HEALTH AND SPORT COMMITTEE

Wednesday 11 June 2008

Session 3

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HEALTH AND SPORT COMMITTEE

17th Meeting 2008, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Jamie McGrigor (Highlands and Islands) (Con)
Irene Oldfather (Cunninghame South) (Lab)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Denise Coia (Scottish Government Chief Medical Officer Directorate)
Iain Hunter (Scottish Centre for Telehealth)
Philip Harley (Scottish Government Primary and Community Care Directorate)
Shona Robison (Minister for Public Health)
Professor Richard Wootton (Scottish Centre for Telehealth)

CLERK TO THE COMMITTEE

Tracey White

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Wednesday 11 June 2008

[THE CONVENER *opened the meeting at 10:01*]

Telehealth

The Convener (Christine Grahame): I welcome everyone to the 17th meeting in 2008 of the Health and Sport Committee. I remind all members to ensure that mobile phones and BlackBerrys are switched off. No apologies have been received.

The first item of business is a one-off evidence session on telehealth. Members will be aware that this evidence session arises out of the preliminary evidence that we have received for our inquiry into shifting the balance of health care. Although the committee agreed to focus the inquiry on the role of rehabilitation services, members also agreed to take the opportunity to hear about the contribution of telehealth to the national health service. I refer members to the papers for the meeting, which include a briefing by the Scottish Parliament information centre and a written submission from today's witnesses, whom I will now introduce.

I welcome Professor Richard Wootton, director of the Scottish Centre for Telehealth. He is accompanied by Iain Hunter, the centre's general manager. I ask Professor Wootton to make some opening remarks.

Professor Richard Wootton (Scottish Centre for Telehealth): I will say something briefly about my background, then speak about our plans.

The Convener: We have your background details in your biographical and career notes, so perhaps you could just speak generally about telehealth and your plans. That would be useful.

Professor Wootton: Certainly. I have been in post for two months, and my first impression of telehealth in Scotland—I do not want this to sound like a criticism—is that it is almost defined by the number of pilots that are in progress. Our first task at the centre is to try to decide which telehealth applications might be most useful for development as national-scale services.

The first piece of work that we have undertaken is to compare current telehealth applications and consider what the obvious omissions are—for example, telepsychiatry. We are comparing and contrasting applications using a number of criteria, such as how feasible it would be to scale applications up to a national service, how they fit with the Government's priorities and how they address the serious burden of disease. That work has enabled us to come up with a shortlist of four potential applications. So far as I know, no other health service has ever thought in these terms. However, it gives us a rational basis for concentrating our resources. One of the early criticisms was that the Scottish Centre for Telehealth was trying to do too much on all fronts.

Having come up with the shortlist, we are trying to address some of the well-known difficulties in telehealth—for example, those involved in changing how doctors work and hospitals operate and in assessing whether the infrastructure is fit for purpose. The long-term strategic intention is clear: we want to hold Scotland up in a few years as an exemplar of telehealth in routine health service delivery. That will mean that telehealth will have been mainstreamed, that nobody will think of it as being different from normal practice and that we will have quantitative information about telehealth activity levels, costs and benefits—I hope that the benefits will outweigh the costs. If we can do all that, we will have achieved something that no health service in the world has been able to achieve and which will be enormously interesting to other health services. That is the current plan.

I should say that my plans have yet to be formally ratified by the centre's executive committee, which does not meet for another couple of weeks. Therefore, the Health and Sport Committee is getting an inside picture before our plans have been formally blessed.

The Convener: Thank you. Do you want to say anything, Mr Hunter?

Iain Hunter (Scottish Centre for Telehealth): I have been with the centre for 18 months, so perhaps I can give you a couple of minutes on where we are at and how we got there. We had to set up the organisation in April 2006 from scratch. The first year was mainly about setting it up and recruiting staff, and we have been operational for the past 12 months.

Members will see in their papers information about the role that we are undertaking. Until recently, we concentrated on an advisory role. However, as uses of telehealth develop, we are beginning to get more involved in service provision. As Richard Wootton said, we are focusing on certain applications. The "Better Health, Better Care" action plan focused us on unscheduled care, remote and rural applications of telehealth, paediatrics and long-term conditions.

There is, of course, a parallel initiative called telecare, which is about monitoring and looking after patients in their own home. Telehealth is more about consulting, with the patient at some distance from the clinician. The natural assumption is that long distances and remote and rural settings are involved, and that is, indeed, what we are talking about. However, with regard to urban settings, getting from one side of Glasgow to the other, for example, is as difficult—well, perhaps not quite—as driving from Wick to Inverness.

The Convener: Be careful, because we represent many rural areas—you may be challenged.

Iain Hunter: My point is that telehealth is as applicable in the urban setting as it is in the rural setting.

Ross Finnie (West of Scotland) (LD): I appreciate that neither of you has been in post all that long, but there is nevertheless an element of frustration about this area. Professor Wootton referred in his opening remarks to Scotland being an exemplar. As a member of the previous Government, I had the privilege some six years ago of going to Canada to look at rural service delivery. Matters might have regressed there in the past six years, but I am bound to say that, at the time of my visit, I was singularly impressed by the extent to which telehealth was well embedded in the Canadian concept and used for monitoring—this was Mr Hunter's point—in both urban and rural settings, despite there being vast rural settings in Canada.

I wonder whether you can help the committee with a particular issue. What appears—it may just be a perception—to be preventing us from making real progress in telehealth? A number of Government and other political contributors have seen the potential of telehealth over the years, but for some reason we have moved slowly on it. Indeed, in the report that the Government produced the other week on the delivery of rural health care, the paragraph on telehealth was underwhelming. You have set out your objectives, but where should the committee put its effort in order to assist you in overcoming the inhibitors to real progress in this field, which has exciting potential?

Professor Wootton: We know the Canadian work quite well, because Iain Hunter and I have been over there several times in the past few years.

The barriers to the implementation of telehealth are also quite well understood. There have been a number of spectacular and expensive failures to implement telehealth on a wide scale over the years, starting—to my knowledge—with an expensive project in 1993 in America. More recently, I was recruited to a Malaysian Government review committee to investigate the rather sorry tale of telehealth implementation there.

You ask what the Health and Sport Committee can do to help, and I think that it is helping by taking an intelligent interest in telehealth in Scotland. I am delighted that you are putting it under the spotlight, as that has not been my experience in Northern Ireland or Queensland.

