

Cross Party Group in the Scottish Parliament on Rural Policy 2015-16

Tuesday 8th December 2015

5.45-7.30pm

Scottish Parliament, Committee Room 5

Health provision in rural Scotland

Confirmed minutes

1. Welcome, introductions and apologies

- Alex Fergusson welcomed attendees to the second meeting of 2015-16 programme of meetings. First meeting on Tues 6th October on Young Rural Decision Makers, and the final one will be on 24th February 2016 on Rural Crime and Responsibility.
- Apologies – Claudia Beamish MSP (co-convener). No others minuted.
- Attendees – Graeme Dey (MSP, co-convener), Tavish Scott (MSP), Jim Hume (MSP).
- Hashtag #RuralPolicyCPG

2. Approval of the minutes from the last meeting

- Unapproved minutes from Tuesday 6th October (Young Rural Decision Makers) circulated on 10th November and with confirmation email prior to this meeting. Minutes confirmed.

3. Short (8-10 minute) presentations (followed by discussion)

Theresa Fyffe, Director of Royal College of Nursing Scotland - Improving access to community health care for older people in remote and rural Scotland

There are many differences across the country. A key challenge facing older people in Scotland is loneliness and isolation. A fifth of people in Scotland live in rural or remote areas, and this population is growing.

Age Scotland in its recent submission to Equal Opportunities Committee Enquiry into Age and Social Isolation said: "Isolation describes a physical situation of not having other people in your immediate surroundings. Loneliness is the stress and emotional response to the difference between the social relationships we desire and those we experience."

RCN are looking at barriers to social contact in the community that help older people stay engaged, including: lack of transport options, local and personal culture and service availability. The report also looked at integrated social care and what this might bring, especially how to build on the assets of communities. In the context of delivering person-centred care, RCN is interested in helping older people develop skills and live independently and increase resilience. The question is how to use community workforce and strengthen resilience in rural and remote areas? RCN published a research report¹ on these issues. Key research questions included: How can health and social care better meet older people's needs? What is the contribution of community nursing? This last question included how

¹ Access the RCN report, Going the Extra Mile at:
http://www.rcn.org.uk/_data/assets/pdf_file/0008/637190/Going-the-Extra-Mile-FINAL.pdf

community nursing helps older people: to live independent and active lives; improve access to care, and helps them to access services.

Report recommendations:

(1) Integration of health and social care and shifting resources to the community. Government has prioritised this move but long term funding and planning for this needs to happen at a larger and faster scale. Delivering healthcare in the community needs to be planned and managed. Health boards face budgetary challenges and competing priorities.

(2) Roles to enable nurses to want to stay and work in the community. Unique staffing models trialled in remote areas are necessary.

(3) Enabling people to use digital technology to improve health and wellbeing. Many people responding to the report survey did not want to use digital technology. The report found that when the need is real, older people used technology (e.g. using Skype to connect with family members who move away). There is a need to understand what people want rather than what policy wants and to support workers to be confident using digital technology. RCN is supporting e-health work but with poor broadband infrastructure in places makes this is a challenge.

(4) Supporting older people to live independent and active lives. Helping people to improve their own health and wellbeing requires true collaboration between sectors, helping people understand what a good life means to them.

Dr Peter von Kaehne, vice Chair of Rural GP Association of Scotland (RGPAS) – GP services in rural settings

Peter discussed the recruitment and retention of rural GPs through an overview of his practice in Rural Cowal. Landslides in the area cut off connection to the ambulance service and affect him personally. Whilst his is a small practice (500 patients fully registered), 2,000 holiday makers due to camping/chalet park at high season.

Peter outlined the wide range of services provided by the practice (e.g. emergencies and minor injuries, palliative care, BASICS responder, fully dispensing) and illustrated this through the increased size of his visiting kit in comparison to practising in Glasgow. Complicated funding arrangements with some elements (e.g. Associate funding) being under constant threat, were outlined as challenges to the practice. Many GP vacancies remain unfilled, e.g. Inveraray practice has been run by locums for 18 months and the situation is worsening due to: depletion of the rural team (lots of nurses have left which affects practices); financial insecurity; lack of perspective and ongoing removal of safeguards (e.g. Associate and Locum funding removed). Peter suggested that this is due to a lack of understanding on the part of GMS contract, health boards, universities and politics and suggested that this could be overcome through:

- GMS contract – recognising the realities of rural practices would be a huge step forward, i.e. providing emergency care/BASICS responder, the existence of temporary residents, dispensing and locum and associate GPs.
- Health boards – could include temporary patients in the count of rural practices, provide locum and associate GP support, IT support (Peter's practice has fast dial up speed much of the time which is insufficient), and education support. The primary care team is depleted and needs to be rebuilt, and the provision of housing and accommodation would help.
- Universities – could support rural applicants, rural undergraduate tracks, rural placements and rural postgraduate training. Local to Peter there are three rural fellows, two of whom have taken up posts locally. This is hugely helpful.

