Health, Social Care and Sport Committee

2nd Meeting, 2023 (Session 6), Tuesday, 17 January 2022

Public Petitions

Note by the clerk

Purpose

1. The purpose of this paper is to invite the Committee to consider and agree how it wishes to proceed with scrutiny of three public petitions which have been referred to the Committee.

Background

2. A its meeting on 15 June 2022, the CPPP Committee agreed to refer the following petitions to the Health, Social Care and Sport Committee under Rule 15.6.2 of Standing Orders, to ensure that consideration can continue:

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

3. The Health, Social Care and Sport Committee considered the petitions at its meeting on 25 October 2022 and agreed to write to rural health boards seeking evidence on the issues raised within the petitions before inviting the Cabinet Secretary for Health and Social Care to give oral evidence to the Committee.

4. The Committee subsequently wrote to the following health boards seeking their views on the petitions:

    - NHA Ayrshire and Arran
    - NHS Borders;
    - NHS Dumfries and Galloway;
    - NHS Grampian
    - NHS Highland
    - NHS Orkney

- NHS Shetland; and
- NHS Western Isles

5. Responses were received from NHS Ayrshire and Arran, NHS Borders, NHS Grampian, NHS Highland and NHS Western Isles.

6. The petitioners from PE1845 and PE1924 have also sent in submissions. All submissions received since the Committee's last consideration are available at Annexe A.

7. Further details of each petition are detailed below.

Petition details

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

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.

Date published: 23 November 2020

Petition PE1890: Find solutions to recruitment and training challenges for rural healthcare in Scotland

Petitioner: Maria Aitken on behalf of Caithness Health Action Team

Petition summary: Calling on the Scottish Parliament to urge the Scottish Government to find ways for localised training, recruiting and retaining healthcare staff in difficult to recruit positions in Scotland.

Date published: 19 August 2021

Petition PE1924: Complete an emergency in-depth review of Women's Health services in Caithness & Sutherland

Petitioner: Rebecca Wymer

Petition summary: Calling on the Scottish Parliament to urge the Scottish Government to complete an emergency in-depth review of Women's Health services in Caithness & Sutherland. Women's health services are now breaching basic human rights and we fear someone will lose their life due to the lack of gynaecology care.

Date published: 20 December 2021

Today's meeting

8. At today's meeting, the Committee will take evidence on all three petitions from the Cabinet Secretary for Health and Social Care.

Conclusion

9. The Committee is invited to consider and agree:

    - To consider the evidence heard and agree next steps at a future meeting.

Annexe A

NHS Borders submission of 1 December 2022

NHS Borders response to Scottish Parliament's Consideration of Petitions

I refer to the petitions referred to the Health, Social Care and Sport Committee in September 2022 highlighting the challenges faced by rural and remote communities and the possible need for support to ensure access to rural healthcare. NHS Borders is pleased to share our general views on the petitions and issues associated with access to healthcare in rural areas.

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

The position of NHS Borders on this petition is that a dedicated agency may not be the answer to this issue and could add another layer of bureaucracy to healthcare in Scotland. What would be more important would be to ensure remote and rural issues are adequately built into mainstream discussions and existing frameworks rather than dealt with separately through a dedicated agency. A more serious discussion needs to be had regarding the provision of healthcare within remote and rural settings in order to provide safe healthcare for communities that are dispersed over a wide geographical area. It will be helpful to have clear links into the Academic & professional communities to support policy development for remote & rural healthcare.

PE1890: Find solutions to recruitment and training challenges for rural healthcare in Scotland

The Integrated Health & Social Care Partnership Workforce Plan and NHS Borders Workforce Plan highlight challenges for NHS Borders and the wider Health and Social Care workforce around access to training, difficult to recruit to roles and retention of experienced staff within the Borders rural setting. Access to local training and development opportunities with clear qualification pathways would enhance our ability to train, recruit and retain staff within the Borders. Opportunities for generic training across Health and Social Care boundaries and a training academy approach are being explored, alongside working with the housing sector to identify the potential to develop housing for key workers and local letting initiatives. Enhancing pay and conditions of employment would undoubtedly make careers more attractive. Although locally we have little influence around pay due to national terms and conditions, we do see merit in exploring staff benefit schemes specific to the Borders, flexible working patterns and ensuring staff wellbeing remains a priority.

PE1924: Complete an emergency in-depth review of Women's Health services in Caithness & Sutherland

NHS Borders do not feel positioned to express views on the Women's Health services available within Caithness and Sutherland. Within our own locality, NHS Borders is working in partnership with primary services and public health to establish a women's health plan to meet the needs of our women within the Borders. Women have access to Gynaecological care and out-patient facilities both peripherally and

within the hospital setting. A gynaecological inpatient service is provided within our Surgical ward, which includes ectopic pregnancies. Early pregnancy concerns/losses are provided within our Maternity service. Sexual health service is provided within community setting. There is a Gynaecological Consultant lead to ensure there is safe access to Gynaecological services across NHS Borders. We are, of course, happy to discuss any element of this response further with you and your team.

