Citizen Participation and Public Petitions Committee

11th Meeting, 2022 (Session 6), Wednesday 15 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 8 June 2022, where it heard evidence from the Petitioner and the petitioners of petitions PE1890, PE1915, and PE1924 on a range of issues relating to rural healthcare. At that meeting, the Committee agreed to consider the evidence heard 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. 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.

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

5. 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 June 2022

The Convener: We now bring together, in one session, four petitions that the committee has been considering. PE1845, which was lodged by Gordon Baird, calls for an agency to advocate for the healthcare needs of rural Scotland. PE1890, which was lodged by Maria Aitken on behalf of Caithness health action team, is on finding solutions to recruitment and training challenges for rural healthcare in Scotland. PE1915, which was lodged by Billy Sinclair, is on reinstating Caithness community council and Caithness NHS board. PE1924, which was lodged by Rebecca Wymer, calls for the completion of an emergency in-depth review of women's health services in Caithness and Sutherland.

Maria Aitken and Rebecca Wymer are joining us as we consider those petitions—good morning to you both. We also have with us Gordon Baird and Billy Sinclair, who are online, I believe—these screens are very helpful if you have good eyesight but not so helpful from a distance. It is good to understand who you both are. I welcome you all.

We also have with us a number of interested colleagues from the Scottish Parliament. I welcome Rhoda Grant MSP, as I seem to do at every meeting—it is nice to have you with us again, Rhoda. I also welcome Emma Harper MSP and Colin Smyth MSP, who both have rural healthcare interests in their constituencies. We will return to our parliamentary colleagues when we have heard from our petitioners, as I know that they are keen to speak in favour of the petitions.

Committee members have a number of questions that they would like to explore, so we will move to the first of those if the panel is happy to do so. I should explain to those petitioners who are joining us virtually that, if you would like to come in at any point, you can put an R in the chat box, or, if you put up your hand, I will probably see that—I can now see you both on the screen in front of me—and I will be happy to bring you in.

For our petitioners in the room, if you can catch their eye, one of the clerks will ensure that I know that you are keen to intervene in response to one of the questions. I should say that there is absolutely no obligation on any of you to feel that you have to jump in and answer questions; you may be content to hear the evidence that is given and to understand how we will proceed.

We move to questions in relation to the petitions. I invite Fergus Ewing to lead off.

Fergus Ewing (Inverness and Nairn) (SNP): Good morning to all our witnesses. I am very grateful that you have, collectively, brought to Parliament the issues around health in rural Scotland, as they are very important.

I start by posing some questions to Mr Baird in respect of his petition, which urges the Scottish Government to create an agency to ensure that health boards offer fair and reasonable management of rural and remote healthcare issues.

Mr Baird, I am sure that you are familiar with the broad arrangements in Scotland, whereby there are 14 regional NHS boards and, since their establishment in 2014, 31 integration authorities. More recently, in 2020, the remote and rural general practice working group published its report on “Shaping the Future Together”. The Scottish Government accepted all the report’s recommendations, including the recommendation—perhaps the most relevant one—to commit to the development of a national centre for remote and rural healthcare in Scotland.

I mention that because it is important to give a backdrop. Following on from that, I have two questions for Mr Baird. I will put them both together.

First, how could the Scottish Government reform the way in which the NHS and social care are currently organised so as to better address the needs of remote and rural constituents and populations? Secondly, will the development of a national centre for remote and rural healthcare for Scotland help to address some of the issues that you raise in your petition?

Gordon Baird: The current structures are very effective in delivering healthcare in many aspects of clinical care. The problem concerns the inequities that occur in respect of access. In the past, that has been dealt with through an advocacy process, primarily through general practice.

In the 1980s, Richard Smith, the then editor of the BMJ, wrote an article with the headline “Dumfries and Galloway: where the NHS works well”. He stated:

> “Most of the doctors in the region know the senior administrators and can find their ear without difficulty; so much so that one doctor suggested that the advisory committees were redundant.”

In short, at that time, the ability to represent local issues was embedded in the system through mutual respect and an advocacy process.

In 1989, Richard Smith followed that up with another specific article in the BMJ, with the headline “To flourish or fade”. At that point, 10 years later, he was describing an institutional view of Wigtownshire as the wild west. By 1999, he was describing the

Dumfries and Galloway health board as "straining but optimistic". That series of articles highlights that there is a long-standing issue.

The current structures alone fail rural patients. As Paul Sweeney said to this committee,

> "the elephant in the room"

is

> "the role of NHS health boards",

which

> "are meant to be the democratic voice of stakeholders in those regions",

and are clearly

> "not performing that role effectively".

He went on to say:

> "There needs to be consideration of how effective those health boards are at representing the interests of those areas."—[*Official Report, Citizen Participation and Public Petitions Committee, 8 September 2021; c 29.]*

We need to alter the capacity of rural clinicians even to influence management thinking, much less create further change. Instead of mutual respect, we have to deal with antagonism and rancour. Even with the best evidence, we are gaslighted and stonewalled. All that is currently going on in the system, and the boards are not particularly accountable. That is true throughout Scotland—I think that you will find that it is the same in Caithness.