To make telehealth work successfully, you need a customer who wants it, a provider who wants to deliver it and a mechanism to connect them. The experience around the world has been that regarding telehealth as a technical matter is unlikely to produce success. In Malaysia, for example, it was shown that simply delivering equipment to hospitals was disastrous. You have to engage the potential users and find the right incentives that will ensure that they want to use the service. Although telehealth might at first seem to be a technical matter—that is certainly what the equipment providers would have you believe—it is not so much to do with technology. The technology is a necessary condition, but the issue is really one of human factors and organisation. The challenge that Scotland faces is for the successful pilots to be joined together, scaled up and made to work across the health service. As the health service is broken up into regions, that will involve addressing issues such as cross-boundary flows of patients and recompense for providing a telehealth service if a journey is avoided. On that latter point, we are keen to start reporting the savings in carbon emissions that are made as a result of a telehealth consultation. We are also keen for telehealth to become a sustainable service in the NHS, which means that there must be a mechanism for recouping the cost of delivering it. That will involve financial jiggery-pokery, if I may use that term, such as taking money out of the travel budget and using it to pay for telehealth.

Those are the sorts of barriers that I see in relation to making telehealth work on a substantial scale in Scotland.

Ross Finnie: In Scotland, as in much of the United Kingdom, we are accustomed to an extremely personal health care service. I dread to say this in the company of my colleague, Ian McKee, who is a general practitioner, but GPs have created a genuinely personal element of service. Therefore, I am concerned about the technical issue of how people can be persuaded that the use of the technology is better for their health.

Reducing the carbon footprint of the health service is a subsidiary element of the process, not the primary one. The primary issue is to persuade people that using the technology will be better for their health and that it is not simply a substitute for people. That issue seems to be seriously undermining progress in this field. As soon as you mention telehealth, people say, "Oh, that means I'm not going to get a doctor."

Iain Hunter: Where we have implemented telehealth solutions, we conduct patient satisfaction surveys to find out what people thought of the experience. By and large, people like the telehealth way of delivering health care. It saves people up in the islands from taking two days off work to travel to Aberdeen or Glasgow. Those people are complimentary about the use of the technology.

10:15

The Convener: Your paper gives as an example of successful telemedicine in Scotland

> "telemedicine-support for minor injuries services (North-east Scotland)."

Is that the only one in Scotland?

Iain Hunter: That is why the Scottish Centre for Telehealth was set up in Grampian. Some time ago, funding was available through the Scottish telemedicine action forum, and Grampian had a particularly successful project. The Scottish Centre for Telehealth was established in Aberdeen because of that work, but there were other pockets of successful work. Paediatrics on the west coast is another good example of a STAF project that is going on to be mainstreamed.

The Convener: I do not want to interrupt too much, but can you tell me how many patients have filled in your satisfaction forms, so that we get an idea of the scale?

Iain Hunter: I am sorry, but I cannot answer that off the top of my head. I will come back to you with that information.

If I may make a general observation, Richard Wootton is right to say that we have spoken to people in Canada. I hasten to add that I was there on holiday and took some time out to go and do that. Recently, I attended a conference with representatives from Europe, which is awash with telehealth pilots. I am not being complacent, but the rest of Europe experiences the same problem as Scotland. It is extremely difficult to take small pilots and mainstream them.

Richard Wootton touched on some aspects of the problem. I am not a clinician. I was originally an information technology person, but the problem is not a technical one. It is about people, change and organisations. Those are the barriers that we must overcome.

Mary Scanlon (Highlands and Islands) (Con): In the briefing paper that you sent us, you state:

> "telemedicine requires changing the way that doctors and hospitals work".

You highlight that as one of the two main problems. Perhaps I am reading between the lines, but there seems to be an implication that there is a lack of co-operation from doctors, hospitals and health professionals. Has that been an obstacle to the successful rolling out of telemedicine?

Iain Hunter: Human nature is such that people are always suspicious of change. Again, I go back to my previous career. I used to be in the oil industry, where people hated change. In health care, there are patients at the end of the line. People are concerned about patient safety and are cautious when it comes to change. Our role is to try to facilitate change by persuading, cajoling and convincing. If we come forward and do that, we can win the arguments.

Mary Scanlon: So you are saying that there is resistance to change.

Iain Hunter: I suggest that there is a natural resistance to change.

Mary Scanlon: I have raised in various debates the important question of how NHS 24 fits in with the Scottish Centre for Telehealth. I have been very impressed by the breathing space suicide helpline, which is first class, and as a member for the Highlands and Islands I have also been more than impressed by the superb cognitive behavioural therapy work in the islands, although I appreciate that that is only a pilot. Is that your initiative, or is it the case that, while you are fighting the battle against those who are resistant to change, NHS 24 is moving forward in a positive way?

The Convener: I think that the language that Mr Hunter is using is a little more tactful than "fighting the battle", but I take your point.

Mary Scanlon: Well, Mr Hunter can use his language and I can use mine. In my opinion, the initiatives that I mentioned are excellent examples of telehealth care for people in remote and rural areas who suffer from depression. Given that they are so successful, I wonder why all that we hear about is problems and resistance.

Iain Hunter: Perhaps that is the way the briefing note has come across.

Mary Scanlon: It might be just my interpretation.

Iain Hunter: We are in constant discussion with NHS 24, which is a wonderful resource that can help us to deliver care to patients, and are aware of the two examples that you mentioned. We are also working with NHS 24—we hope to set up a pilot in Tayside on the management of long-term conditions.

Mary Scanlon: But NHS 24 works separately from your organisation. That is what I wanted to establish.

Iain Hunter: We have strong links.

Mary Scanlon: NHS 24 set up the initiatives that I referred to.

Iain Hunter: Yes.

Timing is always a problem, but we are in constant discussion with NHS 24. We know what it is doing and it knows what we are doing. We constantly make it aware of initiatives that are being developed because we view it as an important arm for the delivery of health care through such technology.

Mary Scanlon: I turn to the second page of your submission, which explains why there should be national-scale services in Scotland. I appreciate the need to achieve economies of scale, but the first reason that is given for setting up such services is so that

> "if a patient is admitted with symptoms of stroke in *any* hospital in Scotland, he or she can be assessed for thrombolysis."

Will you explain further why that is the main advantage of national-scale services?

Professor Wootton: Of course. I do not have the submission in front of me, but I think that that is an example of a national-scale service. Some pilots are under way on early stroke treatment. As you will probably be aware, it is essential that a patient who is suspected of having had a stroke is considered for clot-busting therapy within three hours of the onset of symptoms. That can be arranged in the major metropolitan areas, but it is much harder to arrange in rural areas.

I was trying to make the point that the establishment of a national service would result in the removal of potential inequities of access to such treatment for patients across Scotland. It would mean that, regardless of the hospital to which someone was admitted, they could be put under the nose of a neurologist or a stroke physician within three hours of the onset of symptoms and considered for treatment. When it is required, such treatment is certainly brain saving, if not life saving; equally, if it is given in the wrong circumstances, it can be quite dangerous.

