HEALTH AND SPORT COMMITTEE

Wednesday 2 December 2009

Session 3

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HEALTH AND SPORT COMMITTEE

31st Meeting 2009, 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)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Jamie McGrigor (Highlands and Islands) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Dr Cliff Barthram (NHS Tayside)
Mr Jim Docherty (NHS Highland)
James Ferguson (Scottish Centre for Telehealth)
Dr Malcolm Gordon (NHS Greater Glasgow and Clyde)
Iain Hunter (Scottish Centre for Telehealth)
Dr Catherine Kelly (Scottish Government e-Health Directorate)
Sian Kiely (Royal College of Nursing Scotland)
Dr Alan McDevitt (British Medical Association Scotland)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Wednesday 2 December 2009

[THE CONVENER *opened the meeting at 10:03*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning. I welcome everyone to the 31st meeting of the Health and Sport Committee in 2009. I remind everyone present, including those in the public gallery, to switch off mobile phones and BlackBerrys.

Item 1 on the agenda is to decide whether we take item 6 in private. Are members agreed?

Members *indicated agreement*.

Subordinate Legislation

Food Labelling (Declaration of Allergens) (Scotland) Regulations 2009 (SSI 2009/374)

10:04

The Convener: The next item of business is consideration of three negative instruments. Members have a copy of all the instruments before them, as well as a note from the clerk.

The first instrument amends further the Food Labelling Regulations 1996 to bring Scots law into line with European law. The Subordinate Legislation Committee highlighted the fact that it has taken the Scottish Government six months to correct the defect in food labelling law in Scotland, but it was content with ministers' explanation for the delay.

I see that members have no comments. Is the committee content to make no recommendations on the instrument?

Members *indicated agreement*.

National Assistance (Assessment of Resources) Amendment (No 2) (Scotland) Regulations 2009 (SSI 2009/381)

The Convener: The second instrument amends the National Assistance (Assessment of Resources) Regulations 1992, which concern the assessment of a resident's liability to pay for accommodation provided under the Social Work (Scotland) Act 1968. The Subordinate Legislation Committee had no comments to make on the instrument.

I see that members have no comments. Is the committee content to make no recommendations on the instrument?

Members *indicated agreement*.

Public Health etc (Scotland) Act 2008 (Sunbed) Regulations 2009 (SSI 2009/388)

The Convener: The third instrument makes provision under part 8 of the Public Health etc (Scotland) Act 2008 in relation to the regulation of provision of sunbeds in Scotland. Members may recall that we took evidence on the matter.

The Subordinate Legislation Committee raised two questions with the Scottish Government on the instrument. First, it sought an explanation as to the Government's powers to make the instrument before the relevant sections of the 2008 act were brought into force. Secondly, it sought an explanation for the three-month delay between the notification of the draft regulations to the European Commission and when the regulations were made. The Subordinate Legislation Committee reports that it was satisfied with the explanation that it received from the Scottish Government to both questions.

I see that members have no comments. Is the committee content to make no recommendations on the instrument?

Members *indicated agreement*.

e-Health Inquiry

10:05

The Convener: Agenda item 3 is our inquiry into the clinical portal programme and the Scottish Centre for Telehealth. The committee will take evidence on the development of the clinical portal project in NHS Scotland and then follow up the evidence session that it held in June 2008 with the Scottish Centre for Telehealth. The evidence-gathering process will conclude next week, when we take evidence from Scottish Government officials. The intention is to follow up any issues that arise via correspondence with the Cabinet Secretary for Health and Wellbeing. Any such correspondence will be published on our website.

We start with a round-table evidence session on the development of the clinical portal project, which is designed to allow clinicians to access electronically patient information from a variety of medical databases. This is the first time that the committee has examined the project.

I thank our witnesses for their attendance. I will invite them to introduce themselves—thankfully, members of the committee do not need to do so—and we will then launch into questions. The witnesses should indicate to me if they want to answer a question; I will take those who do so in order. Round-table sessions are mainly used for witnesses to interact and inform us with minimal interruptions, although committee members are, of course, welcome to ask further questions. Such sessions are not like those in which witnesses sit in front of us and we ask them questions.

Will the witnesses now introduce themselves?

Dr Cliff Barthram (NHS Tayside): I am a consultant anaesthetist and one of the two joint e-health clinical leads in NHS Tayside. The other e-health lead is a general practitioner.

Dr Malcolm Gordon (NHS Greater Glasgow and Clyde): I work for NHS Greater Glasgow and Clyde as an emergency medical consultant in the accident and emergency department of the Southern general hospital. I am also one of the health board’s clinical e-health leads.

Dr Catherine Kelly (Scottish Government e-Health Directorate): I am a consultant in the high-dependency unit at Edinburgh royal infirmary and a part-time Scottish Government e-health clinical lead for secondary care.

Mr Jim Docherty (NHS Highland): I am a consultant colorectal surgeon and clinical lead for e-health in NHS Highland. I am also co-chair of the clinical change leadership group.

Dr Alan McDevitt (British Medical Association Scotland): I am a GP in Clydebank and chair of the primary care information technology committee in Glasgow. I am here to represent the British Medical Association.

Sian Kiely (Royal College of Nursing Scotland): I am knowledge and research manager at the Royal College of Nursing Scotland. I am here to give evidence on behalf of nurses, midwives and allied health professionals as part of the e-health leads network.

The Convener: I thank the witnesses for the papers that they have provided to the committee, which are helpful.

For anyone outside Parliament who has tuned in and is desperate to hear the meeting, will you explain in language that they will perhaps understand what clinical portal technology is?

Mary Scanlon (Highlands and Islands) (Con): May I ask you a question, convener?

The Convener: Yes, if you want to. I was trying to start the discussion.

Mary Scanlon: I was not going to say anything before the eminent people in front of us did, but I want to be sure about something. Most, if not all, of the papers mention telehealth and telemedicine. Will we talk about only the clinical portal project today or will we stray into other areas?

The Convener: We will do both. I hope that we will clarify what the different terms mean.

Mary Scanlon: That is fine.

The Convener: The papers tried to tease out matters for us. Language gets intermingled and things get difficult, but I hope that the public as well as committee members will begin to understand the terms.

I asked the witnesses to define what clinical portal technology is. That question will help to start the discussion.

Dr Barthram: A clinical portal is a system that sits above several other systems. We have many systems, which all have bits of the electronic patient record, but no system has the complete picture. The clinical portal sits above those systems and knows which ones hold parts of the clinical record for any patient. It can interrogate the systems and then present the information that it gets from them as if it were a single electronic patient record. The clinical portal is therefore a virtual electronic patient record that takes its feed from many different clinical systems.

The Convener: Is that a particular computer programme that is designed to do that?

Dr Barthram: Yes. It is a computer application.

Dr Kelly: We need to get away from thinking that the clinical portal is a single IT system that we can procure and that everyone will then implement. As Cliff Barthram described, the mechanism for delivering information can be developed in a number of ways. Health boards have several different options for delivering information using clinical portal technology, but each board will have the opportunity to deliver that in a way that suits its own purposes.

The Convener: I see. I could not therefore just buy a programme off the shelf and put it into my computer to extract the required information.

Dr Barthram: A clinical portal is not just a static view or window into the information in various systems. Portal technology will also allow us to move into the system and interact with it without having to reselect a patient. It is a sort of seamless integration with the underlying feeding systems and is not just a view—I have heard it described as a view and do.

Dr Gordon: As Dr Kelly pointed out, the clinical portal is not just a single piece of software; it is more a methodology of looking at information. It works only if the underlying feeds for the data are indexed correctly and have what are called metadata attached to them, which tell us what type of information it is and how it fits into our index. Without that, whatever technical solution we purchase to provide a portal view will not function.

Dr McDevitt: I know less about the technology. However, from a GP's perspective, when I come in in the morning, I switch on my computer—

The Convener: I am beginning to like your language. I was getting lost as well. I like the bits beginning with switching on the computer—that is a start.

Dr McDevitt: I just switch on the system that I use to look at my patient records. At the moment, that is just my system, and no one else looks at it. In theory, however, I could come in in the morning, switch on the computer and go in through the clinical portal. I would still have my clinical system, and I could type in everything about a patient and look at information that I have added. However, I could also look at, say, Dr Gordon's system if my patient had been to accident and emergency the night before, and I could find out what he had done with the patient. If my patient had been admitted to hospital, I could see that, too. If the system was switched on to let it happen, I could see the patient's hospital appointments, results from their hospital attendance and so on. The portal would therefore allow me to see information that is not in my computer but in someone else's.

The clinical portal should also allow me not to have to remember, say, 40 different passwords. The national health service has many different types of system, but I would be allowed to look at all the information that I am allowed to look at through that one switch-on in the morning. That is how I would view the portal.

A lot of technology underlies the way in which the different systems let each other see the information, which is quite complex and not a mean undertaking. However, as I said, the clinical portal facilitates my seeing information that I need to see about an individual patient. We must also agree what information we will share among different systems.

Sian Kiely: A further example of what the clinical portal could mean is that nurses will be able to access a range of information that is currently not available in electronic form. A district nurse will be able to look at, for example, a patient’s discharge letter or their medication history. For people in an acute setting, the nurse will be able to look at a range of information and make much easier and better decisions for patients. It will also enable a much clearer understanding for the patient care that nurses, allied health professionals and midwives can deliver.