Our view is that independent advocacy agencies such as the Office of the National Rural Health Commissioner in Australia and the Children and Young People's Commissioner Scotland have proven to be invaluable. Such agencies have to be established as separate structures—they need to be completely independent. There are other, similar agencies but, broadly speaking, we need an advocacy agency role embedded in healthcare management, and it should be externally imposed.

On the establishment of a national centre for rural health, I cannot argue against that; it is a good thing. However, it strikes me that it would be likely to have a significant provider role, and that would create a barrier to its engaging in an advocacy process.

Secondly, a centre, generally speaking, always seems to be situated in Inverness and Aberdeen and serves people who are near those places. As a general practitioner with 40 years' experience, every time that I hear the word "centre", I rather cringe and think, "Here we go again." We need local engagement and advocacy from the bottom up, rather than a centre that becomes yet another silo, as was described in the Sturrock report.

A national centre will be very useful, and I cannot argue against it, but it will not provide the advocacy role that we are proposing. Furthermore, such an advocacy role would help the national centre to deal with the issues that it would face.

I am sorry that I have taken so long.

Fergus Ewing: Thank you for your answer— you have covered a lot of territory. I will pursue some of the points that you made. Your petition calls for an agency—presumably, that means one agency, if I have understood it correctly. How is one agency going to deliver the kind of advocacy that would be required from the bottom up?

As I understand it, you are suggesting the establishment of an agency not to deliver or procure service provision, but to advocate that services be provided more effectively to people who live in remote and rural areas, and to ensure that inequities in access are addressed and not ignored, with no stonewalling or gaslighting. If that is the case—I put this to you as a devil's advocate, I suppose—would it not be more efficacious, in respect of achieving what you wish to achieve, to have an advocate for the rural voice on each health board?

Would that be perhaps be a different way to proceed, rather than the establishment of one presumably centrally based agency, or wherever it is based? It would have to be based somewhere. Would that be an alternative model that would not change the way that health boards operate, because they would include an advocate among their number with a specific remit to make sure that remote and rural issues are not overlooked and are addressed? I put that to Gordon Baird and the other petitioners, because you are all covering interlocking aspects of the issue. Would that be a better model than having one agency that would inevitably operate on a high level?

The Convener: If any petitioners other than Gordon Baird want to comment on that, they should let me know.

Gordon Baird: I have considered that possibility, but various rural areas have the same issues. For example, we in Dumfries and Galloway have a lot of deprivation; we have the worst 1 per cent of deprivation in Scotland, the worst 1 per cent for cancer access in Scotland and probably at present the worst community maternity care provision in the UK. Caithness and other areas throughout Scotland have the same issues.

The problem has always existed in rural and remote areas, and I was chair of the Royal College of General Practitioners rural and remote practice subgroup. The problem with rural and remote practice is that it is disparate, and is rarely seen as a holistic thing. It is interesting that Professor Sir Chris Whitty, not having much to pass

the time with in 2021, chose to consider health in coastal communities as NHS England's priority. It is a big health issue.

If you join up, there is strength in numbers, and the issue becomes a big problem that Government and boards cannot ignore. Secondly, you can develop shared solutions and create a better understanding of where the solutions lie. It is about sharing information and solutions and gathering information and data. For the past 30 years, I have provided data, in an advocacy role when I was working and when I retired, to try and persuade our health board that we do not belong in the east of Scotland—we are 40 miles west of Glasgow—but I have been profoundly unsuccessful. A specific advocacy taking a national view would help in that regard.

You spoke about having someone on the board. When I was concerned about some local issues I tried to contact the whistleblowing champion on our board, and their response was:

> "It isn't appropriate for me to meet with your group at this stage".

In our group, we have 100 years of experience in the NHS and public service between us. That response was not particularly the fault of the board member; it was the fault of the system. However, the whistleblowing champion was set up in response to the Sturrock report.

I would like there to be national oversight of the issue, and that would be much more easily achieved by a national committee.

Fergus Ewing: I did not quite understand why you did not find acceptable the suggestion, which you say that you had already considered anyway, that each board should have a member whose role would be thus. Why do you not want that? Although that might not be the whole solution, I would have thought that it might be part of it.

Gordon Baird: That sums it up. The Government decided that there should be a whistleblowing champion on each board following the Sturrock report. We are trying to provide advocacy for our patients, but the whistleblowing champion said:

> "It isn't appropriate for me to meet with your group".

That approach does not work.

Fergus Ewing: I do not think that you said you welcomed the national centre for remote and rural healthcare—or perhaps you did—but you said that it was a step in the right direction. Could that new body be set up in such a way that its remit could take up the issues that you have raised? We can raise that with the Scottish

Government following this meeting, if you and your colleagues think that that would be a good idea. Would that be a step forward?