Mary Scanlon: As an economist, I have a better understanding of economies of scale than I do of thrombolysis. Am I right in saying that such a patient would have to be admitted to hospital to determine what type of stroke they had suffered and that a judgment would have to be made within the three-hour period by a proper clinician? In other words, the diagnosis could not be made by a paramedic, for example, and the patient would have to get a scan.

Professor Wootton: They would have to be scanned and be seen by a card-carrying stroke physician or a neurologist. The fact that that is hard to arrange in the peripheral hospitals is part of the challenge that we face in scaling up the service.

Mary Scanlon: That is helpful—thank you.

The Convener: Before we hear from Helen Eadie, I have a supplementary. Our SPICe briefing paper says that your organisation

> "has a reference group, bringing together representatives of the Scottish Government, NHS boards and others".

Does "others" include NHS 24?

Iain Hunter: Absolutely.

Helen Eadie (Dunfermline East) (Lab): A number of years ago, as a member of the Health Committee during the Parliament's second session, I had the privilege of visiting the impressive new hospitals in the Western Isles. I remember the clinicians explaining to us that a big problem was ensuring that when they used the equipment, there would be a consultant or a specialist in place at the other end of the line. To what extent have those managerial and organisational issues been dealt with? As we all know, for the provision of expensive equipment to be justified, it needs to be running efficiently 24/7. If that is not happening, we must ask questions. Would either of you like to comment on that?

Iain Hunter: I am not sure that I will answer your question. We certainly hear from Orkney, Shetland and the Western Isles that although the equipment is available and ready for use, the issue is having someone to speak to at the other end. We have not managed to address that. We must work on a booking service or a service that allows us to direct someone who needs specialist advice to the appropriate person. Richard Wootton has a vision of how that might work. Such a service would undoubtedly enhance the use of telehealth. If people have nobody to speak to, it ain't going to work.

Helen Eadie: That is quite worrying for all of us who are enthusiastic about telecare, but that is one reason why we need to probe this important issue.

You mentioned telecare in your introduction. Some years ago, I read about the European dimension of that and about funding initiatives throughout Europe to support the development and application of new technology for telecare. Where are we with telecare in Scotland? Will you share examples of good practice? We all know that a big issue for many older and disabled people is loneliness. Another aspect is ensuring that their care is adequate. Will you comment on those matters?

Iain Hunter: Telecare in Scotland has been funded to the tune of £8 million in the past two financial years and will receive £4 million of funding in the current financial year. There are 32 partnerships, which involve local authorities and community health partnerships. The partnerships have submitted bids for funding, which has been used in diverse ways. Some partnerships have used it simply to enhance alarm and security systems in patients' homes, and others have expanded the scope to using modern-day telemonitoring equipment in the home. Three pilots are under way—in Lothian, Lanarkshire and Argyll and Bute—and will be evaluated.

I cannot answer the question about the loneliness of the patient or the citizen or whether such a system isolates them. The suggestion is that telecare does not isolate people and that it comforts them to know that they can communicate with somebody. They know that their health will be monitored and that, if vital signs deviate significantly from where they should be, action will be taken. It is early days for us in Scotland, but all the pilots are being evaluated for effectiveness and acceptability to patients.

Professor Wootton: Telecare in Scotland has evolved from local authority initiatives such as those involving alarms for when people fall on the floor. As Iain Hunter said, trials are in progress. The world literature on telemonitoring, for example, shows that it appears to work well in some areas. I have colleagues in Harvard University in Boston who speak highly of telemonitoring for patients who have congestive heart failure, because it keeps them out of hospital. Under the American model, it is financially advantageous—much cheaper—to keep people out of hospital rather than to admit them. Monitoring of patients with diabetes who can report their blood glucose values over the phone line to a server somewhere has seemed to work well in trials in Europe. Patients have liked that and GPs have found it useful. However, systematic reviews of the literature do not show compelling research evidence that such measures are cost effective. We all suspect that they might be, but differences between other countries' health systems and ours mean that we need to run formal trials here. As members probably know, the University of Edinburgh has embarked on formal randomised control trials of telemonitoring technology. We expect to have some answers in a year or two.

10:30

Helen Eadie: Your comments are helpful.

Ian McKee (Lothians) (SNP): I share Ross Finnie's dismay at the lack of progress. My background is as a general practitioner, and I was involved in a telemedicine project in antenatal care 30 years ago. We had videoconferencing and sent results down the line. Women who were out shopping could be informed by mobile phone if monitoring showed that foetal movement or their uterine contractions were abnormal and they needed to seek help from the midwife.

The project was part of a scheme that reduced considerably perinatal mortality in the area concerned. It involved clinicians changing their pattern of working and collecting information in a more logical way, which would have been helpful even without telemedicine. However, the project was never expanded, for the reason that you have given. Pilots tend to involve enthusiasts; when they are expanded into the mainstream, they encounter hospital clinicians who are unhappy about allowing cases to be dealt with outside hospitals and clinicians in primary care who are reluctant to participate. Has the time come to stop having a lot of pilots involving enthusiasts, to choose one or two areas—perhaps managed clinical networks—and to tell everyone in those areas that they must take part in telemedicine schemes, for which we will provide a template, so that we can see how they work? If we do not do that, we will spend the next 30 years having more pilots and never getting anywhere.

Professor Wootton: I am familiar with the work to which you refer—it was initiated by Ken Boddy, who was a true pioneer. You are right to say that it did not go into routine service for the reasons that we have discussed. In my opening remarks, I spoke about how we might concentrate on a small number of areas, as you suggest. I have reservations about being prescriptive and telling people how things should be done—it depends on whether one belongs to the carrot or the stick school. On the whole, doctors are a conservative bunch, and rightly so. Telling them to do things is usually unproductive—it would probably be better for us to provide appropriate incentives. In our four chosen areas, we are seeking to identify the right levers for making hospital consultants warm to the idea of conducting teleconsultations rather than automatically requesting that patients front up in their clinics, for example.

Iain Hunter: I could not agree more. If in five years' time we have 50 pilots up and running, in our book we will have failed. If we have five mainstreamed projects in Scotland, we will have succeeded. Although we are working with individual health boards, we are also working with collaboratives such as the long-term conditions collaborative and the mental health collaborative, with which we have meetings this afternoon. We are looking across health boards to see whether we can approach matters from that direction. If we focus on the 14 mainland health boards, we may end up with a miscellany of pilots, so we must try another approach. I would not like to say whether it involves a carrot or a stick.

Ian McKee: I accept that, as Professor Wootton says, it can be counterproductive to force people to do things. Earlier, you spoke about the customer's needs. I had the impression—perhaps unfairly—that your idea of the customer was consultants and GPs. In fact, the health service's individual customers are patients; collectively, the customer is the national health service, and there are plenty examples throughout the national health service of clinicians having to alter their behaviour patterns and act in a certain way because the rules and regulations have been changed on the basis of evidence. I suggest that, unless that can be done, you will not get very far. You probably need help from the wider national health service network outside telehealth. I challenge your statement and would like a further response on whether we can simply wait until everyone is happy before we can proceed with any combined initiative.