Dr Gordon: It is important to point out that that information is not freely available to anybody; it involves controlled access by authorised users only. There is an audit trail of who has looked at what, down to the level of individual items of information. For example, if Dr McDevitt looked at a letter from the A and E department for a patient who had been there the day before, it would be logged on the system that he had done that, even if he did not add anything to the system at that point.

The Convener: Do committee members have any questions?

10:15

Rhoda Grant (Highlands and Islands) (Lab): I am having difficulty getting my head around what you are saying—the system sounds like a huge Google for health records. According to the information that we have, the GP record to which Dr McDevitt has access is the fullest electronic record that is available. Can someone in A and E change and update the GP record? Will the GP record eventually become the main record, which people can update from wherever they are, or will the system be for people to update a record that is viewed by the GP but is not part of the GP record?

Dr McDevitt: There is no intention to allow anyone other than the GP to update the GP record. Most clinicians would not want someone else to change their record, as it is important that the clinician who creates the record is responsible for its content and able to justify what is there. At present, it is not intended that people should be able to change the information that is on someone else’s system. The portal is more about how we share what we create. Each clinician creates their own record but allows other people to see that record when it is relevant and they are authorised to do so.

Mr Docherty: As Dr McDevitt said, clinicians must be authorised to see records. Let us take the example of a stroke patient. As a colorectal surgeon, I would see a summary of the patient’s stroke episode. However, if I were the stroke physician, I would be able not only to see that record but to access the stroke system and make changes to that. As a colorectal surgeon, I would not have access to that system. People are responsible for the data on the system. As Dr Gordon commented, everything must be authorised. As a colorectal surgeon, I will be able to look at certain things but not to alter them. If there were a surgical system, I would be able to alter that and there would be a full audit trail.

Dr Kelly: It is clear that clinicians generally do not need or want access to all information that is held on every system—they want a summary of essential information. The national survey that we undertook revealed clearly that it is important to share certain aspects of the GP record, such as drug history, information on allergies and past medical history, but that it is neither relevant nor appropriate for clinicians in secondary care to know everything that has been discussed with a GP. The point of the portal technology is that certain types of information can be presented in a format that can be shared through the portal. It is not necessary to provide access to everything that is held on every database.

Ross Finnie (West of Scotland) (LD): I understand that it may not be necessary for some other person in the health service to see information, but who makes that decision? You cannot decide what information you do not want if you have never seen it.

Dr Kelly: Some of the information that is currently held—for example, on a patient’s psychiatric history, which may include a history of depression—is held confidentially and relates to discussions with the GP. It is relevant for me, as a secondary care clinician, to know that someone has a history of depression and what treatment they are receiving, because that may influence the treatment that I give to them. It is less important for me to have a detailed description, based on someone’s discussions with a psychiatrist or the GP, of why they may be depressed. It is clear from the survey that we carried out that clinicians do not want to be bombarded with lots of information—they want a summary of information that is essential for them. There are certain key elements that are critical to making safe clinical decisions.

Ross Finnie: You have indicated why you do not want the information, but you have not answered my question. Who takes it on themselves to look at the record, to decide what information you will not want—without necessarily asking you—and to provide a summary?

Dr Kelly: The survey that we carried out identified core pieces of information that clinicians across Scotland said are important to them. That is the information that we want to concentrate on delivering in the first phase of the portal.

It is a joint decision among clinicians in secondary care, primary care and the nursing and midwife community as to what information they feel it is appropriate to share. That is determined in conjunction with the clinical change leadership group, and it goes out to wider consultation with other clinicians across Scotland.

Dr Barthram: We dealt with the question of who gets access to what information about 18 months ago in NHS Tayside. We have an information governance group, which has representation from among GPs, allied health professionals, IT security people, secondary care clinicians, managers and, most important, patients. All those people are stakeholders in the information. Questions of what information it is appropriate to share and to allow to flow are decided by that group. Then, we have to communicate the decision to clinicians and make it happen in practice.

That is how we have approached the issue, and that is probably the model that we should adopt, scaled up, across NHS Scotland if we are to make portal technology work right across the patch.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have a point on the same topic.

The Convener: We will hear from Dr McDevitt first—and Ian McKee is ahead of you.

Dr Simpson: That is fine.

Dr McDevitt: In an ideal world, the patient would decide exactly what information is shared. We are constrained only because that would be time consuming and technically challenging. As it is, the rest of us have to come up with the best option. Discussions on the issue have been going on for some time in both England and Scotland in relation to emergency care summaries. We have been cautious in Scotland about the nature of the information that is shared and how it is shared. There are divergences of view even in that, and the issue has challenged us at times.

Most people would make certain assumptions, for example that sexual health history is generally sensitive and should not be widely shared. There are often issues around mental health that many people would rather not share widely, and there are some restrictions in that. However, we all know that even a medication record can give information about sexual and psychiatric history. Many GPs are anxious about sharing information that we have gathered in the past, bearing in mind that there has been a certain assumption of confidentiality with patients and of keeping information that has been recorded between ourselves. If either the clinician or the patient were aware that everyone in a hospital could see that information once the patient was admitted, they might be concerned.

There are a lot of historical data, but we are more aware of the issue now when we record things—we can separate out sensitive information from less sensitive information. There are anxieties about historical data, and GPs are particularly exercised about ensuring that only the correctly authorised person looks at the information and that they see only the relevant share of the information that is on our systems. In future, we should be more careful with our patients about what we record and how we record it.

We must have a compromise in the meantime, and patients need to be engaged in the discussion. I believe that the information governance systems that Cliff Barthram has described represent the exact approach that we require. Patients must have their say on the compromise that we are coming towards on the sharing of information.

Ian McKee (Lothians) (SNP): I am interested in what I would call the electronic footprint of the patient. The information might not be desperately confidential, but it might reveal something. For example, somebody may be concerned about a sexually transmitted disease but not want to go to their GP. If a consultant does a haemoglobin or other test, the laboratory results will be recorded, and if the GP looks to see what tests have been done on the patient and finds that someone who is not him—or her—has done a haemoglobin test, they will find out where their patient has been. There might be other similar circumstances in which some fairly innocent information will show what someone has been doing.

Another question relating to patient confidentiality is about the recording of who has looked at certain notes. Is there some overall scrutiny technology that can issue an alert when someone has looked at notes—for example, the medical records of a celebrity—that they are not entitled to read? It is all very well for such information to be revealed in the knowledge but, unless someone knows how to look for that knowledge, the details will be buried.

The Convener: As well as those two questions, it might be helpful if I gathered up Dr Simpson's questions before I ask the witnesses to respond. We will then hear from Ms Kiely, Dr Gordon, Mr Docherty and Dr Barthram—in that order.

Dr Simpson: As a clinician, I experienced the problem at the other end when we tried to get shared information from social work and voluntary organisations that were pertinent to the patient's care. We ended up with a 75-page protocol document, which was being discussed when I left. If such protocols are being reinvented across every health board, is that the most efficient way to go about things? Should we not have some nationally agreed protocols? I entirely accept we should not go down the route of having a national spine, as has happened in England. I like the concept of a portal that can interrogate individual systems, and I like the idea of patient control.

Why has the portal taken so long to develop? After starting things in 2000, we had the electronic clinical communications implementation programme—ECCI—in 2003 and the health strategy in 2004. Do we have any idea when the portals will be up and running and whether they will be compatible with each other? Do we have the structures in place at national level to manage such projects effectively, or are we spending too much time developing them?

The Convener: I will also allow a question from Helen Eadie, who has been waiting quite a while.

Helen Eadie (Dunfermline East) (Lab): My question is on how NHS staff members will access the portal. The BMA Scotland submission expresses concern that the sharing of passwords and user names, which happens to quite an extent within the NHS, could lead to information about patients being shared inappropriately.

The BMA Scotland submission also makes a point about the model that has been developed in England. Does the committee that is developing the portal want to alert us to any lessons that have been learned from what the BMA calls

"the complex English Connecting for Health … model"?

The Convener: I think that Mary Scanlon also has a question. Is it also about confidentiality?

Mary Scanlon: No.

The Convener: That is okay. We will come to Mary Scanlon's question next.

Sian Kiely: The clinical portal technology project should improve the security of patient data because staff will have a single log-on identity rather than multiple log-ons. That should go some way towards removing any reason to share any log-on details.

Access to the data is also role based. For example, nurses would be able to see only the data that help them to care for their patients. We should also record that confidentiality is a fundamental principle of professional practice. Codes of practice, such as the Nursing and Midwifery Council code of conduct and the Health Professions Council code of conduct, require professionals to have regard to principles of patient confidentiality and to ensure that patients are informed about how and why information on them is shared.

Dr Gordon: Perhaps I can quickly answer Dr Simpson's question on whether we are using the portal—the answer is that we are. In NHS Greater Glasgow and Clyde, we currently have 1,300 users logged on per week. Users within the health board areas that have access to our portal access more than 65,000 results and almost 20,000 documents per week.

On confidentiality, it is important to understand that information within the portal is classified at two levels of confidentiality over and above the normal confidentiality at which medical records are held. As was pointed out, information on mental health and on sexually transmitted diseases and similar types of information is classified as highly sensitive so it is even more restricted than general access to the portal records.

Anecdotally, from working in the emergency department, I know that patients regularly express concern that I do not have greater access to their health information immediately. As I have a computer in front of me, they do not understand why I do not have access to information that is held on the GP record. I emphasise the earlier point that we do not want full and complete access to the information; we want summary information from those records. We do not have time to go into the minutiae—we need just a summary.

10:30

The Convener: If an individual patient wanted you to have greater access to their records, and authorised that, could you do it for that one patient?