Gordon Baird: It would be a step forward, and a national centre for remote and rural healthcare is a good thing, but I do not know whether it would solve the issues that I have concerns about. For example, I did quite a lot of work with NHS Education for Scotland before I retired, and during visits or telephone conferences it was commonplace to be asked what the weather was like in Dumfries. Those people are embedded in rural healthcare through NES and they did not even know that not only is Dumfries far away; it is not even in the next county. I have concerns about a lack of focus if such a wide-ranging view is taken. I should say that I am talking specifically about clinical access.

Fergus Ewing: I am putting to you that that new body could be tasked specifically, in law, with the remit of addressing the access issues that you raised. It may not operate perfectly in practice, but if we clearly define the remit, duty and tasks that the new body should perform when setting it up then, surely, if we task it to address inequities of access for people who live in remote and rural Scotland, that would at least give the opportunity for things to improve.

Gordon Baird: We already have those bodies; they are called health boards. The problem is that they are not listening to rural and remote issues.

The Convener: David Torrance is keen to ask a supplementary question that relates to that. Some of our other witnesses might feel they can also comment on it.

David Torrance: What do you think are the recurrent issues that impact on recruitment of health and social care staff in rural areas?

Maria Aitken: We lodged this petition after a meeting with our local midwifery team at which we discussed its worries and disappointment about not being able to recruit midwives in the Caithness area and the impact of the shortened midwifery course that was being delivered at the time by the University of the Highlands and Islands. That course was centralised to Edinburgh and the Scottish Government withdrew the funding for it.

My petition has two aspects. The first aspect is the need for rural communities to be able to access local training for professional healthcare qualifications and to gain skills locally wherever possible. The second is the need for an agency or overseer to ensure that rural communities are not disadvantaged and are given equity in training for qualifications.

A lesson that we learned from the Covid pandemic is that distance should not be a barrier to access training because technology can effectively be used to ensure

inclusion and accessibility for remote and rural communities. Our students should not have to travel hundreds of miles from their homes to access training. They should not have to take on large student loans to pay for accommodation to access a university. They should have a choice to suit their life circumstances. That is important for inclusion and the sustainability of our communities, as research suggests that where a student trains is often where they continue to stay.

Higher education providers should provide inclusive distance learning methods to support rural education and recruitment, using technology to enable remote learning. Wherever possible, they should provide the clinical skills locally. Those are the main issues.

We have worked with health boards for several years following the downgrading of our maternity model. We have found that health boards are not accessible to the public and we have experienced many of the issues that have been raised in previous reports. If someone was to be on the health board to represent our needs and to be a voice for rural and remote communities, it would need to be someone who is independent because they would need to be very strong in order to have the voice to support those communities. That is very difficult to do in a very big health board.

William Sinclair: At the moment, we know that NHS Highland does not work for the rural areas. We know what works because we had it before and Orkney has it. We would like Caithness to be reinstated using what we would call the Orkney model or what Caithness had before NHS Highland took over. I have a wee comment prepared. May I go through it, convener?

The Convener: Yes.

William Sinclair: Prior to 1995, Caithness was in control of its own council and national health service. There were shared, consultancy-led maternity services in the towns of Wick and Thurso and a first-class general surgeon in the Wick hospital. Other than for highly specialised treatment, there was very little requirement for patients to travel out of the county to access the national health service.

Caithness had its own council, so it had control over the budget and could make sure that the money was spent where it was needed. Over a period of six years, Caithness lost all control over its council and health services, when the Highland Council and NHS Highland came into being—both of them are based in Inverness. From that point on, at a local level, there has been a deterioration in the services provided in Caithness by both those agencies. The bullying culture in NHS Highland is well documented in the Sturrock reports. Unfortunately, Caithness has been at the sharp end of that culture for years.

Prior to removing our consultancy-led maternity service, there was a public meeting, which NHS Highland attended. Unfortunately, the board did not listen, the concerns expressed at the meeting were ignored and it went ahead and removed the service anyway. NHS Highland stated that there was no clinical objection to the downgrading. That is untrue, but typical of NHS Highland's culture.

NHS Highland did not even listen to its own staff. One staff member said:

> "the geographic distance and transfer times between Caithness and Raigmore is greater than that accepted for a primary birthing unit."

He also said that Raigmore was not suited to the additional workload generated by the proposed changes. The consequence of the change to a midwife-led unit had an enormous impact on Caithness mothers and babies. Eventually, it resulted in babies' deaths.

After the babies' deaths, a report was commissioned, and "The Safe Provision of Maternity & Neonatal Services at Caithness General Hospital: A Public Health Review" was published in 2016. One of the findings of the report was that the babies died due to "suboptimal care". Not being the smartest cookie in the jar, I had to look up what "suboptimal care" meant—it means care that is not up to standard. The report also stated that, as an area, Caithness is socioeconomically deprived. That is what NHS Highland left us with when it "redesigned" the service. What a damning indictment of NHS Highland. On a side point, no one was held accountable.