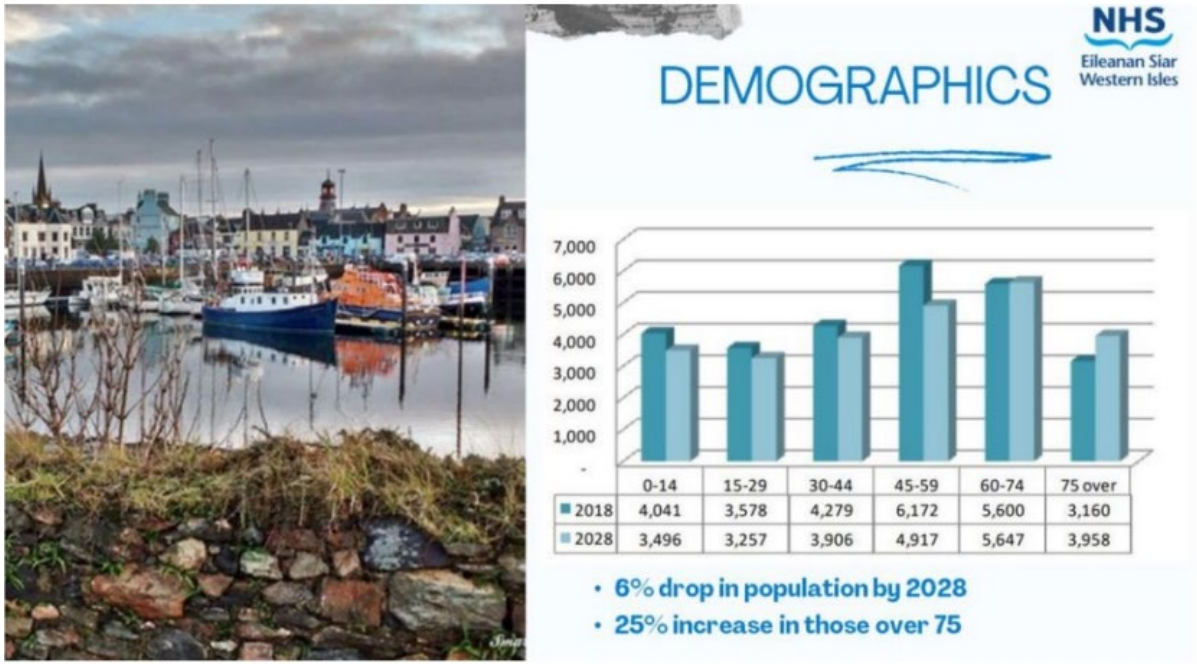
NHS Western Isles submission dated 2 December 2022

The biggest problem the Western Isles faces is the reduction in population which has a knock-on effect on the local workforce. In the last 15 years the population has drop 2% (450) but with a more rapid decline expected in the next 10 years of a further 5% expected. The increased decline is mostly due to the reduction in births against deaths. Current ratio between death and births is very disturbing with the first 9 calendar months ratio of 1: 0.47, which means for every 2 deaths there is just under 1 birth, compared to a Scottish average for the same period of 1:0.75. To put it in perspective 120 years ago the population of the islands was 46,172, estimate census for 20/21 was 26,500 a reduction of 42.6%.

NHS WI is facing workforce issues as a result of being a rural island Board with a declining population. The demography of the Western Isles is predicted to decline significantly with outward migration at 18 when young people leave for training opportunities. NHS WI workforce is ageing with 48% of employees aged over 50 and the highest proportion of employees in the age 55-59 category. NHS Western Isles workforce plan details further information on the age profile for nursing and midwifery where 14.25% (63 employees) were in the 60+ age group. This sees the possibility of employees retiring at any point in the coming 12 months.

It is estimated that over 50% of school leavers attend college and or University the majority in Glasgow or Aberdeen. Majority of these school leavers do not return.

The available local workforce has reduced by 7% in the last 15 years and is expected to reduce further - due to a combination of reduced births over the last 30 years and outward migration of the young. It is noted there is inward migration, but a large majority are people who have retired and are not therefore of childbearing age and do not wish to work in the semi-skilled arena.



Access to local training is imperative for future workforce planning as evidence shows that accessible training allows people to remain and work in their local community. The cost for students to study on the mainland is prohibitive and local opportunities for study, either through a remote/flexible route or through attendance at a local centre of learning has the dual advantage of enhancing positive destinations for young people and the development of skills for the health and social care workforce. A positive example is training for nurses through UHI which has provided a steady supply of nurses for NHS Western Isles. This has been strengthened with the development of a number of newly qualified nurse posts designed to provide a breadth of experience over different settings. Replication in other professional areas, for example AHPs, would be of benefit.