Dr Gordon: No. At the moment, the only thing that I can get is their medication history, which is restricted to an emergency contact with secondary care. Under the current confidentiality rules, if a patient comes to an out-patient clinic or is admitted as a routine, that information cannot be accessed.

Dr Simpson: Why?

Dr Gordon: Dr McDevitt should perhaps answer that.

Dr McDevitt: That is not currently possible as the technology is not in place. There is the alternative technology of the emergency care summary, which extracts information from GP systems on everyone's records unless they have opted out of it. It allows anyone—usually in emergency care situations—to ask the patient whether they can look at their record and, if so, provides a list, mainly of medication and allergies.

The emergency care summary has been the way in which we have stepped into the sharing of information, and we have cautiously expanded who can see it and what is included in it. Due to the sensitivities that I have already mentioned—the way in which it is recorded in GP systems, and our and our patients' understanding of what will be shared—there are anxieties about expanding the ECS to the clinical summary of what someone has wrong with them.

Mr Docherty: I would like to pick up on a number of points. Dr McKee talked about haemoglobin being checked in a sexual health clinic. There is a national sexual health system. If I turn up at a sexual health clinic, I will be asked my name. Many patients use Joe Bloggs—they do not give their real name. They can give their real name if they want to, but they can say that they do not want their GP informed, and they will be given a unique identifier on the national sexual health system. Their haemoglobin will go to the labs and the results will come back to the local repository, which is the Scottish care information store. The results will be anonymised—no one else will be able to look at them; they will be available only to the sexual health clinic.

Most sexual health clinicians ask patients, "Are you sure you want this to be anonymised, because if you come in tomorrow, another clinician may ask to be able to use the data?" A lot of patients say that they want their GP to be informed—there is less stigma about sexual health disease now. The patient's community health index number will be attached to the information, which will be visible to any authorised clinician.

The issue of audits was also raised. All the current electronic systems are routinely audited. Other products are being piloted. For example, one that is being used in Wales is being piloted in Lothian. We are waiting for some feedback from Wales regarding audits. Auditing is about looking for abnormal behaviour and trying to identify people who are looking at results that they should not be looking at. We are reassured that there are facilities to audit who is accessing electronic records. What we really need is a direct clinical relationship between the clinician and the patient.

The Convener: What do you mean by a direct clinical relationship?

Mr Docherty: If a GP phones me up, says that Donald Duck has these blood results, asks whether they need to send them to me for an opinion, and I look at the patient's blood results on the electronic system and see that they have had an ultrasound scan, I have a direct clinical relationship with that patient. Although I have not physically seen the patient, I have been asked by their GP to get involved. However, if I have no clinical relationship with Sally Duck, and I look up her results because she is my next-door neighbour, that should be picked up, and I should be censured. In future, NHS Scotland must pursue high-profile cases against folk who breach confidentiality. We must be able to catch them and prove that they have done wrong—they have broken all the codes of practice and must be punished. If that were done in high-profile cases, people would stop sharing passwords.

If we have portal technology with a single sign-on, so that I can access all the systems that I need, I will be much more inclined to log off and log back on again when I move to the next ward rather than leave other folk able to access all the systems. Doctors, particularly junior doctors, are much worse at doing that than are nurses and allied health professionals on shared ward computers, but if they had the facility to log on and access all the systems that they were authorised to use, they would be much more inclined to log off again. We would then need to have a walking audit in the hospital, such that, if I were sitting in front of a computer, somebody would ask whether they could check who was logged on to it. If Jim Docherty was not logged on to it, I would be censured.

The Convener: Do your computers not shut down after a short time? Ours do if we leave them.

Mr Docherty: No. The computers in a ward never get time to shut down, because there is usually someone looking over your shoulder asking, "Are you finished with that? Can I get on there?" That is why we need the technology to be able to log people in and out very quickly.

Ian McKee: You have helped greatly with my first point, but I need a bit more convincing—I am sure that you can convince me—about the ability of the software to detect illegitimate use. Suppose that you were in a hospital and you looked up your next-door neighbour's details for your own purposes. How would the computer tell that you did not have lawful access when you would have had it if the patient's GP had telephoned and asked you to look up the data? Is it sophisticated enough to sort that out?

Mr Docherty: I will pass that to Cathy Kelly, because she has more input.

The Convener: That is fine. It will take one off my list.

Dr Kelly: In Wales and NHS Lothian, an automated system is being piloted that can produce exception reports. It is possible to ask it to audit how many times the results of people who are not currently in-patients or out-patients have been accessed. That mechanism reduces the time that is spent manually auditing access to information. For example, if a VIP patient came in, we could find out how many times somebody accessed that person's information and manually see whether they had a relevant clinical relationship with them. Similarly, it would be possible to see whether members of staff with the same postcode as a certain patient were accessing that patient's information. Different types of report can be set up in each organisation, taking away the need to spend hours manually processing information.

Ian McKee: I can understand how that would work if Tiger Woods came into your hospital.

The Convener: I wonder why you picked that name.

Ian McKee: However, it would be more difficult if it was an old friend of a staff member.

Dr Kelly: If somebody is currently not an in-patient or out-patient, there is little reason why a staff member would need to access their clinical record. No system will ever be 100 per cent fail-safe, but we try to put safeguards in place to ensure that any abnormal activity is picked up early and can be followed up manually in a way that allows the limited number of staff who are available to do that using resources appropriately.

Dr Gordon: It would be a mistake to focus entirely on technical solutions to confidentiality. It is more important that we have training and support and ensure that everyone has a username and password. Those need to be obtained immediately prior to somebody commencing work within the NHS and not some time afterwards, which is frequently a problem, because the support mechanisms are unable to cope with the rapidity of changeover, particularly of junior doctors, and the increasing number of locums that we have to use nowadays. We also have to spend more time educating junior and, unfortunately, senior members of staff about their professional responsibilities in relation to confidentiality and computers. Those responsibilities are no different from those that apply to paper records.

With due respect, Dr McKee, there would be nothing to prevent my requesting the notes for my next-door neighbour, if I felt so inclined, and nobody in the hospital would question me—the notes would just arrive in my office. It would be the same for pretty much any member of medical staff in the hospital. I suspect that, if a GP were to phone the hospital and ask for a summary or a record of a patient note, no one would question whether that GP had a right to that information. The number of GPs in a practice is large, and it would be assumed that it was the right GP practice, so the information could be sent there as well.

We cannot assume that our existing systems are completely secure and that we are reducing security. In fact, I support Sian Kiely's view that we are increasing security and making it easier to detect abuses of professional confidentiality.

Dr Barthram: It is important to put the issue in context. With paper notes, there is no audit trail to show who has looked at what. Someone with no relevant clinical relationship with a patient can look at their notes and nothing is left behind to say that that has happened. With an electronic system, there are electronic fingerprints all over what is done. Password sharing is a big problem, as that breaks the audit trail. If someone looks at notes that they should not be looking at but they have borrowed someone else's password, that breaks the security trail and two people are potentially in trouble over the accessing of those records.

Portal technology will have to depend on the identity and access management system that is being rolled out across NHS Scotland at the moment, which creates a single user identity for several systems. In effect, the user gets one username and password. The technology could also use two-factor authentication, by which I mean that it could involve the use of a smart card as well, if that were felt to be appropriate. That would not be done without cost, but the system could cope with that. That would reduce password borrowing. I would like to think that password borrowing would be eliminated, but the pragmatic view is that it may not be.

You must also remember that, in general, clinicians do not borrow passwords because they are bad; they borrow passwords for the reasons that Malcolm Gordon has outlined. Quite often, a locum comes into a hospital to do a couple of shifts at the weekend and they need access to the hospital systems because that is how we order blood tests. If they worked in an intensive care unit, for example, how else would they order the tests that patients needed and how else would they get the test results back if they were sent electronically? Because of the way in which the bureaucracy in the NHS is geared up, it cannot cope with rapidly provisioning people into the system. There is also no system that can quickly de-provision them when their employment is terminated.

The identity and access management system will, therefore, be a key piece of functionality in enabling portal technology to deliver what we need to see to do our job. Role-based access controls will be part of the portal and will be another component of the identity and access management system. There is a huge amount of interdependence between the two and, operating in synergy, they will deliver something quite special.

Dr McDevitt: I agree with a lot of what Dr Gordon and Dr Barthram have said. Predominantly, GPs expect to share information with other professionals rather than take information in, but that is because we have had the luxury of quite good IT systems so far. We need to know who is accessing the systems, but we know that the current methods of doing that are not right. That is probably true even in my practice. At the moment, 24 people can look at my patient records. I do not know why they would all want to look at them; they might be looking at their neighbours' records. They would be sacked if we found them doing that, but it is sometimes hard to detect. That is the situation with only 24 people; in theory, everyone in the NHS in Scotland could look at a patient's file.

The cheapest way of ensuring that all the information is available when anybody wants it is not to have any restrictions, but most of us would find that unacceptable. However, confidentiality costs; it is expensive and time-consuming, and in fact it is a bit of a nuisance to maintain properly an identity and access management system and ensure, for example, that people who leave the organisation do not have passwords or log-ons. However, that is what we need to have.

10:45

I appreciate that this would restrict access, but I would like the system to be accessed only by people who have a legitimate clinical relationship with the patient. It should not be enough for any consultant simply to insist that they should see a patient's file; the patient should have been referred to that consultant, should be on their ward, should be in front of them in some way or should have been the subject of a telephone conversation between the consultant and their GP. As I say, I realise that that would make life difficult, as it would restrict some of the access that people need, but we need to explore what we can do in that respect, because I feel that having a legitimate reason to access a version of a patient's record should be an additional condition.