One of the recommendations made in the report was that first-time expectant mothers should travel 120 miles to give birth at Raigmore hospital in Inverness. The report completely ignored the risk to mothers and babies travelling that distance. It also stipulated that no caesarean operations should be carried out at Caithness general hospital. What happens if someone requires an emergency caesarean?

The people of Caithness are desperate for the situation to change before we have another fatality.

The Convener: I just want to cut in here. I think that in response to all our questions, your solution is going to be the reinstatement of that entity, which perhaps does not develop our discussion in a way that might be helpful.

Rebecca Wymer, do you want to respond to the question that David Torrance put?

Rebecca Wymer: I agree with a lot of what the previous petitioner has said.

To go back to the recruitment issues, those of you on Twitter—I am new to Twitter, but I know that this is not the most politically damning evidence—may know that

Humza Yousaf tweeted yesterday that NHS staffing levels are now “at a record high” in Scotland. The argument that I heard from him a few months ago was that recruitment for the area was almost impossible. He has either done an enormous U-turn or lots and lots of staffing is happening very centrally and not in rural areas.

From campaigning and talking to people in the past year, I have heard that when the maternity unit was downgraded, we also saw the loss of the gynaecology department because obstetrics and gynaecology are linked so closely. Our gynaecological services have been picked away to become more and more central and now we have hardly anything. We do not have an emergency gynaecologist, which means that we have no emergency women’s healthcare. It is pot luck whether you get a junior doctor who has done a rotation in gynaecology—that is about as good as it gets.

Many people have said to me that they have been put off moving up to take up professional positions, despite the fact that they are very well qualified—I am talking 10 years in a surgical position. They will not move up here because they and their families cannot access women’s healthcare or maternity services to the standard that they are used to and should expect. If they were to move to the area, they would still live in Scotland and they should have the same quality of care, no matter the postcode.

Humza Yousaf’s post on Twitter is either poorly timed or slightly out of touch. I am looking forward to meeting him in person when he comes up in the summer to discuss the issue further. Time and time again we have seen people move away from professional positions to seek better healthcare or deciding not to move up because they cannot access the healthcare that they should have. Perhaps that sheds a tiny bit of light on why the positions are not being filled. That goes for many different sectors. Hospitality is struggling and the nuclear industry sometimes loses good members of staff because staff will not risk their pregnancy or, like me, they have a condition such as endometriosis or polycystic ovarian syndrome and they cannot access the emergency care that they need.

The Convener: Emma Harper, I know that you have been listening and are keen to come in on some of the themes that have been developing.

Emma Harper (South Scotland) (SNP): Rather than making a statement, I want to ask Dr Gordon Baird a question that might help us to understand why we should consider an agency to advocate for patients. If we were to have members on each health board that were rural, they might then become embedded in the culture of that health board, rather than having a voice with which to advocate. That is why I would support having an independent agency.

Dr Baird, I am interested in pursuing what you said about the rancour or confrontational issues. When I try to represent constituents in Dumfries and Galloway on health issues, it seems to be perceived as confrontational. That is the last thing that we need when we are trying to secure the best healthcare support as we emerge out of the pandemic. How would an agency that can advocate help to reduce the perceived confrontational stance of MSPs or anyone who is not engaging with a whistleblower? How would an agency help to support that?

Gordon Baird: The Sturrock report was excellent and gave a clue as to the way forward. It talks continually about mediation.

Local people, inevitably, have a focus on local issues, but that is not always the best way to deal with things. In the past decades, I have tried to use science to support the argument and to make reasoned, rational, clinical arguments. That is not always popular. The solution that I would offer to Caithness if I were king might not be acceptable, but I hope that it would be based on best evidence and shared best practice and that it would be equitable throughout the area. Such an approach is not happening.

The issue to do with being independent as opposed to part of a national centre needs to be thought through very carefully. A national centre will almost certainly be a provider unit, in that it will provide education and services. You would not get Ofgem run by SSE—that is not going to happen; the provider and the purchaser must be separate.

Let me go back to recruitment. In the 1980s, before the purchaser/provider split, I advertised a job in my practice and got 80 applicants. A practice in the Lake District got 220 applicants. As Richard Smith said in the BMJ, we were able to advocate for our patients. Richard Smith mentioned the connection between the health board—executive and non-executive members— and rural doctors. We knew that when we went to someone on the health board, it worked really well. Today, a practice in a remote and rural area would be very lucky if it got a single applicant.

A commissioner would take over the advocacy role, but he or she would have to be independent and not part of the embedded structures in the political and managerial system. That is my view, which is based on my experience, my research of the literature and my time as chair of the college.

Emma Harper: One of the challenges that I and my colleagues Finlay Carson and Colin Smyth have had is that Dumfries and Galloway is part of the south-east cancer network although nowhere in Dumfries and Galloway is in the east of Scotland. It is a challenge to look at that and to engage. The health board says that it is up to the Government and the Government says that it is up to the health board. We do not want to dictate how cancer care is provided, but we need people to have a choice of

whether to have their radiotherapy in Edinburgh—which might be better—or Glasgow.