In work training has allowed development of staff into specialist roles but this relies on access to training through flexible routes. A training pathway has recently been identified for the development of Health Care Assistants from Band 3 to Band 4 which will allow those currently working for NHS WI in a Health Care Assistant role to develop their skills and career opportunities.

Early conversations are taking place with the NHS Youth Academy on opportunities to developing skills at school level to provide entry skills for health and social care. The apprenticeship pathway is in development with plans to expand.

NHS WI has difficulties in finding accommodation for workers. These generally fall into two categories. The first is those in substantive posts that require to be located outwith the town of Stornoway, for example Uist and Barra. The second are short-term workers employed on an interim basis where the short-term rental market is dominated by tourism. The Board has limited accommodation available for workers which is often at capacity. Key Worker status provides some measure of support through the local Housing Partnership but stock levels remain low in Uist & Barra.

There are no collated statistics on those who are deterred from living and working for NHS Western Isles due to availability of housing.

Distant Islands Allowance is paid at different levels to public service workers in Island communities, with health workers being paid the least. The current rate of Distant Islands Allowance for NHS Western Isles is £1,117 compared to over £2,000 for a local authority worker. There are additional costs when living in an island community including transport, food and fuel. The Western Isles has the highest levels of fuel poverty in Scotland.

NHS Highland submission dated 5 December 2022

I write on behalf of NHS Highland to respond to the above petitions we have been asked to consider. The petitions highlight the challenges faced by rural communities and the possible need for support to ensure access to rural healthcare.

As a Board we aim to ensure equitable access for all our communities working in a people and place approach aligned to improving outcomes for our population. This involves working in partnership with organisations to create sustainable, resilient and best value approaches to our services and recruitment challenges.

Please find below our response to the individual petitions raised.

We have incorporated the supplementary questions into our overall response to each. I trust this gives a comprehensive response to the petitions raised however if you wish any additional information then please do not hesitate to contact us.

PE1845: Agency to advocate for the healthcare needs of rural Scotland: Given our geography this is of particular interest and significance to NHS Highland. As a board and within our integrated systems in both Argyll and Bute and Highland we recognise the importance of ensuring fair and reasonable management of health and social care issues in remote and rural areas.

We also recognise the importance of fair and reasonable service provision in all areas of Scotland, both urban and rural. The Board and partner organisations across the Highland region are designed to ensure that we are working with local communities to provide consistency as well as locally adapted services based on local need and specific issues and challenges.

There are several organisations such as Highlands and Islands Enterprise (HIE), Highland and Island Transport Partnership (HITRANS) and NHS Education for Scotland's (NES) Remote and Rural Healthcare Educational Alliance (RRHEAL) that work in close collaboration with health and social care to support the aim of providing fair and reasonable responses to the issues in our varied communities and as partners provide appropriate challenge in achieving this. NHS Highland is signed up to The Convention of the Highlands and Islands (CoHI). CoHI seeks to strengthen alignment between the Scottish Government and member organisations in order to 'support sustainable economic growth'. It seeks to enable the exchange of ideas on strategic issues affecting the people of the Highlands and Islands. We are very

sighted on and responding to promoting health, social care and wellbeing in line with the Scottish National Islands Plan and ensuring that we respond to specific community need such as our work in line with the Gaelic Plan. Within our own governance structures, we and the wider Board members hold us to account on our performance across all our areas and we have regular and routine dialogue with our communities in several formal and informal forums. They certainly and rightly hold us to account for the services that we provide. As part of our regular dialogue with all parts of the Scottish Government (SG) including our MSP's we routinely discuss remote and rural challenges and our responses to them.

Whilst an agency for remote and rural issues would give a focus to this particular area of challenge in a pressured health care system a standalone agency focussing only on remote and rural provision would not necessarily be aligned to the existing SG oversight of our provision and there is a risk of being pulled in different directions in terms of fairness and equity depending on postcode. In addition, in the current financial climate there is a concern that to create an agency as described in the petition has the potential to take up funding that is very much needed in order to provide services for people and communities.

On balance, as a board, we would advocate for utilising and strengthening existing internal and external mechanisms for ensuring fair and reasonable response to remote and rural issues rather than creating a new agency.

PE1890: Find solutions to recruitment and training challenges for rural healthcare in Scotland: Creating training opportunities locally with clear qualification pathways locally is a key concern and priority action in our strategy. But national decisions on where courses are offered mean for example that we have lost the ability to train midwives within our board area with the removal of the course from UHI.

One of the biggest barriers is the lack of local courses at professional degree level in a number of different job families. We know from HIE research that increasingly young people are keen to remain in the local and work in professional roles but in small job families, AHPs, Pharmacy, Healthcare Science, Social Work, there is just no local training provision or, in most cases, the option of distance/flexible learning. Where we can provide placement opportunities for education providers we do so and have some success in turning these into employments in the future.

