PE1845/F
Dr Jurgen Tittmar submission of 14 January 2021

I am writing to support the petition raised by Dr Baird. I am a single-handed rural GP principal in Argyll where I have worked for 14 years; prior to that I was a GP principal in the Isle of Harris for 5 years and had all my GP training including as a rural training fellow in the Isle of Lewis. I have therefore spent my entire career of over 22 years in rural general practice in 2 different health board areas and I completely agree with Dr Baird's assessment.

A few examples:

Outreach secondary care services to Dunoon are supplied by NHS Greater Glasgow & Clyde (NHSGGS), mainly Inverclyde Royal Hospital. The range of specialties available have steadily decreased over the last 15 years here as services are centralised.

This means increased travel for patients which is especially arduous for the elderly (Argyll and Bute has the highest rate of over 65s of any council area in Scotland). I have anecdotal evidence of patients not attending appointments as they are afraid of travelling or don't have the money upfront to travel and claim back their expenses. Patient transport is gruelling as it takes so long. A better model is having services closer to patients.

Commissioning of outreach services from secondary care seems to depend on the willingness of individual consultants. Rural health boards may want to commission services but are beholden to what the larger central belt boards are willing to provide; the larger central boards have enough on their plate doing their own job and providing for their own patients so rural patients lose out and are required to travel. At the very least we need data to prove this for service planning. We need large central boards to have outreach to rural parts of other boards as equally important as their own patients.

We need best practice to be shared, disseminated and copied. In the late 1990's a new dermatology outreach service was set up at Western Isles Hospital by a dermatology consultant in Raigmore, Inverness. High definition cameras were used by a specialist dermatology nurse practitioner in Stornoway to livestream pictures to a consultant in Inverness. The consultant was then able to give a diagnosis and treatment instructions. Over 20 years on and webcams are standard practice for us all yet dermatology patients in rural Cowal must travel to Inverclyde for review and treatment

The Sturrock report into NHS Highland was right when it spoke of lack of institutional memory with the various management changes over the years. NHS Highland has never properly integrated Argyll and Bute and managers in Inverness are a very far away with seemingly little knowledge of what happens locally. I would debate whether the board are informed about issues in Cowal.

Part of our need is a rural advocate for healthcare as this is sorely lacking.

I'm told others are making representation about the failure to implement the National Centre for Rural Health recommended in Sir Lewis Ritchie's review of Out-of-Hours services in Skye, Lochalsh and South West Ross and that the rural short-life working group (SLWG) chaired by Sir Lewis hasn't met for a year.

Like the rural SLWG, there is a dispensing GP SLWG set up as part of the new Scottish GP contract agreed 3 years ago. The issue is simple - dispensing GP practices offer an essential service and are, by definition, in remote and rural areas but only account for about 9% of all GP practices. We aren't pharmacies, so pharmacy division doesn't want to know us and as a small minority well removed from our urban leaders, dispensing GPs have, in my opinion, been neglected for decades. The SLWG has met 3 times in 3 years, the last meeting in September 2019. Although there were some initial positive moves around training and basic standards of practice, little has been achieved against the long list of concerns identified. As with other areas of rural medicine, it feels like we have been forgotten and neglected as too small or unimportant. I obviously appreciate we've had the covid pandemic but the needs have not gone away.

Finally, rural services are more expensive - we cannot have economies of scale and there is an unavoidable extra cost of any service delivery to a rural area as well as historic underfunding. This is the rationale from the Barnett formula for Westminster's funding for Scotland. Every rural medical service therefore has a rural weighting added on except one - general practice. The rural weighting was scrapped in our new contract and rural GPs were outvoted by the urban majority. Imagine the outcry if the same happened to rural primary schools in a new allocation formula that had not been put out for consultation. If this can happen with a powerful lobby like the British Medical Association, the same can happen to any rural healthcare. This is why we need an agency to advocate for us.