Citizen Participation and Public Petitions Committee

10th Meeting, 2022 (Session 6), Wednesday 8 June 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 4 May 2022. At that meeting, the Committee agreed to invite the Petitioner to provide evidence at a future meeting.

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 decided to hear evidence from petitioners on several petitions on the topic of rural healthcare. This petition will therefore be considered alongside PE1890, PE1915 and PE1924.

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.

7. A private SPICe questions paper has also been supplied to Members for this week's evidence session (Paper 8 in your papers pack).

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 4th May 2022

The Convener: PE1845 was lodged by Gordon Baird on behalf of Galloway community hospital action group. Rhoda Grant again joins us to discuss the petition, which 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.

When we last discussed the petition on 8 September, we agreed to write to the Scottish Government and the remote and rural general practice short-life working group, as well as to rural health boards. We have received various submissions from stakeholders and a late submission from Finlay Carson MSP, all of which have been shared with members.

The chair of the remote and rural general practice short-life working group highlights its recent report and its recommendation that a national centre of excellence for remote and rural health and social care be established. Work on implementing the recommendation is under way, including work to explore the potential role of a rural health commissioner, which is a position that has been successfully established in Australia.

The responses from NHS Shetland and NHS Orkney and from NHS Grampian provide information on their respective approaches to public engagement. We have also received a further submission from the petitioner, which is included in full in members' papers, and a submission from Claire Fleming in support of the petition.

Before the committee comes to a view on what to do next, I ask Rhoda Grant whether she wants to say anything.

Rhoda Grant: I still have a huge number of concerns about rural healthcare. I am concerned that the nature of the proposed centre of excellence is still being defined and considered, and we are a long way from it becoming a reality. Meanwhile, in my region, fast-track midwifery training has been removed from the University of the Highlands and Islands even though we know that there is a huge lack of staff.

Maternity care is a big issue in the Highlands and Islands. The maternity unit in Caithness was downgraded to a midwife-led unit and the same thing has happened at Dr Gray's hospital in Elgin, although they are quite different places. Caithness patients go to Raigmore hospital in Inverness and there is agreement that, at some point in the future, Moray births will go to Inverness too, at least for a period. However, Raigmore hospital does not have enough staff for the births that it has, let alone taking on more. We need to have people in the communities.

The submission from the community in Caithness talks about the distances that people have to travel. I am taking part in a Caithness group that is looking at the cost of living, the impact of price rises and especially fuel costs. It was put to me that people are getting 15p per mile—with the first £10 top-sliced off—for travel to Raigmore. I wrote to NHS Highland on that topic and it has increased the rate by a couple of pence per mile in recognition of fuel costs, which are worse in rural areas. However, that presupposes that the person has a car and can afford to put fuel in it. It takes no account of rural deprivation.

One of the submissions to the committee makes the point that people think that living in rural areas is a lifestyle choice—someone moves to a rural area and it is lovely, and if they are going to do that, they have to accept that they are not going to have an accident and emergency department around every corner. Everyone knows that. However, we are talking about people who have been born and brought up in deprived communities in rural areas being expected to travel hundreds of miles to access healthcare. On top of that, with the Covid situation, there are restrictions on access to hospitals, even during childbirth.

In Inverness, in the height of summer, even budget hotels cost about £400 for a room. That means that people on limited incomes cannot be with their loved ones in hospital. It has huge implications for families and for people accessing healthcare for themselves, and there is a cost attached to that. We need to do better.

I urge the committee to keep the petition open and push for people in rural areas to get the health services that they need. How we supply them should be a case in point, rather than people just receiving the crumbs from the edge of the table. Access to health services should not depend on people's wealth.

David Torrance: I definitely want to keep the petition open. I know that my colleague Emma Harper has been working with the petitioner, Gordon Baird. However, before we invite him to come to the committee to give evidence, perhaps we can check whether there is anything on the subject in the Health, Social Care and Sport Committee's work programme. There are two similar petitions.

The Convener: Implicit in that suggestion is that we are at a point when, in other circumstances, we would hear from the petitioner.

David Torrance: Yes.

The Convener: Are we happy to say that, in principle, we would like to hear from the petitioner, but we will first establish whether there is a work programme issue involving our partner committee?

[Members indicated agreement.]

Alexander Stewart: As Rhoda Grant has indicated, the region is so sparse that it is almost a postcode lottery. I concur that it would be useful to get the petitioner in to give evidence on the process in order to inform how we can progress the petition.

The Convener: Thank you