My technical knowledge of this matter is restricted to what I have learned in discussions with the people who produce the software, but in a model that is being used in Canada there must be a referral to the consultant or clinical team before that clinician can look at the file. Certainly the technology seems to exist, but it would probably make life more difficult and might mean that information was not always available when people needed it. The question is how far we should go in protecting confidentiality and giving clinicians and patients the confidence that the right people are looking for the information at the right time and for legitimate reasons.

Sian Kiely: With regard to securing the best for patient care and taking forward clinical portal technology, I reiterate Dr Gordon's point about training and support. Training helps clinicians to understand and engage with the new technology and ensures that, with issues such as access and signing on, the required professional practice is reinforced.

As has happened in the pilot projects, nurses, allied health professionals, midwives, doctors and other staff need to be kept fully involved and engaged as projects are taken forward. It is important that the wide range of clinicians' views is taken into account; indeed, following on from Dr Barthram's description of the development of the Tayside project, I believe that we need groups of clinicians to get together and discuss how these projects can be developed in particular areas.

It is also important that the new clinical portal programme board, which has just met for the first time, takes all views into account. We have noted the possibility of having a patients' representative on the board and ask that additional representatives from the nursing, midwifery and allied health professions be involved to ensure that the wide range of clinical views in the workforce is taken on board.

The Convener: Did you say that patients were going to be represented on the board?

Sian Kiely: Yes.

Dr Kelly: I point out that a director of nursing from NHS Lothian is a member of the clinical portal programme board, so nurses, midwives and allied health professionals are represented on it.

On Dr Simpson's question about the possibility of having 14 or more different information governance programmes coming up with slightly different outcomes, I should first make the committee aware of the work that is being undertaken at a national level on information governance and information security. Dr Barthram mentioned the identity and access management system, which is critical to the development of the clinical portal programme.

Secondly, a role-based access model is being developed in collaboration with the Welsh informing health care programme, which is somewhat ahead of us in this matter. After a lot of consultation with clinicians and patients, the Welsh have developed a model that we are thinking about adopting in Scotland, and that work is being taken forward by the Scottish Government information governance lead. Moreover, we are auditing IT systems to find out what we actually require and a further assessment of the fair warning system is being piloted in Wales and Lothian.

Finally, the Scottish Government and the NHS National Services Scotland information governance team are looking at providing all clinicians throughout Scotland with better training on information governance techniques and methodology to ensure that more people are aware of information governance as a clinical issue.

As part of the clinical portal programme, we will inform patients. Patients assume that we share more information than we do, but they have a right to know how information is shared. We are probably not very good at telling patients how and in what format information is shared and what might happen to that information subsequently. A wider discussion will take place on information leaflets to make patients aware of the plans for the clinical portal, how their information will be shared, who it will be shared with and when it will be appropriate to ask them for their consent for information to be shared with secondary parties for teaching or research, for example.

Dr Barthram: I return to information governance. Delivering health care by using a system that eliminated trust would be a tall order. An element of trust will always have to exist between health care professionals and patients about how we deliver good practice.

We in Tayside are aware of the sensitivities about primary care data, so we give patients the option to opt out of sharing their GP data by letting their GP know, which allows the GP to set a code in the system that says that the GP information will not go into the clinical portal. It is obvious that opting out has risks for the patient, but they know of those risks.

If the clinician who accesses the portal is not the patient’s GP, we make the clinician declare a reason for access. That self-declared clinical relationship is part of the audit trail. If a GP phoned up to ask to discuss an ultrasound result with Dr Docherty, Dr Docherty could look at the portal and put in the reason why he accessed the result. That would allow him to see the ultrasound report in the context of the rest of the patient’s record and the lab results, rather than to look at a bare report in a radiology system somewhere. Better ways exist of giving the patient a say in the information that is shared. Trust must be in there somewhere, but we must also have sanctions for people who transgress.

Transgressors are a minority—I would not like the committee to get hung up on them. The worst thing that we could do is not implement the proposed system. That would cause far more damage, because we have problems with delivering health care throughout different areas when people do not have complete vision of the electronic patient record and the paper patient record. I would hate the system to be thrown out for being too risky, because not implementing it would be even more risky.

The Convener: That is helpful. Mary Scanlon has been patient; she can ask her questions now.

Mary Scanlon: I have only three questions.

The Convener: I knew that—that is good—but the questions will be in several parts.

Mary Scanlon: It is worth putting it on record that I read all the papers last night, and they were interesting but alarming. One submission says:

> “15% of hospital admissions are complicated by medication errors”.

I was shaken to read that 8 per cent of professionals have access to treatment or care plans—we know that generally as care of the elderly—and that 12 per cent of hospital doctors have access to information about a patient’s current medication. Those figures are the reason why we are sitting round the table today.

I will not go into the nitty-gritty of patient confidentiality, which has been well covered. I read in the evidence that the pilots in NHS Greater Glasgow and Clyde and NHS Tayside deal with different bits and pieces. I have read about all the elements that are essential to the clinical portal. Am I right in saying that, at the end of the two pilots, the best elements of each will be knitted together and will go to the remaining 12 health boards?

I return to Richard Simpson’s question, because it was not fully answered. The clinical portal is more than justified. I would hope that, in a country of 5 million people, we could have one system that was used by GPs and hospital doctors and for social work treatment and care plans. There could also be an emergency record that was used by the Scottish Ambulance Service. I believe that the service does not even—

Dr McDevitt: It does.

Mary Scanlon: Oh—it does now. I was told that that was up for grabs.

Will all the work that is going on with exceptionally eminent people result, in the fullness of time—although sooner rather than later—in one system throughout Scotland and not lots of different and inconsistent systems? When will that happen? That is my first question.

The Convener: I am never disappointed, Mary.

Are we just knitting two systems together? Why do we not have one system throughout Scotland? When will we have one?

Dr Kelly: The answer is that there will not be one single system, as that would not be appropriate. If we tried to have a single electronic patient record, we would run into even more issues about information governance and data sharing, so that is not the plan. The work in Tayside and Glasgow is not a pilot—the health boards in those areas have chosen to do that work to satisfy their business needs, and they will continue to do so. The national clinical portal programme is looking at the lessons from Glasgow and Tayside. It is considering why they have chosen to develop their portals in that specific way. The programme is considering whether we can use that work for other health boards in Scotland.

The likely answer is that it is not as simple as saying that we can knit together the systems and that we should roll out the system to all health boards. However, we are saying that we should not have 14 different versions of the clinical portal. Discovery work, led by a consortium of health boards, is being undertaken to consider the components that we need for our clinical portal to make it work for all health boards. That involves considering the current provision in Scotland to find out what we can reuse and how to maximise the benefits, and what we might need to buy or procure to fill any gaps. We are trying to have as limited a number of types of clinical portal as possible. Ideally, there would be no more than three. It is likely that Tayside and Glasgow will continue with their current portal technology for the foreseeable future, but that might not be applicable elsewhere in Scotland.

We are trying to minimise the future number of other portals, ideally to one or, at a maximum, two. In the longer term, perhaps over the next 10 years, it might be possible to have less portal technology and to reduce the number of portals to one or two. However, that is likely to be in the longer term.

Dr Simpson: In the NHS Lothian internal audit report on the e-health strategy, the overall evaluation is unsatisfactory, and for objectives C1 to C3 the rating is unsatisfactory. We are told that the board has purchased

> “an off-the-shelf system called TRAK”.

To follow on from what Mary Scanlon said, Dr Brian Robson, a director for e-health, said in a talk in October 2007 that 15 per cent of hospitalisations are complicated by medication errors; one in seven hospital admissions occurs because care providers do not have access to previous hospital records; and 20 per cent of laboratory tests are requested because the results of previous investigations are not accessible. That could be prevented by rapid development of the clinical portal system, which we have talked about since 2000, and certainly since the e-health strategy in 2004. We have a really serious problem and we need to make progress.

Next week, we will interrogate officials from the Government in detail on the issue, but when a director of clinical information says that we have

> “a jigsaw that doesn’t exist”,

we have a serious problem.

I understand why we have gone down the route that we have gone down, and I support the philosophy behind it—we have not gone for a central spine because of all the major problems that are associated with that approach. Professor Ross Anderson was extremely clear on the issue in an excellent paper in the *British Medical Journal* in 1996, in which he discussed the patient-controlled access that Dr McDevitt mentioned. That is what I want to see. That is fine, but the figures that I quoted show that patient safety is being seriously jeopardised by our failure to make rapid progress.

What I want to find out from the witnesses is whether there is real impotence—[*Laughter.*] I mean impetus, not impotence—we have got that. Is someone supplying the Viagra to get rid of the impotence, because it seems to me that we have sat around for long enough? Given all the confidentiality problems that we have discussed, we need to adopt an approach that does not end up in our having two systems in 10 years’ time, which would be a complete nightmare.

11:00

The Convener: I wonder how the official report will deal with those comments on Viagra and impotence.

Ross Finnie: Accurately—verbatim.

Dr Simpson: I do not mind that malapropism being recorded.

The Convener: For the benefit of those who were not present, we had a discussion before the meeting about what the official report does. The word “verbatim” was mentioned. What was the other expression?

Michael Matheson (Falkirk West) (SNP): Substantially verbatim.

