members will find this response and context helpful for your future deliberations. Please let me know if I can be of further assistance.

Annex

Shaping the Future Together – Report of the Report of the General Practice Remote and Rural Group – January 2020

Recommendation 5

The Scottish Government should establish a National Centre for Excellence for Remote and Rural Health and Social Care to foster and promote innovation and excellence in Scotland and internationally

Rationale

The time is right to support not only general practice, primary care and clinical practice in Community Hospitals and Rural General Hospitals, but also the wider project of health and social care integration by creating a National Centre for Remote and Rural Health and Social Care. The Centre should serve as a platform for inter-professional sharing that should promote and foster rural innovation both nationally and internationally. The Centre should be developed to deliver against a number of priorities:

• To be a multiplier for rural innovation - It should provide strategy and leadership for stakeholders working to improve remote and rural health and social care for patients and service providers. It should cover a broad range of fields including care quality, quality improvement and assurance, health and social care integration, recruitment and retention, training and education of clinicians, and e-health, digital technologies and telehealth care. Its role should support linking individuals and

groups to develop and deliver collaborative projects and distil lessons to allow application of the learning to other areas of Scotland – rural and urban - and to deliver models at scale.

• To spread and contribute to Scotland's Rural Healthcare story using data to show that our rural clinicians and service providers are exemplars - It should coordinate with groups such as the Primary Care Evidence Collaborative, the Remote and Rural Healthcare Alliance (RRHEAL) and the Scottish Rural Health Partnership (SRHP), to utilise the growing evidence base of innovation in remote and rural settings, explore projects to address unwarranted clinical variation in rural areas, and provide intelligence driven evaluations and recommendations to the Scottish Government and other stakeholders.

• To lead on promoting Scotland's Rural Healthcare on a national and global stage - It should transform this work into a platform for engagement with regional, national and international stakeholder networks to promote Scotland's success in delivering high quality healthcare. In collaboration with Universities, other academic and research groups such as the Scottish School of Primary Care, the nascent Faculty of Remote Rural and Humanitarian Healthcare of the Royal College of Surgeons of Edinburgh and others. It should help build networks that gather and disseminate the learning from other countries with successful rural healthcare delivery models.

The Centre should support delivery of a stronger response to the concerns of stakeholders in rural primary care and rural communities. The Centre should be developed in line with the Scottish Government's National Performance Framework vision for Health and use evidence intelligently to continuously improve and challenge existing healthcare models and have a focus on resolving needs in order to achieve positive health, care and wellbeing outcomes.

This approach is supported by studies commissioned by the Rural Group to compare current models of MDT working in rural primary care provision in a range of developed countries. Health Improvement Scotland carried out a rapid review that indicated there is much value in further study of international solutions to delivering primary care services in remote, rural and island communities. The Group also commissioned

research from Rossall Research & Consultancy, led by Dr David Heaney to identify and compare current models of multi-disciplinary team working in rural primary care provision in a range of countries. The research comprised 20 interviews of healthcare experts across 8 countries. Dr Heaney's work concluded that the culture and context of rural communities has motivated innovation in health service delivery across the world.

That report and the additional work undertaken by the Scottish School of Primary Care (SSPC) and Healthcare Improvement Scotland (HIS), is available on-line via links in the report: Shaping the Future Together.

Additional Notes:

The work of the Remote and Rural General Practice Working Group was substantially curtailed by the Covid-19 Pandemic but has since been restarted, the last meeting taking place on 22 September 2021. Further information is available on the Remote and Rural General Practice Working Group website.

NHS Orkney and Shetland submission of 5 October 2021

PE1845/T – Agency to advocate for the healthcare needs of rural Scotland

Thank you for your letter in relation to an Agency to advocate for the healthcare needs of rural Scotland. I am responding on behalf of NHS Orkney and NHS Shetland in my role as Chief Executive Officer of both Boards.