Where they are unable to train locally but are committed enough to follow a healthcare profession they move out of area, develop a social network and life in the central belt and often do not return until later in life, if at all.

We have made use of, for example, the Open University access to healthcare and nursing courses, and some provision for social worker trainees to use the OU as well.

We continue to work medical education providers to increase the number of training placements within NHS Highland, knowing that placements usually result in a positive employment outcome in Highland.

We are working with UHI to map training pathways with career pathways enabling the gaps in local education provision to be identified and plugged enabling both recruitment and retention for NHS Highland.

Our nursing and talent colleagues are going to meet with UHI in the new year to discuss nurse recruitment, training and retention. We are working with UHI to introduce the Practice Development Award and HNC in Health and Social Care as a distance learning opportunity for Band 4 support workers as a career pathway into nursing. We are offering all UHI Nursing graduates a job guarantee and are linking with other HEI's regarding similar development opportunities for 3rd year students accessing placement and graduate employment in Highland.
The development of the NES led National Centre for Remote and Rural Health and Social Care will be helpful in developing mitigations for the risks posed service delivery due to unsustainable workforce pipelines.

Improving access to affordable housing for the local healthcare workforce in hard to recruit areas is a significant concern for us across the Highlands and Argyll & Bute however it is an area that we have limited leverage to address without national support. We would welcome collaborative working across the public, private and third sector as the housing issue doesn't just impact health and social care and we would urge that more focus is given to increasing the supply of affordable accommodation for let or purchase, prioritising accommodation for key workers across the public sector, increased investment in availability of long term rental accommodation and greater control on short term / holiday lets which takes many properties out of local housing capacity.

We are working in key areas with public and private sector partners and housing associations but by its nature this is mainly where we identify a specific need in a community that is particularly challenging or urgent. Addressing across the whole of the key services is essential as we need emergency services and council personnel as much as we need health and social care colleagues.

This issue disproportionately impacts our lower and entry graded roles, we have been quite successful in attracting medical and more senior colleagues, who can afford to purchase in the area.

We offer financial support for relocation and some temporary accommodation, but this is short term and can only realistically be for single occupancy in most cases, to get people started and in a position to look for their own solution. Especially those with families will want to move to their own home and get settled and we cannot offer this longer term as it's not fair or sustainable and doesn't solve the core issue of availability.

We also need a balance of attracting people to relocate versus growing and keeping our own talent. The biggest issue is about availability and affordability of accommodation and our support package doesn't solve this. I also think we need to be careful not to set up internal competition across boards as that's not a long-term solution.

We need a significant increase in the building of affordable properties for key workers, for both rental and purchase and this needs to be coordinated across the public sector.

With regards to enhancing pay and conditions of employment the main terms and conditions and pay in the NHS via Agenda for Change isn't really an issue as this is consistent nationally and there is an excellent pension and benefits structure, that we need to make more of, which significantly exceeds any private sector offerings, even if base pay is higher.

There would be some merit in looking at whether some framework could be put in place similar to London weighting / distant islands allowance but the criteria would need to be well thought out. It's probably some of our more populated areas where costs are significantly higher (Inverness and Skye especially,) but also probably Oban / Fort William. The challenge we have is that in areas where city centre housing is expensive like Edinburgh and Glasgow, there is a huge range of central belt housing a bit further out with good transport links that make it more affordable and accessible, especially for the core Band 5 / 6 roles which isn't really the case here.

The challenge with this is that it's not permanent and could apply to a number of areas. It also would only be a few thousand pounds at most and doesn't make more housing available or affordable.

We do have a concern that the current approach of offering different % cost of living increases with a focus on the lower grades could impact on the premium for qualifications / advanced practice and make training and progression less attractive. The current agenda for change structure also does not offer any / much salary progress until about 5 years in post in most cases, meaning that good performance is not well rewarded in a timely way.

We fully support the work looking at supplementary staffing nationally includes looking at how we might use premium rates for our own colleagues to try and reduce agency and external locum use which incurs significant charges

PE1924: Complete an emergency in-depth review of Women's Health services in Caithness & Sutherland: NHS Highland is working closely with CHAT and the local Caithness community to ensure sustainable and locally delivered gynaecological services can be delivered.

A team of consultants provide a local gynaecology service in Caithness through a regular rotation to Caithness for a minimum of 40 weeks a year. Our 3 consultants aligned to Caithness provide the following procedures locally on site at Caithness General Hospital: hysteroscopy, laparoscopy, insertion of marina coil, anterior & posterior repairs, hysterectomy, oophorectomy, laparoscopic sterilisation, dilatation and curettage, diagnostic hysteroscopy. In 2021/22 of the 761 elective gynaecology procedures carried out 128 of these were in Caithness which is around 17% of procedures and this would be comparable with the percentage of population of the total Highland population.