The Convener: I will let Mary Scanlon in again on the same point after we have heard from Rhoda Grant.

Rhoda Grant: I have a short supplementary. I am surprised by the information that Dr Kelly has given us, and I wonder how interactive all the different systems will be. Many people like me live in one part of the country for half the week and in another for the rest of it. People travel around. If I were run over by a bus in Edinburgh, I would want the hospitals in Edinburgh to be able to track down any important information on me that was stored at home.

Mary Scanlon: Richard Simpson summarised my concerns. When Dr Kelly talked about the plethora of systems, the one thing that she did not say was when the patient will have their own electronic record. I would like to know that.

The Convener: I want to take all the questions together. Michael Matheson has the next one.

Michael Matheson: Staff training has come up as a key issue for the effectiveness of the system: a computer system can only be as effective as the information that is put into it. I am interested to find out how much training was given to staff in NHS Greater Glasgow and Clyde and NHS Tayside as the portal was being developed. Was training sufficient to ensure that the portal would be used effectively, or have deficiencies been highlighted that have resulted from a lack of training on how to use the system most effectively?

Dr Kelly indicated that it is likely that there will be a number of different portals. I am concerned about a situation that could arise in which a locum works in, say, NHS Greater Glasgow and Clyde on Saturday, NHS Lanarkshire on Sunday and NHS Lothian on Monday. If different systems are operated in all those areas, will that person require to be trained for each of those systems? If that is the case, there will be a lot of pressure on boards to ensure that clinicians are properly trained, which will take up a lot of clinicians' time.

The Convener: We have had questions on a single system and on training for a variety of systems and the difficulties that that would impose on NHS boards and individuals.

Dr Gordon: The interactivity of systems is dictated not by the portal technology but by the underlying systems that feed it and their ability to deliver information that is correctly indexed to information services division standards. We need to put more effort into that. Provided that the data that we want to look at in the portal can be exported from the generating systems with the appropriate indexing information attached to them, it will not really matter what we lay over the top. It will not matter how many systems we have; we will be able to share data effectively across all the systems.

We are still weak, particularly in the acute sector, on ensuring that we think about that when we purchase information technology equipment. We do not necessarily buy systems that can export data so that we can make use of the portal technology. For example, letters and correspondence are among the most effective forms of data that clinicians want to see, and in many health boards, much of that is produced on a word processor. The data are electronic, but they are useless from a portal point of view, because we cannot interrogate them to find out, for example, that the letter on the screen belongs to a particular patient, that it is a particular type of letter with a specific level of sensitivity or whether we have consent to share it.

The Convener: I have not forgotten that Mary Scanlon has more questions to ask. We will hear our medical professionals first and then come back to Mary.

Mr Docherty: Dr Gordon has covered a lot of what I was going to say about the single system and the training that is required.

If you use Google on Internet Explorer, to give an example, the system has to be intuitive. One may never have used a portal before but—as the demonstrations of the systems in NHS Tayside and NHS Greater Glasgow and Clyde have shown—although they can be completely different, they are very intuitive. If you want to look at medications, it does not matter whether “medications” appears in the top right-hand corner or in the bottom left-hand corner: it is still the place in which the medications are listed. It does not matter where clinicians get the information from, but it should be intuitive for them to find where the drugs are or what the medication is—for example, when they click on “recent drugs”, a list of those drugs comes up. It does not matter what the front is; the system should be intuitive for the clinician to use at the end.

Malcolm Gordon's point about standards is important: we are not going down the English route of rip and replace. If we were starting from scratch and setting up a health service today, we would do things completely differently. We have a huge number of laboratory information systems, and, as boards replace out-of-date systems, we are converging towards unanimity throughout Scotland. The most important thing is that we can take the data from the feeder systems and display it on a portal. It really does not matter what the portal looks like, as long as it can display the information in an intuitive way.

Dr Kelly: I think the committee perhaps misinterpreted what I said earlier about the fact that we would eventually move towards one or two systems. That was not to say that nothing is happening in the meantime. The results of the discovery project, which will tell us exactly which components we have for developing clinical portals in other boards, will be available at the end of this year, in the next few weeks. On the basis of that, we will identify the other components that we need, whether that will involve a full procurement or whether we already have access to some of them. That will happen early in 2010.

It is planned that at least two other health boards in addition to Greater Glasgow and Clyde and Tayside will—we hope—begin to implement their own version of a clinical portal during 2010. That does not mean that every single health board will be in a position to do that by the end of 2010, but the plan is to try to move forward quickly, within the next couple of years.

We need to recognise that each health board is in a different state of readiness in relation to implementing a version of the system. Five health boards have recently signed up to implement the patient management system that has recently been procured. They need to consider how they align that system and the clinical portal with resources, and whether they will implement those systems simultaneously, which may be more beneficial to clinicians.

There are on-going discussions that recognise the fact that, as Michael Matheson mentioned, staff move between health boards, so it is important that there is a similar look and feel to the portals, even if the actual technology that is used is different in each board. We are trying to introduce that across all health boards in order to reduce the need for time to be spent on training.

Dr Barthram: In the remit that we gave the developers when we were working on our portal was that, if they came up with something that needed a manual for training, we would not accept it. The system had to be absolutely intuitive: one had to be able to use it without having ever seen it before. That is important in terms of transferable skills, because we have a very mobile junior workforce in the NHS. There is a national standard—the NHS common user interface standard—for how clinical systems should look and behave. Most of the system suppliers are now looking at that in terms of how they build the pages with which clinicians interact. We hope that that will start to eliminate some of the training needs that we had in the past, when lots of systems had different looks, data-entry screens and ways of navigating. I think that such differences will start to disappear.

Dr McDevitt: I would like to respond to Dr Simpson's points. IT will not solve all the errors that he mentioned. It will certainly help a lot, but it is about how clinicians use that information and are able to recognise it for what it is. For example, if someone sees a list of the medications that I think someone has been taking, then gives them all to the patient when they go into hospital even though they have not been taking those medications for six months, there is a danger of harm.

There is also a slight danger because, although in some ways the clinical portal is a simple concept—it is nice and clean and tidy because it lets everyone use their favourite system to see what is relevant—the complexity of sharing information is quite technically challenging. For example, when a lab report is transferred from one system to another, it might not go completely. We have seen examples in which the result has come through in one bit but the comment that the patient has got cancer has not travelled. It is quite a challenge to ensure that the technical information that is being seen is correctly presented in such interactions, and to understand the technical background. That partly explains why, although this apparently simple concept should be rolled out straight away, a lot of detailed work has to go into making sure that it is clinically safe before we share the information.

The Convener: I am going to move on to Mary Scanlon's second question.

Mary Scanlon: My third question will be about telehealth; I would like a discussion on that before witnesses leave today.

My second question is about the document "Better Health, Better Care: Action Plan" from 2007. Although it does not mention clinical portals, it does talk about better use of technology. Was a managed knowledge network launched in April 2008 to provide patients and carers with resources to support self-management? Was the integrated national health information and support system launched in April 2009 to signpost access points for people to get support and information to become active partners in their own care? I have not heard about them, but maybe they have happened.

Sian Kiely: The technology that makes clinical portals possible also has an application for patient portals, and some complementary developments are happening at the moment. The knowledge services group in NHS Education for Scotland has been involved in developing a number of patient information portals and is tackling some of the issues to which Mary Scanlon referred so that patients can access information that will help their decision-making. For example, one of the roles of nurses could be in knowledge transfer to enable patients to access suitable information and to help them to make sense of what might now be available to them electronically.

Mary Scanlon: Were you at the launch of the managed knowledge network in April 2008, and are you part of the integrated national health information and support service that was launched in April 2009?

Sian Kiely: No. What I am referring to is—

Mary Scanlon: I appreciate that but I am honestly trying to understand this.

Sian Kiely: I am afraid that I am not able to comment on that.

The Convener: I am sorry; I was slightly distracted when that line of questioning was going on. Mary, maybe those questions would be better put to the civil servants who will come to the committee. From the reactions that we are getting just now, they are probably not questions that can be answered by today's witnesses. They are on the record now and we will ask the officials when they come before the committee.

Mary Scanlon: It is national health information.

My third question is about the move of the Scottish Centre for Telehealth to NHS 24. Are there any comments on that? Will it be helpful? Will it help to roll out telemedicine and telehealth facilities?

Rhoda Grant: Before we leave the subject of the transfer of information, can I ask one more question?

The Convener: Certainly.

Rhoda Grant: I want to ask about the exchange of information, although the point that was made about lab reports has answered part of my question. I visited a GP's surgery where the staff were laboriously typing in lab results that had been printed from a computer somewhere else, which I thought was one way of getting misinformation. Is there a way of transferring that information electronically, as perhaps happens with prescriptions? If there were a computerised system, people could copy and paste the information rather than printing it out and retyping it or scanning it.

11:15

Dr McDevitt: There are systems that can transfer the electronic information, not just a picture of it. At the moment, we tend to scan in a picture of the result, but that does not allow the numbers to be searched for. If we want to search the information, people have to scan in or type in the information from the pictures.

Some areas, however, have been able to transfer the electronic data straight from the lab directly into the patient's file, which allows the general practitioner to see it. Complications arise where there is more than one laboratory, as different places might code information differently. Those coding systems are coming together now, which should make the process easier. Previously, however, it was not easy to ensure that the information that was sent from one end appeared in the right format at the other. That is a problem because, if someone sends me a lab result and it looks different from what I was expecting, there is a risk that I could interpret it wrongly. We have to ensure that that transfer of information is safe. That can happen, and we expect it to happen soon in all areas. Others might be able to tell you about the more technical aspects of the process.