Professor Wootton: It is important not to get hold of the wrong end of the stick and beat yourself to death with it. All the evidence on what the customers think of telehealth is positive, and you are right: the customers, of course, are the patients. All the surveys around the world seem to show that patients are perfectly accepting of telehealth. Even elderly patients whom one might expect would be concerned about talking to the doctor on the telephone do not mind it at all; if they can avoid significant travel and still have a specialist consultation, for example, that is fine by them. I do not have any concerns about acceptability to the patient.

I agree that we would like to make major changes to how doctors work to make them consider telehealth more often than they do at the moment, but it is not possible to do that if the infrastructure is a bit friable and cannot be expected to work reliably; that would be grossly unfair. One obvious lever that one could pull would be to devolve the patient travel budget down to the level of the referring clinician. If referring clinicians in Orkney or Shetland held the travel budget that paid for the patient to be flown down to Aberdeen, for example, that might make a big difference to how they thought about travel versus telehealth. That brings us back to our initial discussions about the difficulties. The difficulty is not persuading people to use telehealth—doctors are not resisting, although they might remain to be convinced—but there is a large job of work to be done in hospital finance departments on whether it is possible to take travel budgets out of St Andrew's house and devolve them down to the clinicians who are ultimately responsible for spending the money. Those are the sorts of challenges that we envisage in making large-scale changes to how telehealth is done at the moment.

The Convener: That is a practical suggestion for the committee.

Mr Hunter, you have an opportunity to rebut Ian McKee if you wish.

Iain Hunter: There are three customers—the patient, clearly; the professional clinician; and the organisation—and, somehow, we must create incentives or a business model that can benefit each of them. That, we hope, will help to drive things forward and gain acceptance of the use of telehealth.

Michael Matheson (Falkirk West) (SNP): If I recall correctly, Professor Wootton, you identified three inhibitors to the development of telehealth: technology, which further discussions have largely set aside because it is fairly advanced and can be brought on stream as and when appropriate; patients, although it appears from your comments a moment ago that most are prepared to engage in telehealth if they think that it will benefit them; and clinicians.

Your comments suggest that clinicians may be the biggest inhibitor to the development of telehealth, which could benefit different clinical services. Will you give us a bit more of an understanding of why there is, if not resistance, reluctance among clinicians or why they have to be convinced that they should be more open minded about telehealth and more willing to engage in it? Is the reluctance greater among clinicians in acute medicine or primary care? Are GPs more open to the idea—as Ian McKee was 30 years ago—but clinicians in the hospitals more reluctant to engage in telehealth because of the change in work practice that it would involve for them? Will you give us more of an insight into the extent of that type of difficulty?

Professor Wootton: The language is a bit unfortunate. I am not sure that I would describe all the doctors as being reluctant but there is what you might call inertia in the system. Many of my colleagues remain to be convinced, and rightly so. I said earlier that on the whole the medical profession is, with good reason, conservative. What we are asking them to do is see a patient on a TV link, which is an unnatural experience. Why would they prefer to do that than to see the patient in the flesh? Why would they expose themselves to the possibility of making a misdiagnosis because they did not get the full story on the TV picture? We are asking clinicians to practice in an unnatural way, which potentially exposes them to increased clinical risk. The medico-legal basis on which they might be prosecuted if something went wrong is a bit uncertain. There are several good reasons why the medical profession might remain to be convinced about telehealth.

People have tried it, however, and the studies that we and others have carried out show that the risks are perfectly acceptable. There are some strong medical proponents of telehealth, so it is not all doom and gloom. Part of this morning's discussion is the issue of finding the right incentives for practising telehealth. I would suggest using a proportion of travel savings to provide some sort of incentive at the level of the doctor who practices it. I do not mean money in his or her pocket but some enhancement of the doctor's work environment, such as the departmental library.

Iain Hunter: It is right and proper that the clinicians are cautious about telehealth. We have been developing the concept of a medical booth, which would contain videoconferencing equipment and medical devices that the patient could use or someone could help the patient to use. The specialist could be at a distant location. We are trialling that in Aberdeen, where we have an accident and emergency consultant who is a great enthusiast for telehealth. His first reaction was, "We've got to do a safety check on this. How safe is it for the patient?" We have put 100 patients through the booth. The first test was whether the patient would come away with the same diagnosis via a TV screen as they would if they were seen face to face.

There is a natural hesitation on the part of the clinicians, which, at the end of the day, is good for us all as patients. We somehow have to move that forward and prove through evaluations and evidence that telehealth can work safely and well.

Michael Matheson: That takes me to my second question. I can understand clinicians being cautious about telehealth, given the liabilities that it may leave them open to. In other parts of the world, how effective has it been in ensuring that patients get the right diagnosis and that the time taken to go to hospital to see consultants is reduced? If I were a clinician, how would you persuade me to try telehealth? I presume that telehealth has been practised in other areas, which might have years of experience that we could draw on without—in my view—wasting more time on further trials to persuade people that it is safe.

Professor Wootton: You are perfectly correct. There is now a fairly extensive literature on many telehealth applications. You will appreciate that if a new application is dreamed up, as Iain Hunter mentioned, various stages have to be gone through, such as testing its feasibility, safety and acceptability to the users—the doctors and patients. Ultimately, we would also want to know about its clinical cost effectiveness. There is a good literature on some of the former aspects in most areas of telehealth; there is only a limited literature on the downstream aspects of clinical cost-effectiveness in many areas. There is good evidence, for example, on store-and-forward teledermatology, which seems to be highly cost effective in many parts of the world. We believe that telestroke treatment is cost effective in the United States—although, the American health care system is so different from any others that it is hard to extrapolate that evidence to what we might describe as normality. There is certainly a literature on the subject—it exists, and nobody wants to repeat feasibility studies unless they really need to be done.

10:45

Rhoda Grant (Highlands and Islands) (Lab): In your opening remarks, you mentioned that there were four potential applications. I picked up that one was psychiatry, which seems quite obvious, given that it is not physical, or does not require a physical examination at any rate. What were the other three? If you mentioned them I missed them.

Professor Wootton: No, I did not mention them—I was leaving that for your questioning.

The Convener: Well, we have managed to get there.