In addition: gynaecology out-patient clinics are held weekly, face to face by the visiting consultants in addition to telephone or near me consultation. Of the 5572 new and return outpatient appointment carried out in 2021/22 443 were carried out in Caithness. We also do virtual clinics for gynaecology which will reduce the health miles travelled by these communities.

Gynaecology patients who have been seen at a Caithness General Hospital clinic have in general shorter waiting times compared to those waiting to access Raigmore Hospital. Patients local to Caithness who are seen at a clinic in Raigmore may be listed for their procedure in Caithness General Hospital where appropriate.

In addition, there is collaborative working with NHS Orkney to develop a service level agreement (SLA) to provide additional service capacity locally in Caithness from NHS Orkney employed Gynaecology Consultants for Caithness patients.

To ensure rapid local access to expert opinion 24/7 Caithness Out of Hours staff have access to an On-call consultant in Raigmore for any emergency Gynaecological presentations.

A Gynaecology Specialist Nurse is employed to run Colposcopy clinics in Golspie, this service has been located in Golspie to allow for a wider geographical catchment area. For Caithness women this is a more locally based service that travelling the full return journey from Caithness to Inverness.

Work continues to ensure as much clinical service as possible is delivered as locally as possible in Caithness however we have a much wider geography in other areas of Highland, and we need to consider how we work in a people and place approach to our whole population in an equitable way.

NHS Grampian submission of 6 December 2022

Thank you for the opportunity to provide inputs to the Parliamentary Health, Social Care and Sport Committee on the following petitions.

In response to the matters on which the Health and Sport Committee is seeking inputs, it is of note that NHS Grampian is a Health Board that has both an urban and rural footprint. This creates some specific challenges, and opportunities, relating to the kind of workforce and service issues highlighted.

One of the most prominent of these has related to the work to establish plans for a sustainable Maternity service for Moray, due to be submitted to the Cabinet Secretary this month. This is being developed in collaboration with NHS Highland, recognising the benefits that can come from a networked model of care for women in this largely rural area.

In support of this and recognising the key role of partner organisations and communities in the planning, commissioning and delivery of effective services for women, we established in 2021 and Integrated Families clinical and care Portfolio. This brings together a range of hospital based and community services supporting

women and families including, but not limited to obstetrics, gynaecology and maternity, paediatrics, and health visiting within one integrated organisation, with the aim of reducing barriers to the delivery of person centred, safe and effective services.

In response to the specific workforce questions raised:

- There is no doubt that NHS Grampian experiences workforce attraction and retention issues due to our geography, and the additional requirements of working in rural settings. This has been exacerbated by the increased cost of living – particularly fuel prices – which feedback from our teams shows is acting as a barrier to attracting and retaining sufficient numbers of staff, particularly in the Registered Nursing and Allied Health Professions.
- We have discussed with one of our local Health and Social Care Partnerships with a rural footprint, Aberdeenshire, the use of academic opportunities such as research fellowships as a potential means of attracting fully qualified individuals to work and train in rural locations. We have strong connections with the University of Aberdeen and Robert Gordon university that can support the development of such opportunities.
- We are also in regular dialogue with NHS Education for Scotland about the ways in which programmes for Doctors and Dentists in Training (DDiT) can be made attractive and include a rural as well as urban component. This has to be balanced with the choice available to applicants for national postgraduate DDiT programmes and is also subject to outflows from and retention in Scotland of those completing undergraduate education and training.
- We would welcome greater national investment in education and training routes for those in rural areas to be supported into healthcare education and training. Work that we are involved in leading sponsored by the Wood Group that will support widening access to health and care careers for those from areas of deprivation may offer a template for pathways that could support rural areas.
- Improving access to affordable housing would also be of benefit. Whilst not true in all cases, some of the more rural locations – such as the Deeside corridor west of Aberdeen – have very limited affordable housing. The impact that this can have combined with the other factors alluded to above, was recently seen in the temporary closure of one of our rural hospitals due to lack of available qualified staff.
- Another means of addressing this issue could be through enhancing pay and conditions of employment for work specifically in rural areas. However, this is not without cost, and if only applied to rural locations risks impacting on recruitment challenges that are experienced because of other geographic and economic factors (e.g. being located some distance from the central belt; the impact of oil and gas market conditions).
- We have had some initial success working within existing terms and conditions to support dual-site working across our two main hospitals sites in Aberdeen and Elgin, which we hope will offer a template for the future. We are currently exploring how existing national terms and conditions for NHS staff

could be used to support attraction, retention and increased mobility across our patch. However, this will be subject to feasibility testing, with the current financial climate facing our Board potentially providing limited scope for implementation.

NHS Ayrshire and Arran submission of 8 December 2022

Thank you for your letter of 28th October 2022 in relation to the consideration of petitions and the general ask for issues associated with access to healthcare in rural areas.