Dr Gordon: Dr McDevitt has said most of what I was going to say. General practices have access to their patients' information on the Scottish care information store, which is a repository of common laboratory results and radiology results. Each health board has at least one store.

The change in culture and way of working to do with portal technology and the use of information technology is partly to do with the fact that we should not copy and paste information from one system to another. If we can view information satisfactorily via the portal, for example, there is no need to copy it elsewhere—if you want the lab results, clicking on the lab result icon should give you the information when you need it.

The Convener: Ross Finnie and Richard Simpson have questions, which they will ask sequentially, after which you may, if you wish, answer Mary Scanlon's question on telehealth. If you feel that you do not want to comment on telehealth, that is fine, because our next panel will deal with that issue.

Ross Finnie: This has been an extraordinarily interesting discussion. Are cost restraints inhibiting the development of the portals across the country? Can you provide information—now or in writing later; I appreciate that the information might not be readily available—about the cost of developing the portals in Greater Glasgow and Clyde and Tayside? That would enable the committee to form a view about the overall cost of developing the portals, given that the initiative is not going to be rolled out but will involve work being done by elements within health boards. Once we have an idea of the overall cost, we will be able to take a view on the suggestion that it will take 10 years to implement the initiative across the country. Mary Scanlon and Richard Simpson both recoiled immediately at the suggestion that another decade might pass before we move into the 21st century.

Dr Simpson: Dr Gordon's opening remarks are fundamental. We have developed a system in which everyone has been doing their own thing and has their own pieces of software at local level. Although the systems are being merged and there are now some national guidelines, we have a long way to go before the old systems are no longer in place.

There are two parts to my question—I admire Mary Scanlon and try to follow her example whenever possible.

The Convener: It is infectious.

Dr Simpson: The general practice administration system for Scotland—GPASS—is, in effect, being dumped after 25 years, and we are going to have EMIS and Vision. I understand that those systems have extremely clunky back ends.

Ross Finnie: That is a technical term.

Dr Simpson: It is very technical. Will those systems be capable of being interrogated by the existing portals in Greater Glasgow and Clyde and Tayside?

Secondly, I understand that the Scottish care information store, which is one of the successes of the system, displays information in different fields in different areas of the country, so we do not have consistency. Who is driving co-ordination and ensuring that, when NHS Fife purchases a new system, we do not just think about what is going to happen but that it actually fits in with what we are developing, so that we do not acquire more systems that will become redundant because they cannot be interrogated?

The Convener: I ask you to respond to the question about funding and the technical question about clunky back ends. Who is driving the work so that we do not continue to have clunky back ends? I think that that is where Dr Simpson was going.

Dr Barthram: On the costs, my financial colleagues have been struggling to tease out the costs of the portal for us in Tayside because it has been part of our e-health strategy for so long. The bottom line is that I cannot give you a figure because it has been an incremental process and the cost has been low. We did not go out and buy portal technology. We did the work as a collaborative development with In Practice Systems Ltd, and it delivered what we need. I am sorry that that is probably an unsatisfactory answer.

On the back-end clunkiness of GP systems, we had a minor crisis in Tayside in 2005 because the GPs were so dissatisfied with the performance of GPASS that there was a risk that the GPs would splinter into several different groups and go off, under the GP contract, to buy individual systems that they thought were great. At that time, some 75 per cent of practices used GPASS, but we could have been required to support or try to interface with half a dozen different systems. A dialogue took place between secondary care, IT professionals and the GPs to discuss where they were going to go. The GPs were able to come together, and they finally decided that they would move on to the INPS system Vision 3, because it did not have a clunky user interface. They could see that it was much better than GPASS and that it had huge scope for interfacing with the hospital systems.

We do not use SCI store in Tayside. We use Central Vision, which in effect is our shared electronic patient record. In the past, it mainly delivered lab reports and radiology results, and it also does test requesting and various other things, but it has gradually grown to involve documents and other systems. Our portal takes Vision 3 data, so we now have 95 per cent coverage of our population—it might now be even more than that—because the vast majority of our GPs have moved over to Vision 3. We have only two or three EMIS practices and there are no GPASS practices left.

To say that the system has a clunky back end that cannot feed a portal is misleading at best, I am afraid, because our portal works on Vision 3 data.

Dr Kelly: I will back up what Cliff Barthram said. The technical people who have been involved in the clinical portal programme feel that moving to the new GP IT solutions of EMIS and Vision will allow much more flexibility to share information than we have with GPASS and the other GP systems that are in use. Similarly, health boards' moving on to use the new patient management system—Intersystems TrakCare—will make it much easier to share information. Although we plan to implement the portal technology in all health boards in the near future, how that is done and the mechanism through which information will be shared might well change in time.

Initially, most health boards will choose to use SCI store, but in the future SCI store may become less necessary and we may be able to share information more easily through the use of GP IT solutions and patient management systems.

There is clear recognition that we need to keep costs to a minimum. That is why discovery work is under way to look at what exists already and can be reused. We are not saying that we need a new, shiny toy that we can plug in and that will meet all our needs. The clinical portal programme is aware of the need to work more collaboratively across boards. That is new. Traditionally, each e-health department has implemented what was necessary for it. We now have a completely new way of working: we are looking at what is relevant for us across the NHS in Scotland and are learning from one another's experiences. The clinical leads and directors of e-health in health boards are looking collaboratively at what they can learn from one another, the systems that they have and what can be reused, which will keep costs down. We do not want to develop 14 different solutions to the same problem. The more commonality there is, the lower costs will be.

The Convener: You cannot, however, provide us with any figures.

Dr Kelly: The clinical programme board estimate is between £10 million and £15 million.

Dr McDevitt: Unfortunately, I have no information on costs that I can share with the committee. The GPASS system will be respectfully retired in 2012. It has served us and the patients of Scotland well—to say that it has not would be to do it a disservice—but it has had its day. We are moving on to two new systems, EMIS and Vision. The two commercial companies that are responsible for those systems have joined together in partnership to deal with issues of information transfer, to ensure that they can transfer information to our other systems easily. The new systems are much more technically able than GPASS was, although they are also more complex in other ways. We can look forward to that change. It will not make the process any harder—it should make it much easier.

Dr Gordon: Unfortunately, I cannot give you precise figures for costs for NHS Greater Glasgow and Clyde, partly because we have been as opportunistic as possible in how we have developed our portal. Most recently, we have had a big push on and a big improvement in content and usage, by linking portal development to the opening of the new ambulatory care hospitals at the Victoria infirmary and the Stobhill site in Glasgow. Some of the IT that was necessary for those institutions facilitated development of the portal. We were able to offset some information provision against their development.

To answer Mr Finnie's question, we now find that there is a degree of cost inhibition. IT is not cheap, and there is an element of having to invest to save. We anticipate that, if we are allowed to progress our plans to introduce archiving and distributed scanning of documents in the acute sector, in the way that is common in more than 90 per cent of GP practices, we will be able to recoup some of the money that it costs us to store and move around health boards data that are held on paper. That will not be a cheap project to get off the ground, but it will bring savings at the end of the day. At the same time, it will enrich greatly the information that is available to clinicians through the portal.

I agree with Dr McDevitt's comments about GPASS, which has served its time. One of its strengths was the vast number of practices that used the system. In our health board area, about 80 per cent of practices had the same system. That is key when it comes to the costs of IT support and development of information sharing. It will be a bit of a disaster if we get several nice, brand new GP systems that duplicate the same functionality, because that will duplicate the number of interfaces that we have. It will be much better if we have one system.

11:30

The Convener: As a final point, does anyone have any comments to make about the use and development of telehealth? Do not feel obliged to comment.

Dr Gordon: My practice participates in telehealth on a small scale in that we have links with the GP hospital in Campbeltown and a variety of other community hospitals on the west coast of Scotland. The GPs contact us about patients and we can facilitate discussions with those patients by providing access to their X-ray images, for example. The ability of portal technology to provide more information than simply X-ray images—such as background information about those patients—would enhance the consultation process enormously. The portal has a lot to add to the concept of telehealth and telecare.

Mr Docherty: In NHS Highland, telehealth has the potential to have a great impact. We use it to a degree at the moment. The picture archiving and communications system is probably one of the best examples of telehealth that is available in Scotland at the moment. Very few hard copies of X-rays are now printed—they are all digital. If I break my leg in Edinburgh and go back to Inverness for treatment, the folk in Inverness will be able to look at my X-rays there and then. We use PACS extensively for supporting remote and rural surgeons in carrying out cancer surgery. We also have a multidisciplinary meeting on gastrointestinal cancers on a Friday afternoon. Raigmore hospital has been the main site, but the meeting involves clinicians in Wick, Belford hospital, in Fort William, and Stornoway, in the Western Isles. The clinicians all communicate by videoconference, sharing images and pathology. We then design a management plan that we recommend to the local clinicians for when they speak to the patients. That is a good example of telehealth.

Lots of other things have been done through the Scottish Centre for Telehealth that I will not go into just now. It is not really telehealth, but we also use videoconferencing for management meetings. We have an extensive network of videoconferencing in NHS Highland, which is supported by two dedicated videoconferencing advisers. The problem with the idea of extending videoconferencing to video consultations is that that would need to be similarly supported, which is where the Scottish Centre for Telehealth would come in. We need to progress that work to make the different systems compatible.

