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How's your rural health?

In April 2024, three rural community healthcare advocates hosted an online meeting in partnership with Scottish Rural Action:

- Dr Gordon Baird, Galloway Community Hospital Action Group (GCHAG)
- Neil Campbell, Portree & Braes Community Council and Skye SOS NHS
- Ron Gunn, Caithness Health Action Team (CHAT)

They were joined by colleagues from the newly established National Centre for Remote and Rural Health and Care, and by representatives from patient and community advocacy groups including Save our Surgeries Hopeman & Burghead, Caithness Respite Campaign and Spirit Advocacy.

The meeting took stock of healthcare provision in rural and island areas across Scotland through evidence gathered by patients and patient advocacy groups.

The cross-Scotland context was significant. It demonstrated that rural and island communities in different Health Board areas have similar experiences of health and wellbeing inequalities. It also demonstrated, across all geographies, that patient and community engagement in service design and delivery can be improved.

The meeting reinforced repeated calls by rural patients and by patient advocacy groups for increased support and recognition not only for their lived expertise, but also for the depth of understanding of their locality, and of the solutions and innovations that would improve local healthcare provision.

The policy context

The meeting was held as the Scottish Government prepares to publish a vision for Health & Social Care reform in Scotland, and a plan for a National Conversation to shape the future of the NHS. It is not clear how rural and island patient advocacy groups will be considered within this conversation and enabled to participate.

Meanwhile, a Remote & Rural Workforce Recruitment Strategy is due for publication later in 2024, and the Rural Affordable Homes for Key Workers Fund is in early implementation stages.

In the Scottish Parliament, the Health & Social Care Committee recently conducted an inquiry into healthcare in remote and rural areas. The inquiry took written evidence from a range of stakeholders, and oral evidence from strategic and academic leads. It also took into consideration evidence submitted in support of four petitions on different aspects of healthcare in rural Scotland:

- PE1845: Agency to advocate for the healthcare needs of rural Scotland
- PE1890: Find solutions to recruitment and training challenges for rural healthcare in Scotland
- PE1915: Reinstate Caithness County Council and Caithness NHS Board
- PE1924: Complete an emergency in-depth review of Women's Health services in Caithness & Sutherland

The Committee has yet to publish a report.

The practice context – a National Centre for Remote and Rural Health and Care (NCRRHC)

The NCRRHC, led by NES (NHS Education for Scotland), has its genesis in the Sir Lewis Ritchie report on out of hours provision for Skye, Lochaber and Sout Wester Ross (SLSWR). It translates the recommendation for a Centre of Excellence for Learning, Education and Training based in SLSWR into a National Centre delivering on the following four priorities:

National Centre for
Remote and Rural Health and Care

Phase 1 of the NCRRHC, which will complete in September 2025, will focus on primary care, with future phases encompassing acute care and social care. The NCRRHC's purpose is mainly to develop and strengthen effective practice and operational models including, for example, workforce training programmes tailored to the rural context, or digital healthcare provision. An early success story has been the Rural Advanced Practice MSc qualification.

The NCRRHC is currently a virtual institution. Subject to funding, plans are in place for local physical hubs. Community engagement, as shown in the diagram above, is at the heart of the Centre's work with proposals in motion for ***stakeholder engagement networks*** on each of the four priorities. The NCRRHC is already working closely with the Recruitment and Retention Subgroup of the Sir Lewis Ritchie Delivery Group.

More information on the Centre can be found on the NCRRHC information hub.

Summary of meeting discussions

The meeting heard of *health inequalities experienced by patients in rural areas*:

> "Cancer patients from Wigtownshire travel an average 7 hour round trip for treatment in Edinburgh, driving past the Beatson Cancer Centre and other centres closer to them. Data shows that cancer outcomes are worse for patients who must travel, and the journey itself causes a two thirds reduction in

hospital admissions, not because patients do not need to be admitted, but because they cannot physically face the journey, or because they cannot afford it." (GCHAG)

"The problems with our maternity service in Caithness are particularly acute, with mums-to-be travelling over two hours on one of Scotland's most dangerous roads, in all weathers and all road conditions, to give birth. By public transport, the journey is longer – over four hours – and a lot less reliable. Across all health services around 7000 patients a year travel from Caithness to Inverness by car or public transport, and a further 450 ambulance journeys are clocked." (CHAT)

"Short term contracts offered by NHS to rural locum psychiatrists are resulting in high turnover of staff, frequently as they are beginning to build understanding of a place. We are also seeing wonderful staff replaced by digital appointments. Virtual solutions have their place but are not a solution, especially not for mental health treatment." (Spirit Advocacy)