There is no doubt that there are particularly difficult workforce issues associated with delivering services in rural areas, these are exacerbated by depopulation, demographic profiles (including dependency ratio), availability of housing and accommodation and the ability to deliver sustainable and resilient services through smaller teams. The most challenging area for Ayrshire and Arran in terms of rurality and where the workforce issues are most acute is the delivery of care and support on Arran.

Promoting Employability opportunities and engaging with our key partner organisations (including Local Authorities) enables NHS Ayrshire & Arran to promote career development and employment opportunities. This also provides access to career and educational pathways. Employability is a key element enabling us to promote local jobs and aligns with our shared Community Wealth Building ambitions. Our health and care services and teams work closely with local higher and further education bodies to provide routes into employment with specific targeted approaches in rural areas, for example on Arran work experience opportunities supporting placements in the local nursing home and hospital are supported in partnership with the Local High School and the Health and Social Care Partnership. We also have links with Argyll College who deliver an Access to Nursing course which has proven beneficial to local recruitment. Our local College is not always able to deliver some specialist Healthcare related training topics and therefore we have to look towards larger colleges/providers in the central belt.

The rural challenges on Arran have required a creative approach to growing our own workforce and career pathways into our integrated health and care teams which sit under one management structure spanning community and hospital care. The Arran Medical Group is a training practice and also participates in the Rural Fellow programme which has enabled a number of GPs to be recruited over the years. In addition we currently have nursing assistants training to become nurses, along with new Advanced Nurse practitioner roles in our Emergency Department and GP practice which local nurses have been supported to train for. Our new Emergency Department nurses at Band 6 are another pathway on Arran for local development and opportunities to progress.

Our ambition for a single nursing team continues to develop and we continue to expand and develop clear pathways and training with good examples in our work on Frailty with a new Health Care Support Worker role and Advanced Nurse practitioner for Frailty at Band 7. Further work to develop these pathways is now underway. This

is part of our new Clinical Nurse Managers role with a focus on a new combined nursing role to support our nursing home and community. In addition we are working closely with our mainland colleagues to support newly qualified nurses working on Arran.

Attracting staff to jobs on the Isle of Arran is our main challenge when considering recruitment for hard to fill posts within rural areas. Feedback from both candidates and staff has highlighted that the cost of buying or renting property and the housing availability on the Island is a significant contributing factor to them either applying for a post or remaining in post.

The first council housing to be built on Arran for more than 20 years was competed in June 2022, creating much needed affordable homes. North Ayrshire Council Housing services have also incorporated the award of additional housing points to key workers with jobs on the Island via their housing allocation policy, this applies to all health and social care roles.

A key ambition is to have resilient and sustainable health and care services on the Island, it has been acknowledged that the provision of staff accommodation for visiting and covering staff from the mainland is essential to allow the safe provision of services and also to provide support when the Island is cut off from the mainland, e.g. ferry cancellations. The HSCP currently rent a small house for this purpose and are in the process of purchasing a larger property on the Island to fully meet the temporary accommodation needs of staff, this is expected to be in use from February 2023 and will future proof the provision of staff accommodation and the ongoing need to provide specialist services and staff cover from the mainland.

Whilst NHS Scotland offers distant island allowance payments these do not apply to the two Islands in Ayrshire & Arran (e.g. Arran or Cumbrae), there is a need to also consider the conditions which may incentivise recruitment and retention of hard to fill areas. Other incentivised offers such as changes to the working week, more flexible working for those with carer commitments and childcare, support with housing and relocation and access to supported housing and accommodation for newly qualified staff may be more sustainable ways of recruiting and retaining workforce.

In Arran in 2019 an application was made to STAC for a Recruitment and Retention Premium of 15% for 12 Band 5 nursing posts on the island. This was approved for 4 years and has made a significant difference to the ability to recruit. Further discussions are underway to look at an “island allowance” for Arran to bring us in line with other islands.

We do not agree with the need for a dedicated agency, as the approach to delivering and advocating for healthcare needs should sit with local leadership and management. With local solutions to provide equity of access and the assurance of the delivery of safe and sustainable services for communities, with a tailored approach to meet individual community, locality and neighbour-hood needs. The Islands Bill refers to Island proofing - 3 - and considering how the Island Councils are and can be supported to use existing powers to engage communities to deliver improved, more responsive public services and better outcomes for communities.

This shared responsibility is reflected in our Island Plans which include the ambitions for resilient health and care services on the Islands.

We hope this is helpful. Should you have any further queries please do not hesitate to get in touch.

Petitioner submission (PE1845) of 30 December 2022

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

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

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

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

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

Scotland has similar and even greater problems, also overlooked as described in the petition 1845 submissions.