- Politics – politicians could rural proof education, social care and other law and through compelling the GMS, health boards and universities to taken action.

Professor Cam Donaldson from Glasgow Caledonian University – Social enterprise, health and well-being

28 years is the difference in male life expectancy between the best off and worse off areas of Glasgow. Similar health inequalities exist between rural and urban Scotland. It is difficult to shift these patterns, which exist in Scotland alongside world-leading health practices. So why do people die at differing rates between communities? We have to move more upstream into communities to get at the causes of the causes, e.g. homelessness, isolation, lack of purpose – this is where we need to be acting. The main idea driving the Yunus Centre is that social enterprise can be a potential vehicle for acting on the ‘causes of the causes’. We draw inspiration from Nobel Laureate Professor Muhammad Yunus. Our big idea is that almost any social enterprise can be viewed as a public health initiative as virtually by definition they will be through their mission acting on some element of public vulnerability. Whilst the social enterprise’s social mission may not mention health, they will be acting on the social determinants of health.

Yunus Centre research tries to answer questions including: Why do we need to evidence social enterprise? Are social enterprises doing what they claim to be doing? Social enterprises will be seeking government attention and resources, but most importantly communities themselves will want to know if activities taking place are optimal for them. Therefore research on social enterprises is important.

Yunus Centre projects currently include:

- MRC/ESRC, £1.96m, ‘Developing methods for evidencing social enterprise as a public health intervention’ (CommonHealth)
- European Commission, €3.17m [€333,425 to GCU], ‘Enabling the flourishing and evolution of social entrepreneurship for innovative and inclusive societies’ (EFESEIIS)
- Chief Scientist Office of Scottish Government’s Health Department, £211,000, ‘Fair credit, health and wellbeing: eliciting the perspectives of low-income individuals’ (FInWell)
- CommonHealth Collaboration

The Yunus Centre are developing a conceptual framework to explain the potential of social enterprise to enhance health and wellbeing and its researchers are evidencing the impact of social enterprises through conceptualisation, systematic reviews and comparative studies.

Apologies: Gary Malone, CEO of Voluntary Action Angus – A Scotland that actively cares. Due to travel disruption including closure of Forth Road Bridge, Gary was unable to attend.

Alistair Hodgson, Policy Lead, Scottish Centre for Telehealth and Telecare – Technology Enabled Care in Scotland

The Scottish Centre for Telehealth and Telecare (SCTT) is hosted in NHS24. It provides support to local health boards, local authorities, health and social care partnerships, and integrated authorities to use technology to support their clients and patients.

Telehealth is the delivery of health at a distance using technology; telecare is the delivery of care at a distance using technology. Some technology has been around for up to 50 years,

e.g. community alarms, or the warden call system which is roughly 30 years old; through to more modern technology to monitor health and wellbeing.

Infrastructure remains a challenge. Technology requires some way of communicating information back to somewhere: 3G and 4G signal is needed to send high packets of data (e.g. videos) through to video conferencing onto an NHS network, or a mobile phone signal. This is a challenge in a large number of rural communities. However, the challenge of using technology is not unique to rural areas (50% of people in Glasgow have no internet access in their home). The Scottish Government's digital strategy and associated actions is trying to address this through, for example, the digital participation agenda being taken forward by the Scottish Council for Voluntary Organisations which is about ensuring people can use technology in any aspect of their daily lives (i.e. not just health).

SCTT is pushing the digital participation agenda forward through a concept of 'technology enabled care' which is supported by a £30 million programme over three years (they have just completed the first year). This week is Scotland's Digital Health and Care week and guidance on the next stages is released today, which includes support for staff and the public/patients.