"Thor House in Thurso was shut down without public consultation, leaving disabled children and their carers without respite facilities within a 200+ mile radius…and while we understand the budget constraints, families are stuck with large pots of SDS (Self Directed Support) funding we could be using towards these services." (Caithness Respite Campaign)

As highlighted by Caithness Respite Campaign in the quote above, budget constraints on the NHS are widely acknowledged as impacting on services, but stretched budgets are not the only reason that health inequalities are persistent in rural and island areas. *Institutional root causes of health inequalities must also be acknowledged, and they include*:

- An **entrenched urban design bias** across Health Boards which results in a blindness towards rural and island realities e.g. Stranraer is categorised as being in the east of Scotland, which is why cancer treatments are offered in Edinburgh.
- A **tendency towards centralising services** without looking at the knock on (whole system) effects or risks of such decisions, nor at the context e.g. state of public transport, in a given area.
- **Lack of meaningful consideration of protected characteristics** in service design, leading to many equality groups including women, children and people living with disabilities experiencing complex disadvantage and discrimination;
- **Lack of strategic accountability** for delivery with Scottish Government, Health Boards and local government frequently trying to do their best without however taking on ultimate responsibility for addressing failures.
- Compounding the above, **institutional conflict within the remit of Non-Executive Health Boards** struggling to represent the best interests of both practitioners (the shop) and patients (the customers), resulting in a tendency towards prioritising the needs of the shop.
- A **lack of trust** between communities and Health Boards and local government when it comes to meaningful engagement and co-production of solutions.

It was Save our Surgeries Hopeman & Burghead who had the last word on trust, pointing out that communities, and particularly *patient advocacy groups, are frequently best placed to support the NHS with service re-design* drawing on local strengths and the expertise of partner organisations. Many patient advocacy groups have naturally evolved from being campaigning groups to plugging practice gaps, including providing peer support and education services, a good example cited being the North Highlands Women's Wellness Hub.

While it cannot be assumed that patient advocacy groups will wish to take on practical service delivery, they are nevertheless drivers for innovation:

- CHAT for example is promoting the Orkney model for maternity provision, which unlike the current situation in Caithness, meets the Scottish Government's Best Start model
- SOS NHS Portree has improved local recruitment processes for health practitioners, and is looking at ways of supporting practitioners on an ongoing basis with training
- Community and patient groups in the small isles community groups were instrumental in the successful Nuka pilot.

Next steps

The establishment of the NCRRHC was welcomed by meeting participants. There was recognition of its potential role in addressing some of the operational challenges in the delivery of rural health and care, especially around workforce recruitment and development. There was also recognition of its plans for physical hubs, and the necessity of rooting the NCRRHC in rural and island communities rather than being an exclusively digital institution with a base in an urban centre. Meeting participants were keen to participate in ongoing conversations or network meetings of relevance hosted by the NCRRHC, and some participants invited the NCRRHC to their own group meetings.

There was acknowledgement that the NCRRHC will, at least in its early phases, be limited in its ability to work closely with individual patient advocacy groups on place-based priorities. Furthermore, it will not be in a position to take on a national support role for rural patient advocacy groups, something which meeting participants saw as particularly needed given the entrenched institutional root causes of the health inequalities they were all campaigning to address.

In brief, it was felt such a national advocacy support role could help:

- Collate the lived expertise of rural patients and of rural advocacy groups, and help advocacy groups feed it into policy.
- Maintain collective laser focus on the institutional root causes of health inequalities and on the solutions to these, including promoting geographic literacy and the use of safety audits and risk assessments to inform changes in delivery location and care pathways.
- Support rural advocacy groups with training and information for example on participation requests – a formal legal mechanism for communities to ask for co-production of services with public bodies – and on the NHS Performance Escalation Framework
- Support rural advocacy groups to take legal action where there may be a breach of human or children's rights.

To progress discussions, Gordon, Neil and Ron are meeting with their MSPs in the Scottish Parliament. In addition, Scottish Rural Action has offered to undertake scoping of advocacy support models in other jurisdictions including Wales, as well as reach out to organisations that may be able to help with ideas and expertise such as the Scottish Centre for Community Development which runs CHEX – the Community Health Exchange.

An immediate priority is to ensure that our rural and island voices are heard loud and clear through the Scottish Government's National Conversation to shape the future of the NHS.

Additional resources highlighted during the meeting:

Link to research by Gordon Baird: https://scholar.google.co.uk/citations?user=zt4vyC8AAAAJ&hl=en

Contact: If you would like to discuss any aspect of this paper, please contact us: info@sra.scot