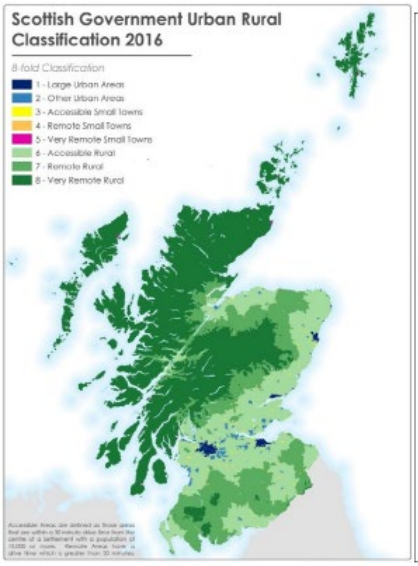
We propose a proven system to cut through the contributory silo mentality. Silos were highlighted by the Sturrock Report. National and international experience supports our proposal. The role of the Remote and Rural Commissioner in Australia and the Children and Young Person commissioner for Scotland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

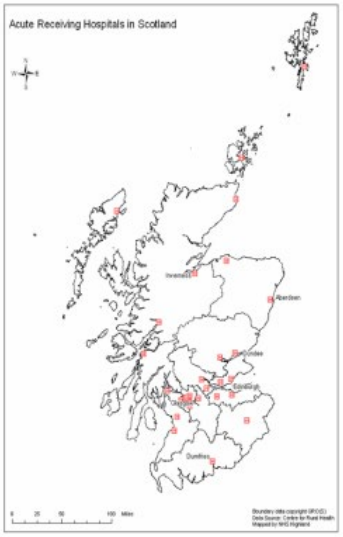
This systematic failure of all the current structures to address these gross inequities causes negative outcomes including associated excess mortality. The evidence in our petition submissions is based on sound peer-reviewed evidence and common sense. It has so far been persistently and systemically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

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

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

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





Petitioner submission (PE1924) dated 31 December 2022

In advance of the next committee meeting please find below some information I would like to put to the members.

["We", refers to: Kirsteen Campbell, Claire Clark & I, through the North Highland Women's Wellness Hub, our not-for-profit community organisation - full info here.

"CGH" = Caithness General Hospital]

On 31.10.22, The Scottish Human Rights Commission (SHRC), penned a letter to Pam Dudek (NHS Highland) and Cab Sec Humza Yousaf.

It stated;

Under human rights standards, for health services and policies to be considered adequate they need to be accessible. This implies that they need to be both physically and financially accessible. In particular:

- *Physically accessible requires for services to be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as women, ethnic minorities, children and young people, older persons and persons with disabilities, among others.*
- *Financially accessible requires for health services to be affordable for all. This includes ensuring that everyone, and particularly those most vulnerable, do not incur unaffordable expenses in order to access medical services, such as through the payment of fees, accommodation and transport.*

Mr Duddy also asked if a "human rights-based analysis has been carried out to determine the impact on women in these regions?"

No reply has been received by SHRC from either party as of the 31.12.22.

Full letter here

The committee has been told by NHSH that 3 consultants work across a minimum of 40 weeks a year in CGH, when our FOI showed:

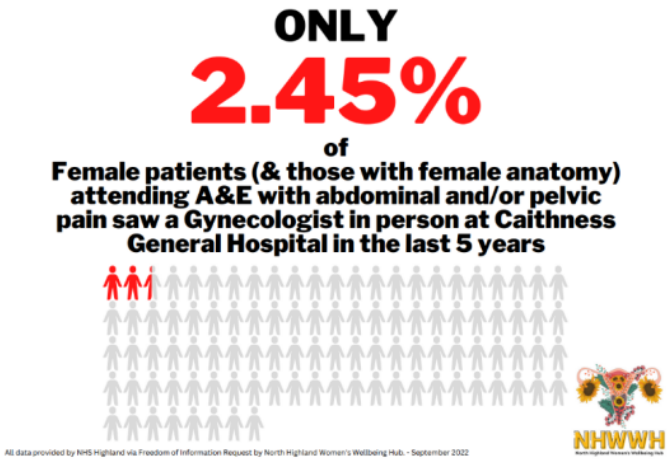
217 days of consultant care (09.11.21-09.11.22) = 31 weeks of the year

I am awaiting FOI response for; Hysteroscopy, Laparoscopy, Insertion of marina coil, Anterior & posterior repair, Hysterectomy, Oophorectomy, Laparoscopic sterilisation, Dilatation + Curettage and Diagnostic hysteroscopy (2021/22).

According to NHSH, these all took place in CGH. A very different picture to what we see day-to-day.

The downgrading of maternity removed gynae care without assessment of human rights or risk to women's health. Earlier this month I spoke to a retired CGH nurse. I heard how we had a full gynae ward, with 2 surgical rotations a week and the beds were always full. If we could provide a wonderful service like this then, surely there is a demand now?