I should probably declare an interest in that I am from a health board that covers remote and rural areas. We need to get health boards in the central belt to buy into telehealth and videoconferencing. We also need to get the Scottish Government to buy into it and to use the technology in its buildings. I was meant to take part in a videoconference yesterday afternoon with 10 or 12 colleagues in St Andrew’s house. I was staying in Inverness because I had a colonoscopy list in the morning. Lo and behold, the videoconferencing technology failed. If I had been having a videoconference with a clinician in Wick, that would not have happened. We need buy-in from health boards in the central belt, which have less to gain from telehealth. Remote and rural areas have most to gain from it.

The Convener: Was it a technical failure?

Mr Docherty: Yes. The problem is that it is difficult to get hold of someone in St Andrew’s house to fix the connection. I phoned the local bloke in Raigmore hospital and he told me that it was a busy line and that we needed someone in Edinburgh to fix it.

The Convener: That is the story at the Parliament building, too—it is hard to get someone to fix the link.

We are coming towards the end of the session. Mr Docherty, it would be helpful if you could write to us with the examples that you said that you could give us. I hope that that would not be too onerous for you. It would be useful for us to have that information before we have the Government officials before us next week. Perhaps you could tell us about the breakdown at St Andrew’s house and who needs to be called to fix the problem.

That has been an extensive and informative evidence-taking session, as is usual at round-table meetings. I thank you all very much for your time.

11:34

Meeting suspended.

11:45

On resuming—

The Convener: I welcome our second witness panel: Iain Hunter, general manager, and James Ferguson, clinical lead, from the Scottish Centre for Telehealth. Thank you for your written submission. I think that Mr Hunter wants to refer us to paperwork with regard to a matter that was raised earlier.

Iain Hunter (Scottish Centre for Telehealth): Yes. At the end of the previous witness session, Jim Docherty mentioned that he had examples of the use of telehealth. The Scottish Centre for Telehealth has a catalogue of initiatives that are going on now. If you like, I can send your officials a copy of that before the next committee meeting.

The Convener: That would be very helpful. We will circulate it to members before the next meeting. As your written submission is very full and you have been patiently waiting, for which I thank you, we will move straight to questions.

Helen Eadie: Members of the previous Health and Community Care Committee visited the then Western Isles Health Board area a few years ago, and I remember an issue that was raised then. I would like to know how things have moved on and whether improvements have addressed that issue. There was concern about ensuring that, for telehealth consultations, appropriate consultants were available at the other end of the line—for example, in Glasgow or Edinburgh—who would respond timeously to clinicians in places such as the Western Isles when they used the new technology, so that photographs or other images could be beamed down in connection with particular problems that patients presented with. Are you confident that all that is well organised?

James Ferguson (Scottish Centre for Telehealth): We have several on-going projects in the Western Isles, but we certainly do not have national systems set up yet for every specialty. We have moved forward with the ear, nose and throat specialty and speech therapy, which do not involve emergency situations and for which appointments are scheduled on a clinic basis anyway. I suppose the most important project that we are moving forward is the telestroke project. That is being arranged regionally, so that some epilepsy clinics can be supported as well. We are still at the early stages of developing the systems. Much of the work has been about developing the equipment and seeing how it works on a pilot basis, so the work is by no means ubiquitous yet.

Iain Hunter: The vision is that you would be able to sit in the Western Isles and see who is available, where and when. You could therefore route your inquiry to, say, Glasgow or Aberdeen—whichever was appropriate. We are slowly leading towards the use of technology that will identify not just what equipment is available and where, but who is available and what skills that person has. However, that is some time off.

Helen Eadie: I just clarify that the issue in the Western Isles was not with the technology, which was spot on and bang up to date, but with the personnel at the other end of the line. That problem was identified four years ago; I am just concerned to know whether it is an on-going issue.

James Ferguson: In which specialty or particular clinical application was that the problem?

Helen Eadie: I do not know. The issue was raised by the consultants who showed us round the fabulous hospital that had been built in the Western Isles and all the tremendous new technology there. They said that, across the board, the problem appeared to be that they did not have the consultants at the other end when they needed them. That is a scheduling issue, and if patients present with an emergency it becomes a problem. However, I presume that, given the number of hospitals across Scotland and the number of consultants who are on call, it should not be beyond the wit of man or woman to organise a system that addresses the issue. That problem was identified four years ago and I am disappointed to learn that it is still on-going.

Iain Hunter: It is interesting that the technology appears in this case to be reliable and robust, but something simple such as the scheduling of available people is not quite there yet.

James Ferguson: It is worth saying that the use of telehealth is not routine among most senior clinicians. One major problem that the SCT is having to address is that telehealth is currently a hobby for the majority of clinicians. A few clinical leads have seen the potential of telehealth and are leading projects, but in no way is it widely used by consultants as part of their daily work. One of our challenges is to ensure that, in future, telehealth delivery of services is routine, with face-to-face delivery the default if telehealth cannot be used, but we are a long way away from that.

Mary Scanlon: I want to look at telehealth for self-management when a patient has a CardioPod, which is used in places such as Argyll—I realise that there are many other uses for it, such as for patients with diabetes. I understand that the evaluation of the Argyll pilot study was phenomenal and that the number of emergency admissions of patients using the CardioPod is zero, so there are obviously savings to be gained from the system. There is no doubt about the benefits of the technology, particularly in the Highlands and Islands, which is the area that I represent, but where do we go from the end of the pilot? Let us assume that the system is 100 per cent successful. How can we ensure that appropriate patients throughout Scotland are given access to the technology? There seem to have been some excellent pilots, but when they end people say, “That was wonderful. Cheerio.” Will moving the SCT into NHS 24 be a way of rolling out these excellent, innovative products that are hugely beneficial to patients?

Iain Hunter: I will respond to the question on the move into NHS 24 while James Ferguson contemplates the answers to your other questions.

The move into NHS 24 will be a good move. As you know, we have been based in Aberdeen for some time. We have been hosted by NHS Grampian, but we are perceived as being part of NHS Grampian. One of the barriers that we therefore faced was in trying to roll things out nationally when we were perceived as being something in Aberdeen or the north. The fact that NHS 24 is a national delivery organisation will give us much more strength when it comes to trying to implement things nationally. The SCT was set up not only to try to get a whole load of pilots working in health boards but to look at the provision of national solutions such as the one that we are discussing. We dovetail quite nicely—telehealth started with the telephone, and the NHS 24 service is telephone based. We add something to that organisation’s delivery arm. I believe that the move will be a good one; it will give us a national reach and it is thoroughly in line with the goals of NHS 24.

James Ferguson: I think that Mary Scanlon was saying that, basically, this is about homecare and how we manage long-term conditions. The SCT can have the biggest potential impact in monitoring the care of patients with long-term conditions. The problem that is holding things up is that nearly all the applications have been on a small scale. Although one pilot says that telehealth is 100 per cent successful, others are saying that it has increased clinicians’ workload and that it costs more for little benefit. There has been no one big study into that.

My personal opinion, and the opinion of the SCT, is that the benefits are probably somewhere in between. The companies will claim that there will be big gains, and pure academics will say that there has not been much difference. Telehealth definitely has a big potential application, but the big question is how we embed it into our existing care programmes. In effect, we still work with the idea that if a person is ill, either they will go to a hospital or somebody will come to see them. The issue is not so much with the technology, which works; rather, it is with how systems are set up to maximise potential efficiency savings and the delivery of care to patients.

The biggest thing that we are looking at in Scotland is chronic obstructive pulmonary disease. The SCT conducted a review that showed that some monitoring of pulmonary rehabilitation may be effective. Rather than saying, “Let’s have a big trial and not do anything until that happens,” our approach will be to let things run, but to funnel all the results through the SCT so that we can evaluate them and find common areas and problems that we can address. I hope that we can take a more pragmatic approach to encouraging implementation generally throughout Scotland.

Mary Scanlon: I am trying to understand the process, so can we start again? Let us assume that we have a first-class telehealth system that has been piloted for three years and has led to greater empowerment of patients, better management of conditions, savings to NHS accident and emergency services, and a report that says the pilot has been 100 per cent successful. I am concerned that someone is saying, "That works in Argyll, but it won't work in Edinburgh." As the previous witnesses said, we could have 14 or perhaps 20 or 30 separate telehealth systems running in Scotland. Is there someone in Scotland or in NHS 24 who can say, "That's a wonderful way to manage long-term conditions, from diabetes to asthma and all the rest, so let's roll it out in all the areas of Scotland where people think that using it would be appropriate"? Is such a system in place? If there is, I have not seen it.

James Ferguson: The simple answer is no.

Mary Scanlon: Why not?

James Ferguson: Because the projects are still at the pilot stage.

There is another issue that relates to our previous discussion about e-health. A large amount of the management of patients with chronic conditions depends on people having information about what is normal for them. If you come into my emergency department, how do I know whether your blood pressure of 150 is high or normal for you? COPD in particular is an exemplar. The problem is that the markers for deciding whether you are ill will not work in a national system. If your blood pressure was a bit high, alarms would go off all over the place, people would go to your house, and we would suddenly be spending more money looking after patients. The aim is to have a national system in which parameters will be sent in, a person who is becoming unwell will be highlighted early, and someone will respond. Until we reach that stage, smaller groups or areas will have to build up expertise. At the moment, I find it almost impossible to get health information about any patient who is not based in Grampian.