A big challenge in large rural areas is that nurses have to go back to base to input notes from seeing patients. To overcome this, the Western Isles invested in digital pens whereby nurses write on special paper and this sends notes back to base. This technology enables more people to be seen or to be seen for longer. Other approaches in rural areas include carrying out video conferencing. Shetland and Orkney, for example, do not have certain specialist consultants so outpatient appointments have to be carried out at Aberdeen Royal Infirmary. This is costly, burdensome and has a detrimental impact on the patient. These areas now do video conferencing so that patients have a consultation over video with a consultant in Aberdeen. Similarly, and also in remote areas of the Highlands, dementia consultants are now able to have consultations with patients over video conferencing rather than patients travelling 3-4 hours to see a consultant in hospital in Inverness. Instead, people are seen in their regular state, there has been a reduction in antipsychotic medication, and through sitting in on video consultations, care home staff are becoming upskilled in their ability to deal with patients with dementia, particularly those who become violent.

As a final point, most technology is simple and works with a good connection – the challenge is making sure people use it and want to use it.

Dr Issie MacPhail, Research Fellow at the University of the Highlands and Islands spoke about the work of The UHI Rural Health & Wellbeing Research Group (UHI RHWRG) and insights yielded through the arts based methods used in the Representing Cromarty project which includes a range of researchers from different academic backgrounds. She said that Scotland has lots of different kinds of rural experiences which need taking into account. The suspicion amongst the UHI RHWRG is that there is an under-examined habit of thinking that we will fix rural health by making it more like urban, but this is not appropriate or cost effective. Characteristics of rural health include higher suicide rates, higher accident rates, and challenges recruiting primary care staff. People living in rural areas are more used to a habit of self care and have a habit of resilience. The downside of this is that people present late to a GP or hospital compared to urban areas. Self employment is high in the Highlands and Islands and in the Borders. Regarding health and wellbeing, this gives a different fabric to household, village or township life and wellbeing, e.g. people can't afford to take holidays as they are self-employed. These details affect wellbeing.

In terms of mental health there are fears of privacy and visibility in rural areas, e.g. being seen to have a Community Practice Nurse (CPN) at the door – there is a very different set of worries from a more urban setting.

The Representing Communities Study takes a broader sense of health and wellbeing and is striving to take a broader view of mental health and wellbeing and reduce the burden on hard pressed rural health services. This project is striving to explore how visual art, music, poetry and fiction about places to support health and wellbeing. Cromerty is the rural case study. After Now, a former Scottish Government project, is important as it gives a history of health policy in UK and globally and evidences the contention that aesthetic issues are crucial to health and wellbeing and not an optional bolt on.

Alex Fergusson – we received an email from the Youth Borders Chief Officer who is concerned about referrals of young people with emotional health and wellbeing or low level mental health needs in the Borders. Interested to know what the CPG thinks about rural mental health issues.

Issie MacPhail – I run activities in village halls with community groups for different ages. Intergenerational work is particularly exciting, e.g. youngsters do IT clinics for older folk.

Dr Peter von Kaehne – Mental health care in a GP practice is challenging. I have lost count of the number of CPNs asking for no more referrals for up to 6 months – there are recruitment difficulties for rural CPNs. There are charities in towns and cities and other things that people can be a part of. On the other hand, you can be quite eccentric and lead a very happy life in a rural area. Getting support for someone I'm worried about takes a long time, and is a lot worse than my time (as a GP) in Glasgow. Rural areas have less of the other things that make life easier if you are not healthy.

Alistair Hodgson – We are involved in a European-funded programme called MasterMind which is about using computerised CBT for people with mild to moderate depression. Clinical evidence on this is robust and this has been used for a number of years in the Forth Valley and Tayside. They are rolling the programme out to Fife, Grampian, Lanarkshire and Shetland. 44% of Scotland's population will have access to this in the initial stage. It is targeting GP referrals and smaller communities where services may not exist or where people may not want to 'show face'.

Jim Hume, MSP – I spent Friday morning with Claire De Bolle from Youth Borders who explained that they have lots of referrals of young people. Across Scotland the stigma of mental health is disappearing but in a rural setting stigma exists more. I ask the panel, regarding mental health, is there good practice in a rural setting to address stigma?

Theresa Fyffe – There is, but it comes back to the workforce's ability to support people in rural areas. I was shocked recently as I was in an area where they are struggling to recruit mental health nurses. Highland used to be desirable place – used to be able to recruit here easier than in Dundee. Infrastructure and transport are so limited, which mean that people can't get to the place they need to engage. I was dismayed at the number of young people who can't afford to travel – one young person described how much she has to spend to get her Job Seekers Allowance, for example. There are good small pockets of practice but if you can't keep workforce engaged, the community approach won't work. I am dismayed about stigma. I did Gay Pride today in Glasgow. Two people said it is hard to get support groups in rural areas – they were asking me for help. But this comes back to workforce issues. We have to make careers more attractive with promotion. We reward esteem in bigger places, but don't reward so well in rural areas.