That is just one example. Folk fae Stranraer are not given a choice about making a 260-mile round trip. We are told that they are given a choice but we do not really have evidence of or feedback on that. I am interested in pursuing an advocacy approach, whether we do that through a commissioner or an agency, so that we can look at the challenges in rural health care.

The Parliament's Health, Social Care and Sport Committee is undertaking an inquiry into health inequalities. Many of the issues that we have been talking about in this meeting are coming to light.

I am hearing from the other petitioners that there are challenges for remote and rural areas, whether we are talking about Caithness, Galloway or the Borders, and it would be great to be able to join up all the work that has been done and see how we can take it forward to address the needs of our people. I will stop there.

The Convener: We have two other parliamentary colleagues listening to the discussion today. Now that all the petitioners have spoken, they might want to comment.

Rhoda Grant (Highlands and Islands) (Lab): The petitioners have made it very clear what the issues are. There is a huge distance to travel to access healthcare, and they are not being heard.

Let me give the example of maternity services in Caithness. I have been asking the health board for a risk assessment of the journey between Caithness and Inverness for someone who goes into labour early, for example. I know that there are people who are more likely to be induced or to have an elective caesarean, but there are people who go into labour and need to drive down that road. The road is horrendous in winter and can often be blocked.

As we were discussing before the meeting, expecting someone to drive down there with a partner who is in labour is unacceptable. It is an offence for someone to use a phone while driving a car. Imagine what it is like for a driver to have someone in active labour beside them while they are trying to concentrate on a really difficult, dangerous road. No one will risk assess that journey. I have asked the same question in relation to routes in Moray. I hope that the committee would at least request that a risk assessment is done on transporting people in emergency situations where there is no local healthcare.

When this situation started in Caithness, there was not enough ambulance cover. Quite often, if one person was being transported by that means, the area was left

without an ambulance. That problem has been resolved to an extent, but the situation is still not ideal.

I support the petitioners’ argument that the healthcare service that they have received is not equitable.

Colin Smyth (South Scotland) (Lab): My interest is primarily in the petition from Dr Baird, who is a constituent of mine. However, his proposal is pertinent to all the petitions that we are discussing—the common theme being inadequate healthcare provision in rural areas. The fact is that no one appears to be advocating on behalf of such communities and they are not being listened to.

Emma Harper highlighted the example of cancer care in Dumfries and Galloway, where our constituents in Stranraer have to travel to Edinburgh for treatment when there is a hospital in Glasgow that could provide it. Neither the health board nor the Scottish Government is tackling that problem.

In our discussions, a number of ideas have been suggested for how we could do so—in particular, by Mr Ewing, who said that we should have on health boards people with rural interests. I would hope that people who are appointed to a health board in an area such as Dumfries and Galloway would already have knowledge of rural healthcare. To reinforce that point would not do any harm.

However, we are failing to recognise that we have a Scotland-wide problem in rural healthcare. There will be commonality between the challenges in Caithness and those in Dumfries and Galloway, so there should be Scotland-wide solutions. When it comes to finding such solutions the problem is often—but not exclusively—the health board.

It was also suggested that the proposed national centre for remote and rural health and social care could have an advocacy role. I understand that it will be primarily a delivery mechanism, although crucially it will be part of the NHS, so it will not be independent. It is interesting that, yesterday, the Scottish Government announced that it now supports the proposal for an independent food commission and has rejected the idea that Food Standards Scotland could take on that role—I presume that is because it is independent of the Government.

It is key to our discussion that no independent national authority is advocating on healthcare on behalf of rural communities. There is a model for that in Australia, where there is the Office of the National Rural Health Commissioner. We should consider that model here in Scotland. I see no harm in carrying out a piece of work on how we could strengthen advocacy for rural healthcare in this country, whether it be through a commissioner or another model. It is absolutely clear that the current set-up is simply not working.

The Convener: I thank our parliamentary colleagues for their interventions. I now want to bring the petitioners back in. Rebecca Wymer is keen to contribute again.

Rebecca Wymer: I will make a quick point. I thank Rhoda Grant for her input on travel times, traffic incidents and the quality of roads. I have asked Mr Yousaf about those issues in correspondence before and during the petition process.

I have a business on the north coast 500 route, so I can tell the committee exactly how busy it is in winter and summer. The road is appalling in the winter. My dad was in the police for 11 years, during which he pulled many people out of smashed cars there. That was before it became one of the busiest roads in the world. It is now one of the top 10 busiest traffic routes; it is incredibly popular.

A worrying trend that we are seeing is groups of eight, nine or 12 young people—under-25s—hiring sports cars and racing each other as though they were going round a track. We can imagine what might happen if they were to hit an oncoming ambulance while they were overtaking, and if there were someone behind those vehicles, trying to concentrate on the road. It is almost impossible to get from Inverness to Wick without some sort of near-miss incident.

