PE1845/B
Petitioner submission of 6 January 2021

In 2019, the Scottish Government published the Sturrock report, an independent review report looking at cultural issues related to allegations of bullying and harassment in NHS Highland, conducted by John Sturrock, QC and mediator. Although specifically looking at NHS Highland, the report, and the follow up from Argyll & Bute reflects all rural Scotland.

The report shows that remote and rural managers and clinicians find urban-centric objectives create unintended consequences and difficult to achieve. New Public Management (NPM) introduced in 1980s to improve accountability is simplistic. NPM misinterprets quality and efficiency of small units serving dispersed communities by ignoring demonstrable inequalities from inaccessibility. No access means no benefit. Focusing on measurable metrics discounts a holistic view of access, travel costs, social exclusion/isolation, discomfort and patient wellbeing, creating rural health inequalities. Sturrock describes rural structural inequality creating resentment, conflict and misunderstanding with bullying behaviour an inevitable consequence. This paper proposes a pragmatic solution to a national problem through a Rural and Remote mediator to capture and promote the vital (albeit harder to measure) aspects of service quality.

1. Why do managers resort to bullying behaviour?
2. Is it more prevalent in Rural & Remote settings?
3. What can we do to resolve it?

1. In the 1980s NPM efficiency and individualism replaced universalism and equity. Imposing private sector culture, including targets.[1] Goodhart, a Thatcher economic adviser, cautioned 'when a measure becomes a target it fails to be a good measure'.[2] NPM delivers definable objectives but with an associated loss of compassion.[3] Algorithm or protocol ignores rural issues during system development. The absence of agency perpetuates rural inequality.

In my experience, centralised management groupthink "You don't see the big picture" is a common (silo) defence for unacceptable policy. Effective in delivering highly structured application (which benefits technical such as cancer care, cardiology, joint replacements) NPM fails with innumerate, compassionate but immeasurable, objectives. Sturrock describes a lack of compassion. Rural professionals see first-hand the emotional and physical detriments caused by urban values but lack an effective agency for change.

- a "silo" mentality.
- "promises made and not kept".
- "little corporate memory".
- "inadequate provision of information to the board".

[1]https://www.researchgate.net/publication/228123933_The_Impact_of_the_New_Public_Management_Challenges_for_Coordination_and_Cohesion_in_European_Public_Sectors_Review_Essay
[2] Goodhart's law; Just stick to the facts.
https://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC4032009&blobtype=pdf
[3] The effect of introducing NPM on compassion https://www.nursingtimes.net/clinical-archive/leadership/the-effect-of-introducing-new-public-management-practices-on-compassion-within-the-nhs-12-06-2017/

- "the board weren't allowed to know exactly how bad it was" and as a result "the board has not functioned optimally in its governance and oversight role".
- "non-executives were deemed to be wasting the time of executives by their questions and/or requests".

Sturrock's comments apply to Highland but are a national rural phenomenon.

2. Socio-economic deprivation measures are urban-centric.[4] Poor access to rural health services is a form of deprivation.[5]

The Sturrock report noted

- reduced abilities of rural teams to influence the local provision of care or appropriate referral pathways.
- a poor awareness of the need for compassion and the effect on individual patients.
- inadequate provision of information to the board.
- A silo mentality that reduces the ability of rural and remote providers to influence managers or connect with other agencies such as senior board executives.

These rural issues apply to Galloway and other boards. Non-executive board and politicians are unaware or deliberately excluded. Specific issues relating to economies of scale/cost, promises made and not kept (a recurring theme), a feeling of being deceived, and that urban solutions may not apply to rural areas, budget cuts applied without even discussion, top-down management, command and control.

Peer reviewed sources and reports are ignored. Nationally, rural cancer patients are much less likely to receive specialist care[6] and travel unnecessary distances without benefit. D&G board rejected the reality that patients were refused choice. A board decision to perform an option appraisal is one of over a dozen unfulfilled promises since 2016.[7] If policy involved sending Glasgow urban patients to Aberdeen, or Dumfries patients to Dundee, boards or government would immediately resolve it on principles that do not apply to rural Scotland.

Galloway women in labour are asked to travel 75 miles to return home to await "established labour". A training budget request for A&E medical and nursing staff filling gaps in intrapartum care was rejected.

3. NPM has unintended consequences, marginalising smaller and disparate issues arising from remoteness/access. The Sturrock report reflects all rural Scotland, mentioning mediate or mediation 70 times, rural 33 times and remote 10 times. A commissioner for child and young person's health[8] in Scotland has a guardian role and Australia has a commissioner for Rural and Remote Health.[9]

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[4] Rural deprivation: reflecting reality https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1314032/

[5] Poor access to care: rural health deprivation? https://bjgp.org/content/bjgp/56/529/567.full.pdf

[6] Travel time and cancer care: an example of the inverse care law? https://www.rrh.org.au/journal/article/1003

[7] Board Statements regarding referral pathways.
https://www.dropbox.com/s/v3c8ut91exka9cz/Previous%20Board%20Statements%20regarding%20referral%20pathways.pdf?dl=0

[8] www.cypcs.org.uk

[9] https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner

Would a rural & remote guardian/commissioner work? Communicate with and between silos? Representing compassion and caring? Informing senior board executives, board members and government? Ensuring promises are kept? Mediating over perceptions of lies and deceit? Ensuring relevant involvement in difficult decision making? Sharing best practice? I believe that it could create an accountable and demonstrably fairer system.