Issie MacPhail – There is a crisis of carers support which is pushing people to the limits. Cromerty Cares project has been set up to recruit carers in this area. Transport continues to be a big issue – the (travel) card for young people, older people and disabled continues to be important, but there is a disjoint between Highland and regional transport – everything goes via Inverness. There is also a conceptual issue as we're still not good at words to do

with mental health – there is no time of illness that doesn't have both a mental and physical aspect. You get referred to a CNP if they can't find anything else wrong with you and we have a long way to go in addressing this. The Here Now Project includes spirit, mindfulness and dignity. Surely the process needs to rebalance if we're serious about wellbeing.

Ross McLaren, Scottish Churches Rural Group – 20 years ago there was a book produced on single handed practices around Scotland. Vacancies in rural practices comes down to individuals – is it old fashioned to ask whether in the training the issue of vocation ever arises? This is about keeping rural practice as a possibility. Does there have to be a challenge to young people training about the different challenges they might take up in their time as a GP?

Dr Peter von Kaehne – Experience shows that rural recruitment of GPs is aided by exposing students (to rural practice) throughout their university years and afterwards. I'd expand this to nursing. When I started there were a lot of double and triple duty nurses – they were very individual people who brought their training together in a rural practice in a rural way. We're making rural practice more urban by making it more centralised (e.g. more facilities/services in Oban and Inverness). Rural nursing has been more centralised which has an impact on doctors. The same thing seems to happen in the plan for the new contract by making things bigger and centralising them, whereas it should be the opposite. Planning for rural and then applying this to cities might work better than the other way round.

Theresa Fyffe – The changes that have happened for professionals (nurses) working in rural areas where isolated rural GPs worked years ago are the changes from regulatory bodies and other such demands on them which requires nurses to have more support. We can never go back to a more isolated role but can use other forms of technology to enable more support to people to work differently. We have centralised the recruitment of students more in nursing – we know if we recruit from local rural areas that many people want to stay to work there, but if there aren't jobs, they will go. So we need to look at the workforce model and education model in a way to allow people to want to work and train as a nurse and stay.

I wouldn't go back to triple duty – that's exactly where regulatory bodies and the public have challenged on what knowledge and skills people have to do their job. Today's world is a very different one. It's a multidisciplinary world which demands working together and finding a new model. We need to come back to how we use technology and, with respect Alistair, digital pens are yesterday's news – community nurses need tablets to connect to the GP, pharmacy, and other agencies and so they can show the person they are with how technology can support them. This is a different way of looking at a mobile workforce. We haven't adapted to communities in remote and rural areas who want it differently. Recognition and esteem are important so that that if you stay working in an area that you will get the opportunity to do something different. Exposure is the issue – if they (nurses) can get out there and see the work, many will love it.

Louise Hughes, Young Scot – I work with communities in Glasgow and am a community development student. In Glasgow, people are reluctant to access their GP as they say they'll go to hospital if it gets any worse as hospitals are so easy to access and waiting times in urban communities for doctor is weeks. What is it like in rural?

[Graeme Dey MSP welcomed by Alex Fergusson]

Theresa Fyffe – I agree – I'm astounded at the effort people make to get to an appointment (e.g. a 2 hour journey), so can understand why people are reluctant to use services.

Alex Fergusson – people tend to turn up at A&E in Dumfries & Galloway because of

difficulties of access to GPs and hospital rather than waiting. And people are also dialling 999.

Andrew Hanton – Moray Youth Council and working with Young Scot on National Conversation. To Alistair – when talking about technology to promote health and wellbeing, certain innovations won't be useful if they don't work. Are the people who use the platform given the opportunity to help develop technologies?

Alistair Hodgson – Yes, for example people are involved in developing the Living it Up platform. This is a digital platform pulling in information from NHS Informs and community asset information from the ALICE system, funded by Scottish Government and the UK Government's Innovate UK funding, to develop a platform in a co produced way with users and a technology company. Also, residents in Moray worked with the Glasgow School of Art to design a pendant (for medical purposes) which people would want to wear.

Ann Packard – A question for Dr MacPhail: to what extent are the carers you mentioned trying to go through school and to what extent are they older people who may have a different kind of resilience?

Issie MacPhail – There is a crisis of respite care and carers more amongst older people. Distance to respite care brings distress. There is a lack of valuing carers and it is important to support them. We need to recruit them as they are pivotal to the dignity of that support.