Most of you have probably already been to the area or have a similar problem where you are but, for those of you who have not, I point out that the one-way journey from Wick to Inverness, which is the most straightforward route if you live in Sutherland—if you live in Bettyhill, near Thurso, it is slightly longer—is the same distance as the journey from Edinburgh to Newcastle upon Tyne. The mileage for the combined return journey equates to the mileage from Edinburgh to York. However, it is on far worse roads. It would not be acceptable for women in Edinburgh to travel such distances on far better roads for routine scans, appointments, clinics or labour. All miscarriages, including active miscarriages past 12 weeks, are expected to travel on those roads for upwards of four or five hours in the summer and three to four hours in awful conditions in the winter.

I spoke to Mr Yousaf about that and, rather than taking into account the near misses and small accidents, which can still cause harm to patients in emergency stop situations, he decided to focus on road closures. He spoke to Transport Scotland and came back with a bunch of statistics saying that the road had been closed for only less than 4 per cent of the time over the past four years. However, the past four years include two years in which nobody could travel, so the statistics are not necessarily accurate. If that exercise was rerun now, there would be a much clearer and more accurate response on how often the road is closed on one side or both, or there is a diversion that takes on to a very rural track on which one cannot get to hospital anywhere near as quickly.

I will leave it there. I have more to say on the travel situation, but I wanted to back up Rhoda Grant on the fact that it is simply not safe. An assessment of that journey has been skirted around for quite some time and needs to be looked into.

The Convener: Thank you. Your point about distances was well made. Characterising the journey in terms of a journey from Edinburgh is possibly more familiar to members than the one about which you are talking, which means that it is well understood.

William Sinclair: I will follow up on what Rhoda Grant said about the distance and the hazard that is associated with travelling it.

Last year, a Wick lady started a journey in labour and had to stop at Golspie, one hour away from Inverness, where she gave birth to the first of her twins. She was then loaded back into the ambulance and sent off to Raigmore, where she had her second baby. It was a miracle that mum and both babies were well. There was another case of a lady giving birth in a lay-by near Golspie. That could happen again in the current circumstances.

Think about what trauma those ladies suffered at what is supposed to be one of the happiest times of their lives. Is that really the best outcome for Caithness mums? What would members of the committee think if it was their wives, partners or daughters going through that?

The Convener: It is a while since Maria Aitken has had a chance to comment. Is there anything that she would like to say at this point? [*Interruption*.] I think that we have lost the link to Ms Aitken. Perhaps I will come back to her.

Paul Sweeney: The testimony that we have heard has been compelling. The democratic deficit in decision making on health boards, and the tension between the tendency for the medical profession to want to centralise in national centres and build capacity, and the rights of rural patients to access services, have been borne out in discussions that we have had on a number of petitions.

I will ask the petitioners about defining the rights of patients regardless of where they are. Perhaps the advocacy body that has been proposed would be the best way of defining the right of a patient to access services safely, whether in gynaecology or any other context. Examples such as William Sinclair described in relation to Caithness could be identified through data, study and inquiry as unsafe provision. That would mean that the health board would have an obligation to address the situation. The advocacy body could place on the health board an obligation to deal with it.

An alternative to that might be to say that, in instances in which it is appropriate to travel to Glasgow for an operation—in neurosurgery, for example—the patient has the right to have their travel costs covered and the right to accommodation for a companion for the duration of their period of surgery and recovery.

Those are mechanisms by which the rights of patients could be defined and advocated for, so maybe they are the ones by which those rights could be delivered. A national body in which stakeholders from different geographies can come together and define the standards that all citizens should be entitled to in different contexts, and one that can take evidence from clinicians and patients is, perhaps, what we are all driving toward. Would petitioners agree that that is where we need to arrive?

The Convener: Before we hear from Gordon Baird, we will hear from Maria Aitken, who is now back with us after we unfortunately lost her connection.

Maria Aitken: I agree. In 2016, when our maternity service was downgraded rapidly and without any consultation, we went to just about everyone to try to get help and to have our voices heard, but no-one listened to us. We went to the Scottish Health Council—which is now Healthcare Improvement Scotland—and MSPs, who listened, but no actions were taken after what was said. We feel that we have been forgotten and ignored. We are disempowered in decisions that are made about our communities because decisions tend to be made in central Scotland by people who might not have lived in a rural area and who do not know about the challenges and barriers that we face.

For example, most of our medical clinics and so on are at Raigmore, which is a 200-mile journey from us. I think that the amount that we can claim for fuel costs has recently gone up to 15p per mile. When we looked at the rate of subsidies that the Scottish Government gives for attending courses, we saw that you can claim 20p a mile to take your bike to the Scottish Parliament for meetings, while we are given only 15p per mile to access our healthcare. Many people cannot afford that, so straight away they are disadvantaged and must decide whether to have heat, food or access to healthcare. We need people who know about living in rural and remote areas to ensure that we are heard, and that decisions are based on what is best for our communities.

To leave the matter on a positive note, I note that a good example of recruitment practice comes from obtaining of a professional teaching qualification in Scotland. People can study up to masters-degree level through distance learning using technology; they do not have to leave their home, family or community. They can do a year or two of part-time distance training for a postgraduate diploma in education and do a paid year of teaching experience in their local area.