The steps that NHS boards currently take to address the needs of remote and rural communities. The NHS in both Shetland and Orkney holds its responsibilities for delivering the highest quality of health and care to our community. Presently both Boards are working through refreshed Clinical Strategies which underpin how we intend to deliver NHS services for the coming 5-10 years. Public engagement and involvement in shaping these critical documents has been front and

centre to their development. Due to Covid this has had to occur online rather than the traditional in person models, but we feel this has been effective especially for those on ferry linked isles where travel can be a barrier to engagement.

The Community Planning Partnership has proven to be an effective method for communications. This is a joint forum with all key partners across the community who are engaging collaboratively, rather than independently approaching the community separately, as this recognises the inherent links between health, society and welfare. An example of this is the Shetland Partnership Plan and the Shetland's Islands with Small Populations – Locality Plan, links for each are enclosed below.

Shetland's Partnership Plan 2018 2028

Shetland's Partnership Plan 2018-2028 Working together to improve the lives of everyone in Shetland Local Outcomes Improvement Plan for Shetland 2018 to 2028

www.shetland.gov.uk

Populations Locality Plan - Shetland Islands Council

www.shetlandpartnership.org Page | 6 Participation People Place Money The Future "The people living within Shetland's Islands with Small Populations can thrive and are actively influencing decisions on services and the use of resources." The Shetland Partnership is committed to supporting islands with small populations to develop their www.shetland.gov.uk .

When considering the need to adapt and change care in response to alterations in legislation or sustainability of services, we routinely engage through community councils, user groups and other parties. Most recently in Orkney we have worked closely with a ferry linked island to develop a service profile and recruitment pack that reflected the opportunity for any staff member working there.

Without doubt, Covid has created challenges and our patient engagement groups have been unable to meet, however, we have used alternative methods to keep in touch with our communities so we can

hear the needs of the remote and rural community directly. Examples of this include online feedback following the Covid mass vaccination programme that we have built upon to adjust the model for the booster and flu programme. Additionally, the Board established a monthly CEO led Facebook live session that enables the public to directly engage with the Health Board as well as find out more about services they may not be aware of.

Recently in partnership with LGBT Youth Scotland, we shared the excellent work taking place in the Shetland and Western Isles to support younger members of the LGBT+ community, with the aim of helping build a network of good practice that reflects the unique experience of being a member of the LGBT+ community in a remote a rural setting.

As island Health Boards, we also see our role in ensuring the needs of the remote and rural community is maintained in our discussions with the Scottish Government. An example of this was the acknowledgment of the fragility of the island Health Boards during the Covid vaccination programme and the support we received to accelerate this to those aged 18 ahead of the mainland.

Finally, we routinely work together as remote and rural health and care organisations where it makes sense for us to do so. Examples of these include mental health and cancer treatments such as Chemotherapy, by collaborating we are able to strengthen the voice of the remote and rural communities and ensure the access and treatment they receive is as equitable as our geography will allow us.

What further steps could be taken to respond to the concerns raised in the petition. Many of the functions identified in the petition are already in existence, but we as Health Boards may not highlight the work we are doing in these areas. Whilst I have tried to give a flavour of the breadth of our work above there are many more examples that could be shared and whilst Covid has presented real challenges the commitment to our community remains absolute.

It should be acknowledged that the IJB in each area has a clear commissioner remit, and it may be possible to enhance this function through the new proposed Community Health and Social Care Boards.

I hope this feedback proves useful, please do not hesitate to come back to me should you need any further information.

NHS Grampian submission of 3 October 2021

PE1845/U – Agency to advocate for the healthcare needs of rural Scotland

Thank you for your letter, dated 10 September 2021, seeking the views of NHS Grampian on the above petition and explicitly to understand the steps we take locally to minimise the challenges associated with rural access to services.

My initial reflection relates to our overall approach, expressed through the work in both Moray and Aberdeenshire, to maintain services as locally as possible through general practice, community pharmacy, optometry, dental, out of hours provision and community hospitals. Our network of community hospitals deliver many services which, in other areas, you might have to travel to a major centre to receive. We support this work with our local clinical and managerial leadership.