Professor Wootton: Collectively, we at the Centre for Telehealth considered the whole range of telehealth pilot schemes in Scotland that are under way, and some of the more obvious ones that are not. Telepsychiatry was one of those. We used six headings. For the record, they were first, whether or not there was good scientific evidence that the treatment was clinically effective; secondly, practicability, or how easy it would be to scale up the treatment to a national service; thirdly, how well the treatment would conform with the Government's priorities in the chosen area; fourthly, whether the treatment addressed a severe burden of disease and whether the condition was life threatening; fifthly, the potential service profile, in other words how many occasions of service the treatment would be expected to deliver, how big the target group was and whether society had special preferences—for example, society often treats neonates and the newborn quite differently from how it treats geriatrics; and, lastly, if the treatment was to be implemented on a national scale, whether the net cost to the NHS could be expected to be neutral, or whether there would be enormous expense or huge savings.

The four areas that come out top are chronic obstructive pulmonary disease—COPD; hyperacute stroke, which relates to what was said about telestroke earlier; telepsychiatry; and general medical services, including minor illnesses and injuries. Those are the four areas on which we propose to concentrate, with a view to scaling them up to become national services across Scotland.

Rhoda Grant: Ian McKee was saying that such treatment was being used 30 years ago and that it has not moved forward. I was struck by the thought that 30 years is almost the length of someone's career. Could we use training at the very early stages to encourage people, or to remove their fear of getting things wrong? Could training also be given throughout someone's career, perhaps through continuous professional development? Have you considered such approaches for dealing with those real concerns?

Professor Wootton: Yes. We, too, believe that training is essential. That means continuing the professional training of the people who are in place at the moment and trying to reduce the anxieties of the nursing students and the medical students who will become the next generation of doctors.

As for my experience of that, I have been to see the deans of two medical schools to discuss putting e-health and telehealth lectures into the curriculum. That was laughed out of the room, because the medical curriculum is so overcrowded. It is therefore not easy to achieve that in practice.

In Brisbane, we developed a postgraduate course in telehealth and e-health. The difficulty is that it involves preaching to the converted. The answer is probably what you have put your finger on: to reduce anxieties at the undergraduate level if we can, knowing that the people at that level will ultimately become the doctors and nurses of the future. I have not been over here long enough to have that conversation in Scotland, but I hope that I will get a different reaction when I do.

Rhoda Grant: I hope so too.

My final question—I suppose that this depends on the ailment that is being treated—is about how practical it is to get the technology into people's homes. Would people access telemedicine only in health centres, which are more local than where the specialist might be based? What are the practicalities of getting the technology into people's homes?

Professor Wootton: On the whole, the practicalities are fine. Normally, one adjusts one's aspirations to suit the telecommunications available. For data monitoring of patients with diabetes, an ordinary telephone line is fine. Mobile phone networks—I imagine that coverage is available over much of Scotland, but I am not familiar with the details—provide another medium. You are right that there is an intermediate stage between the home and the hospital. Community centres and doctors' surgeries provide locations where individuals might gather for certain kinds of telehealth activity.

We have been impressed with the patient support that is offered in Canada to women who have been discharged after an operation for breast cancer. In rural Canada, such patients can meet a convener by telephone conference, which seems to provide enormous patient support. We have had discussions on whether such activities might be useful in Scotland.

Although much of the technology—videolinks and so forth—that is required for hospital-to-hospital telehealth is relatively expensive, it is important not to assume that all telehealth must be done by video. Useful telehealth in the home can be done over the ordinary telephone network.

The Convener: I recall the days of the Open University, which pioneered tutorials by telephone so that students did not have to travel.

I have a follow-up question on medical schools. Did you say that, for fairly substantive reasons, none of Scotland's medical schools has telehealth on the curriculum?

Professor Wootton: I believe so. Telehealth is not included explicitly on the curriculum.

The Convener: Do any medical schools in Europe have telehealth on the curriculum? Unless we start at that level, might the inertia that you are fighting—I should not use such aggressive terms—still prevail?

Professor Wootton: In Norway, and at the University of La Laguna in the Canaries, telehealth is included explicitly in the undergraduate curriculum. Those are just two examples that I can think of. Informatics is, I think, included in the undergraduate curriculum in Scotland, but I am not aware that telehealth is explicitly identified. As I said, that is a conversation that I would like to have.

The Convener: When was telehealth introduced into the curriculum in Norway, which is a fairly near neighbour? Has that had a noticeable impact on delivery?

Professor Wootton: I think that the Norwegians spent quite a long time getting themselves organised, but the subject is also included in a postgraduate course. I think that telehealth was included in the undergraduate curriculum only last year.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I apologise for being slightly late for the beginning of this session.

Telecare interests me because it seems to have as much promise—which has been as little fulfilled—as almost any area. When are the pilots in Lothian, Lanarkshire and Argyll and Bute likely to report? Is it correct to say that telecare links in homes in West Lothian have already demonstrated a considerable reduction in hospital admissions as well as improved confidence on the part of those who can now stay at home rather than go into more sheltered environments?

Iain Hunter: On that last point, the people in West Lothian are probably leaders in the field. The project is being pioneered by David Kelly and has proven to be very successful. You are right that the evaluations show that admission and readmission rates to hospital have demonstrably decreased. Scotland is leading the field in that sort of example.

The other pilots that you mentioned are just at the starting line and it will be 18 months or two years until the full evaluations are done. Different concepts are being used in the pilots. The Lanarkshire pilot, which will start shortly, will be based primarily on the use of the telephone. Patients will lift the phone and answer a questionnaire. The responses to that will be analysed. In Lothian, a number of set-top boxes have been put into people's homes. We are at the starting line and we have to let the pilots run for a period and do the evaluation. I will have to come back to you to say how long it will be before we get the results, but my guess is that it will be about 18 months.

Dr Simpson: I worked in West Lothian for a bit and I understand that a significant number of houses were involved. Do you know the figure offhand?

Iain Hunter: Sorry, but I do not.

Dr Simpson: I think that hundreds if not thousands of houses were involved.

Iain Hunter: Certainly hundreds. It is a good demonstration and Scotland should be proud of it.

The Convener: Thank you both very much for an interesting session. It will be helpful if you can give us information in writing later about the number of houses involved, which was the issue that Richard Simpson raised, and also the number of people who were treated in that fashion and then took part in the survey, because we are missing data.

10:56

Meeting suspended.

11:06

On resuming—

Mental Health Services for Deaf and Deaf-blind People

The Convener: Agenda item 2 is on mental health services for deaf and deaf-blind people. It is a follow-up to the evidence session at last week's meeting, at which we heard from charities and professional bodies with an interest in the matter. I refer members to this week's committee papers, which include written submissions from the Minister for Public Health and the National Deaf Children's Society and further written submissions from LINK Scotland and the Scottish Council on Deafness.

I am pleased to welcome to the committee Shona Robison, the Minister for Public Health. She is accompanied by Scottish Government officials: Dr Denise Coia, principal medical officer—mental health; Philip Harley, senior policy officer in the mental health division; Peter Kelly, policy officer in the adult care and support division; and Dee Fraser, policy officer in the mental health division.