The Scottish Government has also set up a system whereby students who tick the "go anywhere" box can get £6,000—or £8,000 for secondary teaching posts—if they are willing to teach in any area. I spoke to a lot of teachers who have done that and who now live in this area. They have come to rural areas and love living there, so they are bringing up their families in those areas. That is a way to keep our communities sustainable and to encourage professionals to come and live here.

When courses are set up, the independent person should be able to say what can be done remotely. People should not need to attend a central university to get a professional qualification. When people can get a professional qualification, that removes them from poverty. I did it; I would not otherwise have been able to get my teaching qualification, because I had a family and I live up here. I could not have left to get a qualification in Inverness, even. I was able to access training, and my and my family's life changed because of it. That access is about fairness and equity; such things have a huge impact on communities in rural and remote areas of Scotland.

The Convener: I turn to Mr Baird, then I will come back to Paul Sweeney, who posed the question.

Gordon Baird: The symptoms of what has happened are perfectly clear, and they are dreadful and disabling. We have all heard from rural and remote agencies that are suffering from a sick system. The system is wrong because of new public management, which has had enormous benefits in technical things such as joint replacements, minimally invasive cardiology and neonatal survival. The reason for that has been the power of the providers. Boards and, I suspect, the new national centre for rural and remote health, will be very focused on provider issues.

That is good, but public organisations that provide telephony, power and water all have independent agencies that look after people who otherwise lack advocacy. All that we are asking is that the NHS, which had a good advocacy system in the past, do what other new public management systems do, which is provide a good advocacy system and minimum standards such as we have talked about.

By the way, I note that neurosurgery and neurology patients—at least, when I was working—went to Edinburgh. That does not suit people with motor neurone disease; it is not acceptable that such people have to travel that far. There has been no advocacy for those people, but the providers are quite happy, because they look at the figures and say that they are okay because they get good results. We are asking for common practice with other public management systems.

The Convener: Mr Sweeney, do you want to come back in on that? This is where we began with Mr Ewing. Having heard all that we have heard, is there anything that you want to ask, finally?

Paul Sweeney: The discussion has been really worth our while, in that it has focused on what the effects need to be. We need a check and balance on health boards and providers to ensure that, where necessary, there is correction, through inquiry into people's experiences by giving them a proper formal voice and through the ability to put obligations on providers. In that sense, the petitioners' requests are significant and require further advocacy by the committee.

The Convener: Mr Ewing—you posed a lot of questions at the start of the meeting. Having reflected on the evidence as it has unfolded, have any questions for the petitioners occurred to you?

Fergus Ewing: I have listened with interest to what the petitioners have said. I will mention two issues. One is that Mr Sinclair and our two online witnesses call for reinstatement of local provision of services, whereas Dr Baird calls for a slightly different additional model of advocacy. Both arguments have a rationale behind them. I understand that, but our job is, to some extent, to play devil's advocate.

I will put this to Dr Baird to see what his response is. Rhoda Grant, Emma Harper, Colin Smyth and I represent constituencies that are largely or partly rural, so we are performing an advocacy service of a sort in the casework that we do. I expect that we all take that job very seriously. It is a big job, and we each represent tens of thousands of people. How on earth can one centralised body hope to advocate for the interests of people throughout the country who live in a plethora of differing remote communities, each of which has its own particular needs, problems, interests and challenges? How could one centralised body effectively perform such an enormous role? How would it be accessible to people? Is there a risk that it would be just another faceless organisation, adding to the number that exist already?

I am sorry that I am putting it a wee bit provocatively, Dr Baird, but I am trying to make a point, as someone who takes advocacy for the remote and rural areas in my constituency seriously. It takes me a day properly to go over a case with an individual, if I want to do it justice. We need to really listen in order to be able then to represent and articulate that individual's concerns properly. It cannot be done quickly and we cannot cut corners. It is inevitably, and rightly, time consuming. How on earth could a national agency be efficacious?

The Convener: It might take a day to go over a case, but we no longer have a day to discuss the matter, so I ask Mr Baird to make a final comment. I will then invite the other petitioners to make any final points that they would like to contribute to our thinking. If you could be quite concise, Mr Baird, that would be appreciated.

Gordon Baird: I will do my best. It is not my forte.

I did not envisage the agency taking on individual cases. There are plenty of ways in which that can be done. That is the role of all of us around the table, whether as community groups or politicians.

The issue is that there is a systemic failure. We have clearly identified that. Science has not addressed that over the past 30 years. That is the way that I have tried to influence things. If you google me on Google Scholar, you will see the publications that have gone before. They have not worked.

We are looking at systemic failures. Caithness has a problem and we have a problem in Dumfries and Galloway. We become a more accountable issue for boards and politicians if we get together. We also benefit from shared solutions.

I was not envisaging the agency taking on individual cases but, having said that, for new public management, it is pretty common—indeed, it is almost invariably the case—that a formal agency is provided to ensure that minimal standards are applied. The agency would be about minimal standards and not excellence.