Sonography is accessible only 23.8% of the week at CGH, with no on-call service for emergencies. In my experience & anecdotally, women are discharged with painkillers (often opioids) far more than scanned due to the expense of patient transport to Inverness and the lack of a consultant to decide on the course of action in A&E.



The Royal College of Obs & Gynae state in their Good Practice no.9 that;

It is essential that there is ready and timely access to the following [doc here] :

Diagnostic support services, Operating theatres, Critical care facilities, Specialist or tertiary level services, Psychological support services & Governance.

They also state that

Patients' views must be taken into account when developing emergency gynaecology services.

When raised at our most recent meeting with NHSH management, the response was that the islands 'manage' and we should too. When questioned on if “managing” is the best we can strive for, they answered; no death had been directly caused by access to services, then it's safe. Why wait for the death? I would also argue that affected fertility due to lack of care, is indeed, a loss of life.

The A9 north of Inverness was closed with no road diversion +5 times in December. When this happens, Caithness becomes an Island.* Yet our ‘island’ has a fraction of the facilities of Orkney. Caithness has become the neglected middle-child between Orkney and Inverness where funding & access to care are forgotten.

Patients often forced to travel the same distance as Holyrood to Newcastle (104 miles) and back again, even for basic care.

It's dangerous and discriminate.
Freezing fog makes air transfer extremely challenging if not impossible. The lack of de-icing facilities in Wick Airport was voiced by the SCAA/SAS during a meeting with us a few weeks ago.

Ongoing communication with Humza Yousaf had to be rearranged in November and unfortunately our 2nd meeting is the day following this evidence deadline. We will be asking why the SHRC are yet to receive a reply and stressing why Women's Health is important, even when they are not pregnant, as the focus is often on Obstetrics and Gynae is left behind.

*Photographs taken at various points along the route to Raigmore from CGH. December 2022

Maria Aitken on behalf of the Caithness Heath Action Team submission (PE1845) dated 31 December 2022

Maria Aitken on behalf of the Caithness Heath Action Team supports Petition 1845 for an independent agency or commissioner for rural and remote healthcare issues.

We accept that this agency would help to ensure there are fair and reasonable recruitment and retention systems in place for all rural and remote healthcare areas in Scotland, not just within the island areas as has been the case during recent times.

Petitioner submission (PE1924) dated 4 January 2022

Please find this further submission following a recent Freedom of Information Act request for Caithness General Hospital figures relating to the following procedures between 1st Jan 2021 & 8th December 2022 (date of submission);

Hysteroscopy, Laparoscopy, Insertion of marina coil, Anterior & posterior repair, Hysterectomy, Oophorectomy, Laparoscopic sterilisation, Dilatation + Curettage and Diagnostic hysteroscopy.

In NHS Highland's response to this petition, they state that in 2021/2022 17% of these procedures (combined total) took place in Caithness General Hospital. The recent FOI results show that only 12% of these took place in Caithness.

1397 total procedures

171 caithness procedures

= 12.24%

Outpatient Procedures between 1st January 2021 and 8th December 2022

Procedure	Caithness General Hospital	Raigmore Hospital
Hysteroscopy/Diagnostic Hysteroscopy	0	459
Insertion of Mirena Coil	18	196

Inpatient/Daycase Discharges between 1st January 2021 and 8th December 2022

Procedure	Caithness General Hospital	Raigmore Hospital
Hysteroscopy/Diagnostic Hysteroscopy	65	142
Laparoscopy	18	95
Insertion of Mirena Coil	13	61
Anterior & Posterior Repair	9	9
Hysterectomy	6	205
Oophorectomy	0	16
Laparoscopic sterilisation	10	38
Dilation and curettage	32	<5

Save our Services NHS Skye Group submission (PE1845) of 5 January 2022

The Save Our Services (SOS) NHS Skye group acting on behalf of the Skye community supports petition 1845, and agrees that a national independent agency reflecting the reasonable needs of Scotland's rural and remote communities would improve services and public confidence.

Petitioner submission (PE1924) of 6 January 2023

Myself, Kirsteen Campbell & Claire Clark, all of the North Highland Women's Wellness Hub were due to meet with Mr Humza Yousaf and Ms Maree Todd on the 28th of November 2022. This meeting was cancelled on the 24th November 2022
A rescheduled date of the 9th January 2023 was set and agreed. As of 5pm today (06.01.23), that meeting has been cancelled by Mr Humza Yousaf.
Women's Health in the Highlands is seemingly a very easy issue to drop at the last minute.

All three of us volunteer our time and hold down full time jobs, fitting in the hub work around them. The inconsiderate actions of the Cab. Sec and his team speak volumes. I feel this lack of commitment of a single hour of time to hear our ongoing concerns and the hard work we have put in over the last few months to create positive change in Caithness and Sutherland is relevant to the committee.
I look forward to watching the committee meeting on the 17th and thank you for your time.