We actively participate in remote and rural issues as a matter of course and are represented on the Scottish Rural Medicine's Collaborative. We have a named GP member of SRMC, and our Career Start programme lead has supported the SRMC at national GP recruitment events. Since inception in 2016, SMRC has worked to:

- Understand and address retention issues for working age GPs;
- Promote Scottish General Practice as a positive career choice;
- Encourage alumni to stay in / return to Scotland;
- Develop sustainable models of remote and rural primary care;
- Support the education infrastructure in primary care;
- Providing high quality support and information for prospective GPs in Scotland;
- Make the most of expertise of remote and rural GPs at the end of their careers;
- Support implementation of NHS Scotland Partnership Information Network (PIN) policies.

All Primary Care clinicians in Grampian are aware of the challenges of trying to provide sustainable market town and village primary care. This is reflected in their active involvement in, and commitment to clinical education, starting early by supporting school leavers in their locality to gain entry to University, moving through to undergraduate, early junior doctor training and ultimately GP specialty training. In addition, the PCIP programmes for the more rural HSCPs in Grampian specifically address the challenges of recruiting, training and maintaining Multi-Disciplinary teams in Primary Care. This maps across to pharmacy, optometry, dental and out of hours provision and includes the training and development of additional Primary Care specialists; Advanced Nurse Practitioners, Paramedics, Pharmacists and more recently Physicians Assistants.

NHS Grampian has supported the GP rural fellow programme for many years. We recognise that there are specific and additional skills needed in order to operate effectively and safely in remote locations. Providing additional training through the Rural Fellowship aims to hold onto those Doctors motivated to live and work in this way. The detail of the programme is described:

The ‘standard’ rural fellowship has been in operation since around 2000 and is based within rural and remote general practice. It provides extra training and support for GPs who wish further experience in rural practice and is based on the curriculum for rural practice developed by the Remote and Rural Training Pathways Group (GP sub-group Final Report Sept 2007).

Service redesign, workforce issues and revalidation issues have conflated over the last number of years in a need for a complementary approach to provide extra training and support for GPs who wish to work in a more intermediate care setting, including no-bypass hospitals and small district general hospitals. The GP Acute Care Rural Fellowship option was developed based on the agreement of a list of GP Acute Care Competencies following from the agreement of the Framework for the Sustainability of Services and the Medical Workforce in Remote Acute Care Community Hospitals.

The agreed aims of these two fellowship options are:

1. To promote rural general practice as a distinct career choice.
2. To help GPs to acquire the knowledge and skills required for rural general practice
3. To help those GPs who wish to develop skills to provide acute care in remote hospitals develop these competencies
4. To provide the opportunity for GPs to experience rural community living.

Despite all of the above, Primary Care Leadership in NHS Grampian recognise that the existing challenges of maintaining and developing General Practice and Primary Care in 'non city' settings is a challenge, one made more pressing by the recent Pandemic and it's consequences for staff attrition. A number of our rural villages /towns have had significant challenges in providing ongoing GP services as existing staff retire and we have temporarily taken control of some practices that were experiencing difficulties operating under the standard GMS contract. In others we have assisted by supporting a reduced level of their usual enhanced services activity if appropriate.

At a grass roots level, Cluster Leads and Community Hospital Medical Directors are fully aware of the rural challenges and have been involved actively in recruitment & retention of both GPs and other clinical professions, supporting clinical education and development, and exploring portfolio working to provide diversity and opportunities for younger doctors. This has included temporary changes to contractual status, Enhanced Services and Service Level agreements. Providing additional local services, such as minor surgery, diagnostic imaging and near patient testing carries a benefit for patients, whilst at the same time adding value to the clinical role.