Anne Packard – Are there lessons for other parts of rural Scotland in terms of learning about what may work with young people in one area or another? The stress on young carers is enormous and may have an impact on their whole lives. Is this mapped in any way?

Issie MacPhail – There are barriers for young carers to use the respite care possibilities that are proffered because of issues of visibility.

Alex Fergusson – Is there a role for social enterprise in this?

Cam Donaldson – Social enterprise is riven through this. We tend to revert to services, health, human resources, doctors, nurses – these are crucial issues but we also need to think about how to better engage younger people in rural communities that will prevent these issues happening in the first place, and there might be ways to commission service-like services for young people that they are involved in designing. Are younger people being engaged in terms of what they want? In rural communities one solution may be to expand out of hours services – it may be needed, but where's the innovation in this solution and who is that innovation coming from? We need more evidence to back up what's being said.

Emma Cooper – Scottish Rural Parliament – What is the future of telehealthcare and are young people responding positively to this?

Alistair Hodgson – Scottish Government is taking forward a separate piece of work around making GP practices more digitally enabled, e.g. making appointments online. The technology is there but is just not 'turned on' in some practices. We're finding that some young people are demanding this more so as they do everything on their phones. In Australia, you can go into a virtual waiting room in the hospital for sick children – I think this will become more normal and people will start to do more routine transactions from the comfort of own home. Also, you can take kids on holiday and have a way to connect with a consultant if they are sick.

Jim Hume (MSP) – We'd like to think that we are leading but is there somewhere further ahead in the world than us?

Alistair Hodgson – I was at the European Telemedicine Conference and we were on a par with similar regions in Europe, but since the Scottish Government started investing, we're ahead – we are one of the few EU Governments investing which has meant over the last year or so we've surged ahead. Probably the best example is the US Veterans Association – a free service for all US veterans which is a telehealth first organisation. They closed a number of centres and their default position is virtual and remote. They invest a third of their budget in using technology whereas we invest a tiny fraction of our overall budget. If we're serious, we'd need to invest more. In Canada there is the Ontario Telemedicine Network. 95% of the population lives in the greater Toronto area; north of this is an area the size of Europe. They introduced telehealth pods staffed by a single nurse 365 days a year – they recruit well – a single caravan in areas and they can videolink into Toronto itself.

Alex Fergusson – We need to look at this: in Galloway, 50% of GPs are due to retire in the next five years and it's over 8 years since a GP was appointed in Galloway from outwith the region.

Artur Steiner, Yunus Centre – Question is to Alistair and Peter: Alistair, you talk about technological solutions; from Peter the challenges of recruitment – why not put the two together and create hybrid models for health and care service delivery?

Alistair Hodgson – Technology can support recruitment, for example in stroke services. The Western Isles health board could not recruit a stroke consultant and relied on an NHS Lanarkshire consultant flying there once a week. This was fine for patients in recovery but no use for those who had just had a stroke and needed immediate care. They introduced a video consultation service so people had direct access to a stroke consultant 24/7 and trialled this approach into New Zealand where a consultant working in the day could see patients in Scotland at night. This was cheaper and worked perfectly. The converse of this is telecare and the routine community alarm system. Between 150-180,000 people have a community alarm installed in their home and the biggest challenge is that when they pull the alarm, there needs to be a service that can go and respond. If someone falls, they need help to pick themselves up. There is no Responder service in the Highlands, and so then the default becomes calling 999 when all that is needed is someone to help pick them up.

Peter von Kaehne – It is a good point – combining rural generalists with medical specialists and I'd challenge Theresa – New Zealand and Canada are moving towards a rural generalist nurse. We can call EMRS in emergencies into our services to advise us – a year ago a colleague and I spent a couple of hours keeping a small baby alive – we could physically do things (e.g. putting in lines) as we had the training but had a consultant to advise on the things we saw and what we felt. There was rapid interplay which is very important. There's a big case for having more rural generalist training for GPs and nurses.

Theresa Fyffe – With respect, I wouldn't dream of telling you [Peter] what GPs should do. Triple duty is an old word and nurses don't want to go back to it. We need to find something innovative and persuade people to work in rural communities.

[NB Christian Allard MSP was welcomed by Alex Fergusson]

4. AOB - none

5. Date of next meeting Wednesday 2^{4th} February, Rural Crime and Responsibility. Please note this will be the final Rural Policy CPG for the 2015-16 session due to the election. Unapproved minutes of the meeting tonight will be available on the SRUC website shortly along with presentations/videos from tonight and a 2-page Rural Policy Centre Policy Briefing summarising the key issues discussed.