The Convener: Rebecca, would you like to make a final comment?

Rebecca Wymer: Yes. Sorry—I was waiting for my microphone to be put on.

The question was raised about having one advocate to address all the issues. There are already advocacy bodies. There are already community groups and people shouting about the problems and advocating. I have a dossier of stories from 42 women, who gave them to me six months ago to pass round Parliament. I have been blocked at every stage of trying to get those stories to the people who need to see them.

An independent advocacy system that listens to the community groups and filters down to members of the public works like the branches of a tree. Those branches exist already; it is just that the trunk is not listening.

The Convener: I invite Maria Aitken to make a brief final comment.

Maria Aitken: To echo what Rebecca Wymer and Gordon Baird just said, the centralisation of professional training and qualifications needs to be governed by someone. The fast track to midwifery course that was funded for the UHI in Inverness— a really good university—had that funding withdrawn. Someone needs to ensure that examples such as that are monitored and assessed for fairness and the equality impact on rural communities. Things like that should not happen.

The Convener: Mr Sinclair, do you have any final thoughts?

William Sinclair: Most of the talk until now has been about maternity services, but we also have 14,000 people travelling to Inverness every year as outpatients. That is a colossal number of people. We are trying to go green these days, are we not? That is 14,000 journeys down to Inverness.

Those people are ill but, if they travel by train or bus, we are talking about eight hours' travel to get down there and back again. That situation must be changed. That is what we are calling for, because what we have at the moment certainly does not work.

The Convener: I ask for a couple of sentences each from the parliamentary colleagues who are with us.

Emma Harper: In Dumfries and Galloway, patients are means tested for the reimbursement of travel costs, whereas in other parts of the country it is a given that people are supported in that way. I think that an agency could advocate to change that model.

I thank the witnesses who are here in Edinburgh and those who have joined us remotely today, because it is really good to hear their input. I am keen for progress to be made with the petition.

The Convener: Maybe we should be offering them an operation while they are here, having made the journey.

Colin Smyth: That might not go down too well in Stranraer, convener, where people are trying not to travel to Edinburgh. They are trying to get the service a bit closer, in Glasgow.

A very powerful case has been made on the need for a further bit of work to look at how we advocate—to be frank, we do not advocate—for healthcare in rural areas. It is not about individual cases, although looking at the issues collectively will probably reveal policy failures; it is about trying to assist. The commissioner model in Australia, for example, is about providing policy advice to Government on how to tackle some of the big rural challenges. It is important that we look at that model and at whether we need an advocacy service to support rural healthcare in Scotland. I hope that the committee will support that—it is certainly something that I very much support.

The Convener: Thank you. Finally, I ask for a comment from Rhoda Grant.

Rhoda Grant: I wonder whether the committee has had any discussions with the Health, Social Care and Sport Committee about whether it will look at the subject. I know that the Health and Sport Committee in the previous session of Parliament

looked at some issues to do with rural healthcare. In a way, the problem extends from the very start of the process, with the training of clinicians, right through to how we support them in different areas. They are now all trained to work in huge teams, but when people work in rural general hospitals, they are not in a big team.

In addition, the standards of care, which are written for urban areas, are not transferable to rural areas. One of the lessons that I have learned from my time in Parliament is that policies that are written for rural areas work in urban areas, but that is not the case the other way round. We should be turning this on its head so that we make sure that people have access to the services that they need.

I wonder whether the committee has discussed the matter with the Health, Social Care and Sport Committee, because a light needs to be shone on it and some detailed work is required to make sure that we get the changes that we need. We certainly need to have people advocating for our rural areas, because that is just not happening.

My final point is that, in the Highlands and Islands, we get assistance with travel and accommodation, but it is absolutely inadequate when people get £40 a night to stay in Inverness and they cannot find a room for less than £400 a night. That is impossible, and it is creating a barrier to healthcare.

The Convener: Thank you. The possibility of such a referral is among the options that the committee has considered ahead of today's evidence session. When we consider the evidence afresh, that will be one of the options that are open for us to explore further.

We have gone 20 minutes over the time that we thought we would need to discuss the petitions. I am very grateful to you all, because they are all very important petitions. They are thematically linked, but each has its own individual characteristics, and I very much appreciate the way that the witnesses both online and in the room have advocated on behalf of their petitions.

Historically, we used to hear from all petitioners, but the volume of petitions is now such that we do not hear from everybody. However, we all very much value the opportunity to meet and talk with petitioners and to hear them advocate on behalf of the petitions that they have lodged. It is still quite a big thing for petitioners to come before the Scottish Parliament and present their evidence in that way, probably thinking that they are up against a team of inquisitors. I hope that it has not proved to be too intimidating and that we have encouraged you to contribute as much as possible during the session.

I also thank our parliamentary colleagues who joined us for this morning's session.

Before we move on to consider other petitions, do colleagues agree to consider the evidence that we have just heard at our next meeting and to review our actions at that point?

Members indicated agreement.