There are obviously challenges joining up services such as CTACs, VTP, Blood Hubs and Pharmacotherapy within a diverse non-urban environment, and in sustaining them in the face of staffing demands and opportunities. There is a fixed and limited pool of professionals such as Physiotherapists, Dieticians, Psychologists, Occupation Therapists and Community nurses, most of whom are unlikely to be found living in a town with a population of 5-10,000 people, let alone a village of 1500. Creating teams in a rural context needs to take into account travel times and distance, team members operating in multiple locations and teams,

and the communication, delegation and decision making difficulties this brings. On the positive side, the explosion of non face to face solutions brought by the Pandemic has already provided opportunities to support both clinical and managerial solutions to some of these challenges.

Considering the various existing streams of work and planning moving forward both within Primary Care and the wider organisation, and adding in the potential impact of designing and delivering a National Care Service, it will be important to keep a focus on the challenges faced in delivering equitable and effective health and social care in more sparsely populated areas. The proposal to have a network of Remote and Rural GP Champions is one way of keeping a focus on these populations in the forefront of planning groups in Health Boards, although existing structures, particularly in Moray and Aberdeenshire, are already aware of the problems (and indeed the potential solutions). Where such posts are positioned in terms of seniority and influence would be key to their success and, critically, Accountability and Governance would need to be considered should such posts be adopted in future. This concept mirrors, in many ways, the development of MCNs in the past, which, where effective, have added huge value to the work of Health Boards and ultimately patient care, but which have often suffered from being external to the ‘usual way of doing things’.

We have a long established network of community hospitals. The work, especially in Aberdeenshire, has for some twenty years aimed to establish many services within their network of community hospitals (ultrasound, x-ray, endoscopy, blood transfusion, minor surgery) with the aim of delivering many services, traditionally delivered in acute hospitals, locally. This work was led in partnership with acute hospital colleagues. Its success was dependent on local GPs having an interest in developing the skills and identifying the time to deliver the services (their time obviously being remunerated). The pandemic disrupted much of this work. Changes in the staffing within the community hospitals is still in place and the resumption of these services is not yet clear.

For the Moray population there is also access to the district general hospital in Elgin which is called Dr Gary’s hospital (DGH). This has much

wider services including medicine and surgery, as would be expected in a general hospital.

I hope that these comments are helpful to the work of your Committee and if I can provide any other information or further detail on anything here then please let me know.

Petitioner submission of 19 December 2021

PE1845/W – Agency to advocate for the healthcare needs of rural Scotland

I submit this statement to the petition on behalf of Galloway Community Hospital Action Group (GCHAG) Caithness Hospital Action team (CHAT). We are concerned about the disconnect between boards with a lack of awareness of the negatively synergistic combination of rurality and socio-economic deprivation in reducing quality of care outcomes, and advocates for rural and remote communities.

At the last hearing of Petition 1845, an MSP stated “let’s look at the elephant in the room, the role of the NHS Health Boards who are meant to be the democratic voice for the Stakeholders in their regions and are clearly not performing that role effectively if this is an issue arising from the organic groups underneath’’ … ‘’there needs to be consideration of how effective these Health Boards are at representing the interests of their areas’’.

Our local attempts at advocacy deliver limited success. Boards have a conflict, a dual role, balancing the needs (and capabilities) of the organisation, against access to care for rural and remote patients. The nature of this conflict is articulated in the Sturrock report for Highland Health board, which states "Geographic element has its impact in rural areas. …. communities themselves have felt bullied because of promises made and not kept, giving a feeling of being lied to and deceived.” Section 2.32 states "For a number of reasons, including inadequate provision of information to the Board which was not conducive to effective and informed decision-making and a culture which tended to discourage challenge, it appears that the Board has not

functioned optimally in its governance and oversight role leading to a situation where allegations apparently could not be raised and responded to, adequately, locally."