Does the minister want to make some opening remarks?

The Minister for Public Health (Shona Robison): Yes. I thank the committee for the invitation to discuss progress and our future plans for an important group of people. I am happy to elaborate on any aspect of my submission and to follow it up with the committee as necessary.

I know that the committee has a lot on its plate, so I will just say that it has received a copy of my submission, which gives an update on the key action that is under way and is planned to improve how we and all our partners plan, assess and respond to the needs of those with a mental health problem and a sensory loss.

I make it clear at the outset that I am not entirely happy with the current position, which falls short of what we would want for those affected. However, I am happy with the attention that is being given to the need for change and the response so far. Progress is being made and there is some momentum. We always aim to better integrate groups of people with communication needs, including the deaf community and others, into mainstream provision, but I have never been of the view that that should be at the cost of sensitivity to particular needs. Those are the needs within needs, if you like, which should be considered by any service planner for any care group.

You will have heard that we are, without prejudice, helping partners to prepare the case for a specialist service and a specialist unit. Partners are aware that our help does not signal that we are minded to establish such a unit and that we, like others, are keen to see and consider the evidence base before we make any decision.

The issues that we will consider are what is workable, what is pragmatic and whether what is being suggested is a specialist service, a managed care network or a hub-and-spoke model. We will also take into account specific considerations for children. I am aware of the care and continuity benefits of having their needs addressed within children's mental health services that are linked to paediatric units, but whether to have a specialist service, unit or whatever will be considered over the next few months.

As indicated in my submission, there is other progress to report, although some might feel that it is neither fast enough nor wide-ranging enough. I understand people's frustration, but I think that we have a broad consensus on the way forward that will help to maintain momentum and to bring about change as quickly as possible.

Progress on delivering the aims of the sensory impairment action plan has addressed individual needs in part by delivering community care priorities for people with a sensory impairment. We are seeing new approaches and better retention than was the case when the original petition was submitted. For example, Glasgow has developed specialist deaf awareness training for mental health officers and other staff. NHS Lothian has set up a service, including a community mental health nurse and an occupational therapist with sign language skills, that is closely linked to social work services provided by Deaf Action. I am pleased that the initiative is centred on a new counselling service specifically for those with a mental health problem and sensory loss—that is a new approach. Evaluation will show what lessons have been learned and what gains have been made; I hope that there will not be too many disadvantages. We will seek to extend the practice that I have described to other parts of Scotland.

We have funded a leading change initiative at a Glasgow-based recovery project that focuses on two mental health client groups—people from ethnic minorities and people from the deaf community. Investment to create a bigger pool of British Sign Language-English interpreters is showing progress—65 interpreters are now available in Scotland—although there is always more to do.

Finally, our national suicide prevention strategy, choose life, provides resources on suicide prevention and awareness training in Braille and large print. In recognition of the fact that the deaf and deafened community is at no less risk—some would say, at increased risk—of suicide, we have been active in recruiting two deaf or deafened applied suicide intervention skills trainers, one of whom is based at Deaf Connections in Glasgow. A lot of work is under way, but there is still more for us to do.

I am happy to answer members' questions.

The Convener: Thank you for that full statement. I advise the committee and the minister that committee clerks from the Malawi National Assembly who have been observing Scottish Parliament committee proceedings this week are in the public gallery. I met them yesterday and they are very welcome.

Mary Scanlon: Minister, I have no doubt that you have looked at the evidence that was given at last week's meeting. The main problem seemed to be that—allegedly or in reality—there is huge unmet need, but no one seems to know the extent of it. It was suggested that some NHS boards do not refer to the John Denmark unit and that some general practitioners do not know about or refer patients to the one-day clinic that the unit runs in Glasgow. There seem to be problems related to awareness, communication and referral pathways. Rightly or wrongly, I concluded that we need to ascertain the critical mass of unmet need that exists before considering whether to establish a six-bed unit. What work are you doing to identify the extent of the unmet need about which we heard last week?

Shona Robison: In my opening remarks, I indicated that a great deal of evidence is being gathered to back up the case for establishing a specialist unit in Scotland—without prejudice, because we need to remain impartial on whether such a unit is required. The aim of the exercise is to identify the level of need in Scotland. It takes account of both current referrals to the John Denmark unit and the possibility that there is unmet need because people who would use a Scottish service currently do not want to travel to Manchester. We must also bear in mind the fact that, whenever a new unit is established, there is increased awareness of an issue, which may lead to a higher level of interest and more referrals. The evidence that will be submitted to me will seek to take account of that.

That said, one of the things that I picked up from last week's evidence is that there is a weakness in the available statistics. There are reasons for that: whether in primary care or the acute sector, it is often the complaint with which the person presents that is recorded rather than underlying problems—for example, depression compounded by isolation through deafness would not necessarily be recorded in that way—which means that we are missing some important information. I am happy to explore that with ISD Scotland and to consider, for example, how we can get better at capturing such data through the codes that GPs use to record information, which are reviewed continuously.

A lot is happening, but I agree that the statistical base has some weaknesses.

11:15

Philip Harley (Scottish Government Primary and Community Care Directorate): The Government has also provided £40,000 to the Royal National Institute for Deaf People for a research study into need, preferences and gaps in provision.

The Convener: We have that in our briefing paper.

Philip Harley: That study will inform future practice.

Michael Matheson: Minister, your written response to the committee is helpful in light of the evidence that we received last week. I will ask about counselling. We heard some evidence last week about the pilot project that is running in the Lothians. You say in your letter that "early indications are encouraging", but I am concerned about what will happen once the project has been independently evaluated. I note from your response that the evaluation

"will be promoted and disseminated to encourage"

other NHS boards to consider the model. I am concerned that, when a pilot in one health board area is proven through evaluation to be successful, other health boards do not necessarily start to provide a similar service in their own areas, although they might receive the evaluation report. That inevitably leads to a postcode delivery of certain services. Can the Government do anything more to guarantee that, when a pilot in one area is evaluated as being successful and effective, a more systematic approach is taken to ensuring not only that the report is disseminated, but that health boards in other areas take on the idea and start to use it?

Shona Robison: I understand exactly where you are coming from. The health service is getting better at rolling out change and good practice than it perhaps was. We have better systems in place—for example, in the Scottish Government, we have strong performance management and change teams whose job is to go in and help health boards to redesign their services in light of current and emerging good practice. However, a level of local decision making is involved, and although a service such as the specific counselling project in the Lothians may be appropriate for some of the larger boards, it might be difficult for some of the smaller boards to deliver; they might have to think of other ways of delivering it.

We have ways of getting across particular messages about the progress that we would like to see. For example, the regular meetings that the Cabinet Secretary for Health and Wellbeing and I have with the chairs of all the health boards are often good forums for us to impart important messages and we often have people come in to outline to the chairs a particular innovative service in a health board with the clear understanding that we are asking them to consider how that practice can be developed in their own health board area.

Although it is ultimately for a health board to decide its own priorities within national policy, when something such as the counselling project works and there is a critical mass of people who could benefit from such a service—which applies particularly to the large health boards—we would give every encouragement to such a service being developed. We would also obviously keep an eye on the situation and monitor it.

Philip Harley: There are twice-yearly visits specifically on mental health to all partners in each health board area when such issues can be promoted or queried and people can ask, "Why are you not doing it here? What is the evidence that prevented you from doing it?" That kind of promotion of all aspects of mental health is on-going, particularly when new evidence comes out that shows what works well in a given area.

Michael Matheson: So it is the sort of thing that could end up on a list of questions that might come up in the course of a review.

Philip Harley: Absolutely.

Dr Denise Coia (Scottish Government Chief Medical Officer Directorate): In the two training meetings that we have had, we have tried to develop a clinical network that involves the voluntary organisations, where much of the expertise lies. Through the doing well by people with depression programme, we set up a clinical network that disseminates information on different services throughout Scotland. We aim to do the same through the network for sensory impairment. The problem is that a big training agenda is attached to that because the workforce is not trained in the way it was for the depression programme network. We have another meeting of the sensory impairment training network in September when there will be presentations on the counselling project to let people know how it has worked out.

Ross Finnie: Minister, as you will be aware, PE808 started life as a request for an in-patient service. You acknowledged that as different committees interrogated the evidence in support of the petition, different programmes have been exposed.

My take on the evidence that we listened to last week, about which you will have been advised, is that although we might like to have in-patient beds, the position has moved on, and the major issue in dealing with various aspects of mental health that has emerged is the need for clinicians who are absolutely fluent in BSL. That is not easy, because we are not talking about a single clinician. The issue raised is whether we would need such clinicians in all health boards or could have a core of people with BSL fluency who could act in a hub-and-spoke way across all health boards and could counsel individual patients and offer in-depth advice on their problems because they could communicate with patients in a way that someone who is not so proficient in BSL could not. The core issue raised last week was how we could achieve that—through individual health boards or centrally.

Shona Robison: I appreciate that. I outlined in my letter some of the training developments, for example within the Royal College of Psychiatrists, which is working on the inclusion of deaf awareness training in the curriculum for trainee psychiatrists. There will be more about that later in the year. Although I recognise that deaf awareness training is not the same as training in BSL, making clinicians aware of the issues is an important part of their training. We must ensure that clinicians recognise, in the same way as they recognise the need for other interpreting services, the need to use a BSL interpreter on occasion to help in their dialogue with a patient. Ensuring that they have basic awareness of the issues is important, and that is the stage that we are at with the Royal College of Psychiatrists. As a key group of staff involved in dealing with mental health issues, ensuring that they have better awareness of the situation will be an important part of their training.

Other groups of staff will also be involved and I outlined the work that is going on to improve awareness among community mental health nurses and so on. I am not saying that that, in itself, will resolve the issue that you are talking about, but it will go some way towards ensuring that people are at least aware of the issues.

Ross Finnie: It was raised with the committee that it might be unrealistic to expect every health board to replicate that degree of interpretation. I appreciate that that raises various organisational issues. A hub-and-spoke model has been suggested, in which there are a number of people with a higher level of understanding and language to deal with the deaf-blind, particularly in relation to mental health. That could perhaps be replicated throughout health boards.

Shona Robison: The hub-and-spoke model is a good one, particularly for some of the smaller boards, whose ability to have the right specialist services might be limited. The hub-and-spoke model could ensure that they had access to those services.

Dr Coia: Ross Finnie makes a good point. In the case of people who have a major mental illness such as schizophrenia, and who are quite psychotic, mistakes can be made if there is no in-depth understanding of BSL. For example, a psychiatrist might not correctly pick up the flavour of a person's delusions and hallucinations. We had considered training specialist psychiatrists. There is only one psychiatrist in Scotland with that depth of understanding. There are training schemes in England, for example at St George's in London, and Ireland is starting to offer training for that specialist group of doctors. The hub-and-spoke model would work with that kind of specialist training because we could offer intensive support at a distance, while people would also be prepared to travel in to the hub for that kind of expertise.

Training other staff is important for Scotland's rural areas. We would consider ways to increase the expertise, particularly in nursing, so that services could be provided locally for people who did not need specialist care. Specialist input is a huge training agenda for the Royal College of Psychiatrists, but the resource is scarce for that at present.

Rhoda Grant: It was clear from last week's evidence that people who use BSL are the best folk to deal with this issue. However, there appears to be no funding even for interpreters for counselling. We have received an additional paper from Lilian Lawson about a social worker in Glasgow who had identified 55 deaf or deaf-blind people who badly needed counselling. However, because the social worker had to raise funds for an interpreter, only one of those people got one. Even at such a basic level, because health boards are not willing to provide interpreters, the services are not available. While it is not our aspiration that the service should take such a basic form, surely health boards could be asked, as a stop-gap, to provide interpretation for people who need counselling, thereby keeping them away from the more specialist services.

Shona Robison: Health boards have a duty to ensure that they provide their services equitably to everyone in their area. If people are not getting access to services because of interpretation difficulties, that is an issue for health boards to resolve. I am happy to discuss that with health boards and get an understanding of which ones have the biggest challenge in that direction, because I do not think that the situation is universal. I am happy to come back to the committee with a fuller answer once I have been able to do that.

Rhoda Grant: I would be grateful for that.

Dr Coia: The issue is the availability of interpreters. The provision of interpretation to people who are receiving counselling is quite a specific area. Interpreting in a therapeutic situation is complex—interpreters must have specialist expertise so that they do not misinterpret or overinterpret what is happening. The same applies to interpreting for people who are asylum seekers. My experience with boards is that sometimes the problem is not the lack of an interpreter, but the lack of an appropriate interpreter with specific expertise in mental health.

11:30

Rhoda Grant: I understand that specialist interpreting is required, but the information that we have received indicates that there is a lack of financial resources for the service and that boards are unwilling to fund it. I would be grateful if you could provide us with more information.

The Convener: The member is referring to paper HS/S3/08/17/6, which highlights boards' refusal to pay for the service.

Ian McKee: I will put my question to the minister, although it relates to Mr Harley's directorate. The research that you mentioned is the key to the whole business. Until we have an estimate of overall demand for mental health services from deaf people in Scotland, we will not know what services we should provide. We are dealing with a specialist group of people, scattered across Scotland, with, we suspect, a high level of needs. It is difficult for clinicians to interpret those needs unless they are specialist psychiatrists and are assisted by people who are adept at British Sign Language. However, you will get the results of the research in about nine months' time, having spent £40,000. Can you reassure me that a proper assessment of the needs of the people concerned is achievable for such a small sum and within such a short timescale?