GCHAG met with a senior member of the non-executive board, to discuss a mediation process to help deliver better care for a rural community. There was a suggestion, (previously expressed at several levels of the board), that being rural and remote is a positive life choice and thus rural and remote patients should expect to travel. This correlates with the Highlands report of inadequate provision of information to the board. West Galloway is a very deprived area which affects life choices, and inability to choose relocation. This conflict between the board perception of a "rural idyll" with life choices being the solution while overlooking cumulative effects of remoteness and deprivation continues to be nationally widespread. It prevents boards from throughout Scotland appreciating the unfair disadvantages imposed on remote communities, for whom the poverty trap is wider and deeper. We support the concept of a national rural and remote advocacy framework to assist boards in the provision of fair and reasonable care pathways.

An essential pre-cursor to that is for all parties to recognise that for those in poverty, frail, ill, disadvantaged patients (and families) rurality can mean not having appropriate care. This is unacceptable. Boards and Scottish Executive should recognise the need to account for challenges facing rural and remote communities, either providing local services, accessing remotely, or providing better support for necessary travel. A national advocacy service as proposed would inform boards and politicians in a balanced, informed, and equitable process.

Claire Fleming submission of 27 April 2022

PE1845/V: Agency to advocate for the healthcare needs of rural Scotland.

Following a request from Dumfries & Galloway Health board I have been a user of Wigtownshire maternity services and inform and support the

work of Galloway Hospitals Action Group (GCHAG). While we have very personal negative experiences, engaging with local advocacy has revealed widespread and avoidable negative effects of care pathways.

We support petition PE1845 to provide a national advocacy service for rural and remote healthcare. While we appreciate the board's current engagement processes for maternity care it has come very late in a 10 year process of service deterioration from almost 100 local births annually and a 24hr local on-call local midwife to one planned local birth in the last 3 years. Out of hours contact is limited to telephone support or a 3 hour round trip of up to 180 miles. Having accepted this as service users, we now, as a result of local advocacy, understand how the service had been reduced without community engagement or national oversight even to mitigate the consequences of travel.

Frequently those unable to advocate for themselves through poverty, lack of education or poor family circumstances have suffered disproportionately. Stranraer is home to the 1% most deprived in Scotland. While we willingly bore personal expense, many women without access to personal transport or family depend on the kindness of others. This need not be the case. Maternal choice is a centrepiece of Scottish maternity policy. In our view Community Led Midwife Units (CMU) are safe, reduce interventions, the need for analgesia and for rural patients the significant risks of travel in labour. GCHAG has data that before 2010 Stranraer was the 8th biggest of 22 Scottish CMUs. GCHAG, as our patient advocate, finds it is not just us that are kept in the dark. Stranraer is still designated as effectively CMU in the website of the Scottish Paediatric Network, and even in the board's own web information. The Scottish neonatal transport service website describes "17 midwives in total, with 1 on duty with 1 auxiliary at any time, with another 2 on call." Access is now suggested to be the worst in Scotland with every woman needing to travel 150 miles to give birth. Labour induction means only 1 in 4 has normal labour. Working with GCHAG we have become aware of the accounts of unnecessary anxiety, occasionally terror, associated with a trip of over an hour and a half in labour. Not to mention roadside delivery on the A75, the second most dangerous road in Scotland, distracted by a passenger labouring without pain relief.

Management and politicians compare a 2 hour car journey to urban patients using transport for short journeys. This is as ridiculous as comparing a fall from a chair with a fall from a building. This disconnect between patient experience, management and policy makers is what

makes advocacy more important and the inequality between Stranraer and other areas of Scotland highlights the need for national oversight.

While we are grateful to GCHAG for advocating over these issues, and are happy to give our personal time, the board has expressed the view that GCHAG is not representative. Even if true, they are all we have. In our view, Petition PE1845 would consistently ensure:

- better engagement with boards;
- inform politicians;
- share experiences and best practice;
- Sottish Government policy outlined in “best start” could be applied in a fair and reasonable manner.

The investment of £10 million in Elgin, only an hour from Inverness bears no comparison with the current absence of even the most basic services for Wigtownshire and Caithness. Rural and remote issues need independent and informed advocacy. Petition PE1845 has the potential to achieve this.