Shona Robison: The research will put us in a better position; whether it will answer every question about every service that may be required is another matter. We are looking to have far better evidence on which to base some crucial decisions. There may be work for us to do beyond that, but it is a first stage that will allow us to make early decisions.

Philip Harley: There will be a 12-month study, starting about now and reporting in 12 months' time. The study will be conducted by Glasgow Caledonian University, with the Royal National Institute for Deaf People. As the minister said, it will not be the sole source of information, but it will add information to what I accept is a low base.

Dr Simpson: I hope that the research project will be useful, but in her written evidence to us Linda Sharkey suggested that basic information at primary care level is not particularly good. What is happening at that level, given that something is likely to happen to the general practice assessment survey? Is ISD Scotland comfortable with the way in which information is being collected on this group and with the specific annotation that is being used in diagnosis? In other words, do we have data that will provide the statistical evidence that is needed, as opposed to the patient experience evidence that the RNID study will provide?

Shona Robison: As I indicated, there is no doubt that there is an issue at primary care level. I was not aware that there are more than 100 codes covering various forms of deafness and hearing loss. The codes apply to cases in which patients present with one of those 100 conditions, but we may not always be recording conditions that are a factor in the health care need for which patients present—they give us only one part of the picture. I gave the example of depression that is compounded by isolation through deafness; important parts of that picture of a person may not be recorded.

I am happy to explore the issue further. As I said, the codes are reviewed twice a year, so we have the opportunity to consider what changes might be required. ISD Scotland keeps its information-gathering processes under constant and on-going review. We will ensure that ISD Scotland is aware of the issues that have been raised about the recording of information in this context.

Philip Harley might have something to add.

Philip Harley: There is not much to add. ISD Scotland is reliant on the information that it receives, so it is a two-way situation.

The Convener: I have a brief question on another issue that falls within the ambit of petition PE808, which urges the Government to develop a specialist in-patient mental health unit for deaf and deaf-blind people and to provide resources for mainstream psychiatric services in the community to make them more accessible to deaf and deaf-blind people in Scotland. Having read the submission from the National Deaf Children's Society, I suspect that identifying children with hearing difficulties involves a different kind of quest from identifying adults with deafness and that different kinds of services are required. I do not know whether that falls within the ambit of the various actions that are mentioned in the minister's letter.

Shona Robison: Such specialist services are provided mainly through the paediatric intensive care that is offered at Yorkhill. Perhaps Denise Coia will say more on that.

Dr Coia: The convener is right that the two issues need to be separated out. In children, we are dealing with developmental disorders that require full in-depth assessment of developmental issues across child and adolescent psychiatry and paediatrics. With adults, the issue is different, as we need to try to provide the specialist services but link those firmly into general adult mental health services. The two issues are separate, really.

The Convener: The minister mentioned Yorkhill, but what services are offered to children in disparate areas throughout Scotland who display behavioural problems in which deafness may be just one issue or the whole thing? How is that dealt with?

Dr Coia: We are looking across the gamut of child and adolescent mental health services—CAMHS—particularly in rural areas. We are starting to develop regional pathways for the whole range of child and adolescent services because simply putting one specialist in each area does not work. The clinical pathways that we are developing will include sensory impairment, but the pathways need to be firmly tied into education and social work so that they cover all the agencies in rural areas. We have just started that work, but I hope that those pathways will play into that agenda rather than be part of the adult sensory impairment specialist service.

The Convener: To me, the spectrum of educational provision would need to be involved. Given mainstreaming, that is where the issues will arise, so the problem needs to be tackled in other portfolios as well. Is that being done?

Shona Robison: The work on CAMHS is at a relatively early stage but, yes, officials will speak to their colleagues in the appropriate directorates to take the work forward. As the convener has identified, education is a key service that will be very much involved in the discussions on how we improve CAMHS provision.

Mary Scanlon: On the issue of services for deaf children, I visited the new Donaldson's school not so long ago. I think that I am right in saying that the school's facilities are fairly underutilised. When the Government is looking at referral pathways for children, will it also look at how children can benefit from spending some time at the school? Will the expertise at Donaldson's school be utilised in the research on unmet need?

Shona Robison: We will consider that.

The Convener: That concludes this evidence-taking session. I thank the minister and her officials. Today's session has shown us again how useful petitions can be in ensuring that we explore issues that might otherwise be neglected by the Parliament at large.

Petition

Mental Health Services (Deaf and Deaf-blind People) (PE808)

11:40

The Convener: Item 3 is consideration of petition PE808, which was lodged on 17 January 2005 by Lilian Lawson, on behalf of the Scottish Council on Deafness, and calls on the Scottish Parliament to urge the Scottish Executive to develop and establish a specialist in-patient mental health unit for deaf and deaf-blind people and to provide resources, such as training, for mainstream psychiatric services in the community to make them more accessible to deaf and deaf-blind people in Scotland.

I invite committee members to comment on where we go from here. I refer them to the recommendations in paragraph 5 of paper 4. We are not bound by those recommendations and any other suggestions are welcome.

Michael Matheson: Given the response that we have had from the minister about the work that is being done on the possibility of establishing a specialist in-patient service, we should keep a watching brief on the issue and revisit it once that evaluation has been carried out. To judge by the minister's letter, that should be October 2008. We can reconsider the matter then.

Mary Scanlon: That is the option that I prefer for the same reasons. There is no need for us to produce a report, given that a significant body of work is being undertaken in respect of the petition. I support option B, which is to maintain a watching brief.

Dr Simpson: I agree—option B.

Rhoda Grant: There is no need for a formal report as such, but I suggest that we write to the Scottish Government pulling together some of the issues that were raised with us in evidence. It would be useful for us to feed those into the work that is being done.

The Convener: Yes, I am content for us to draft a letter to the minister about the issues that have been raised. We will definitely return to the matter once the evaluation has been done in or around October 2008. That is a commitment.

Helen Eadie: Convener—

The Convener: Rhoda—

Helen Eadie: I am Helen.

The Convener: I know you are; that was just a senior moment. I am allowed one a day. I have had mine, so you can have yours now if you like.

Helen Eadie: I do not disagree with anything that has been said, but will we send copies of the *Official Report* for both weeks of evidence to the individuals who lodged the petition?

The Convener: I am content to do that, although I am sure that they are monitoring it. We will close the petition—it does not go back to the Public Petitions Committee because it is live and active with us—and write to the minister with the issues that have been raised in evidence. We will also write to the petitioners undertaking to return to the matter so that they are secure in knowing that it is not just parked and kicked into the long grass.

Thank you very much, committee. That concludes the formal business for today.

Meeting closed at 11:43.

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