Mary Scanlon: I am sorry, but if a patient management system works on the Isle of Bute, surely it will work in the Western Isles, Orkney and Shetland and the remote areas of Sutherland. I simply cannot understand why there is pilot after pilot. People will get fed up, think that no progress is being made and go away. I was hoping that you would say that, if we find a first-class system that is hugely beneficial for patient care, we have the methods to move it forward so that patients in Scotland will benefit, but I have heard only what the problems are.

12:00

James Ferguson: The simple answer is that there are systems that can work; the problem is how to implement them within health boards' current systems of delivering care. We can get this or that information, but we must remember that these are only pilots and, when they end, everyone reverts to what they did before.

At the end of the day, we are an advisory group.

Mary Scanlon: Oh dear.

James Ferguson: We can tell you that this or that system works; the question is how it is implemented.

Iain Hunter: As James Ferguson has pointed out, we are only an advisory group. We cannot say, "We have the most wonderful evidence from the Western Isles that this or that system works, so implement it now across Scotland." However, we are in discussions with NHS Quality Improvement Scotland about whether we can drive the use of telehealth by embedding it in clinical standards.

The Convener: I am hearing gasps all around me from committee members.

Rhoda Grant: I share other members' frustration about the time that it is taking for telehealth to be introduced. It seems like it has been around for a very long time, if the number of times that the committee has discussed it is anything to go by. I suppose that whether it works or not all depends on the enthusiasm of individuals.

Unless telehealth becomes part of the training of clinicians and medical professionals—and part of the continuous professional development of existing practitioners—we will not get any further with it. There is mistrust around it, and what we need are enthusiasts to push it forward. Telehealth must be mainstreamed, must form part of training and, perhaps, should be included in guidelines for patient pathways.

Iain Hunter: That has been recognised. For example, the health department's recent review of telehealth and, in particular, the SCT identified the need for improved training and education, and we have been charged with, where possible, working the issue into our discussions with NHS Education for Scotland and academic institutions.

Rhoda Grant: But are the training bodies involved in those discussions? What influence do you have over them?

James Ferguson: I could not agree more with your previous comment. Everyone uses IT in their daily lives, but it has never been included in training. I certainly think that telehealth should be covered at medical school and nursing school level. Although we have interacted with various bodies, including nursing colleges and NES, the issue is still regarded as an add-on when it should be seen as absolutely necessary. We all have to use computers, so why are we not being taught how to deliver telehealth?

The fact is that, at the end of the day, we do not have any teeth; all we can do is say to organisations, “We would like you to do this”. Glasgow Caledonian University and others have bought into the proposal and we are trying to produce teaching materials for them but, as I say, telehealth is still generally regarded in this country as something extra that we do while we are on the hamster wheel trying the best we can to do what we did before.

We are making progress, but it is not happening at the pace that you might want. At the moment, people are not running to us, asking us to set them up with telehealth. We are still knocking on people’s doors and saying, “Why aren’t you doing this? All the evidence shows that it saves money and gives better care.”

The Convener: Your comment that you do not have any teeth is important. We accept that you are an advisory board and that you can offer practical help, but you cannot go in and impose anything.

Dr Simpson: I want to pursue that point, because I think that it is fundamental.

When I visited a brilliant, wonderful community hospital that has just opened in St Andrews, I asked the staff to tell me about their telehealth services and was met with a blank stare. I do not know how many years you have been doing this, Dr Ferguson—I am sure that you will tell us—but there they are, sitting with a minor injuries unit that is still not connected to the Victoria hospital in Kirkcaldy. The situation is totally ridiculous.

Moreover, you say in your submission that

> “Other Boards are committed to follow”

your telestroke programme. I understand that you need to start with pilots—three of them are now operating—but what incentives can we give health boards? Rather than just allowing boards to follow the pilots sometime, how do we make the point that the programme works and that Scotland could have the best telestroke programme in the world tomorrow if the boards would only follow what has been done? I will question Government officials on the matter next week, but I think that we should keep the Scottish Centre for Telehealth with its advisory role—I am not saying that you should run the whole thing; we do not need another board to run everything—and to give you something that allows you to incentivise telehealth, such as a budget. For example, if a telestroke programme for the Forth Valley area costs £1 million, you could put in £500,000 if the health board were to find the rest, which would come back to the health board in the form of savings. That could be the first incentive.

The second incentive should be to require, under the efficiency savings programme, the introduction of telehealth, with boards that do not introduce it being penalised for not introducing those efficiency savings.

Those are just some ideas—some of my ideas are good, and some are not so good.

The Convener: You are giving us lovely evidence—you are quite right.

Dr Simpson: My question to the witnesses is: how would you drive telehealth into the system if you had an untrammelled, unfettered opportunity to do so? That is what Mary Scanlon was asking. How would you drive that approach into the system so that the system adopts the things that work? I am thinking about the A and E project in Aberdeen, which is fantastic, given the number of patient journeys that you have saved. I understand that about 17,000 or so such journeys were saved, as I am sure you will tell us.

James Ferguson: We need to split up the different drivers. Over the past year we have been discussing how to start applying some pressure. Until now, we have been saying, “This is a good idea. Please use it,” but we really want to say, “Guys, you really should be using this.” The next stage is to ask, “If you’re not using it, why not?” Boards could be penalised in some way—there should be at least some way of driving the system forward.

From the clinical point of view, we need guidelines from the Scottish intercollegiate guidelines network and QIS standards. At the moment there is very little in the clinical domain to encourage doctors, particularly secondary care doctors, to adopt telehealth.

We are starting to make inroads. One standard tells people in urology that patients in rural areas should have access to a clinic; telestroke should now be used for clinical guidance; and we hope to include something about COPD in the QIS standards.

We are working away and we are applying some pressure. As individual specialties find that they are struggling to deliver their services in the old, traditional way, they are starting to approach us and listen to us. Ultimately, the requirement to consider telehealth will need to be specified in job plans and in clinicians' contracts, and they will have to show why they are not using it. At the moment, we are trying to prove to clinicians that they should be using telehealth, but they should be required to do so.

Turning to the process with health boards, the health improvement, efficiency, access and treatment targets are useful, but there might need to be more detail. We are supposed to reduce attendances at A and E departments by 10 per cent, although that figure is not specifically stated. Inherent in that target is the fact that it cannot be delivered unless telehealth solutions are adopted. We might need to be much more explicit about how services can be delivered. If a board is seeking additional resource for another two consultants to keep services running on the hamster wheel, perhaps it should be told that it cannot get that money until it has demonstrated that a telehealth solution is not more cost effective and will not provide the same result.

There are lots of different ways to approach the situation. At the moment, we are left saying, "Please come and help us," or, "Please try this."

The Convener: The committee is taking evidence on telehealth because we want to drive things forward. Before we move on, I advise members that it is open to the committee to deal with the matter in a letter to the minister, having heard from officials next week, or in a short report. There is nothing to stop us doing that. The committee can be part of the drive to make progress. We understand that this is not in the SCT's remit, but we could put pressure on officials, the minister and the cabinet secretary to take up some of the ideas that have been aired by Richard Simpson and the witnesses. Telehealth is a good idea, but it often just gets parked.

Dr Simpson: Does the SCT have access to, or any connection with, the change and innovation fund, which I think is now called the health improvement fund? It has been used primarily in relation to waiting times, but it should be about driving innovation, too.

James Ferguson: Several of our projects, for example in teleneurology and ENT, were initially funded with money from the centre for change and innovation.

Although we have a lot of evidence and are still doing development work in some areas, I always thought that the SCT's role would change over time and would move on from dealing with initial pilots that demonstrate the worth of telehealth. We now have lots of evidence that it is cost effective. We may be treating only 40 or 50 patients, but we have managed even with those numbers to find that, once we have treated 30 patients, we save money and provide a better service. Therefore, we want to apply the system to every patient, and it is frustrating that we cannot move forward in that way.

With our move into NHS 24, the SCT is moving into much more of an implementation role; before, we were in an almost research and development, advisory role. Now, we need to move into an implementation phase, particularly on national projects, and we may need some teeth or powers to keep the momentum going.

Ross Finnie: To be blunt, I did not follow the answer to Mary Scanlon's question about the SCT moving in with NHS 24. If the Scottish Centre for Telehealth cannot operate in Aberdeen, God save us. I simply do not accept that the Highlands and Islands and the Borders can forget it unless you operate from the central belt. Should we be saying that the Food Standards Agency is wholly ineffectual because it operates out of Aberdeen, and that Scottish Enterprise's food promotion function, which also operates out of Aberdeen, would be far more effective if it operated out of the central belt? That is just nonsense, so I did not understand that answer. Does that mean that the SCT is simply a nameplate? Have you simply moved to a more convenient and more prestigious location in the central belt, or are you being integrated with parts of NHS 24? If you would just give me a simple answer to that, I will ask about that integration.

Iain Hunter: I cannot answer that because we are in the middle of transition. The first meeting with NHS 24 took place at the beginning of November, and the transition will be complete by 31 March next year, so I have no—

Ross Finnie: Is the purpose only to have a nameplate that avoids the embarrassment of your being in Aberdeen, as you put it?

Iain Hunter: No. I am sorry; I withdraw the comment about Aberdeen. I said that it was a perception.

Ross Finnie: It is a perception that any service might attract, but it is up to the SCT, which operates the service, to operate efficiently and effectively and to get a reputation that makes it clear that the Scottish Centre for Telehealth is a Scottish body. With respect, you should not denigrate Aberdeen for causing a problem that can be caused only by the people who run the centre.

James Ferguson: I am an Aberdonian and I quite like the SCT being in Aberdeen, because it means I am at home. The move is not really about us physically moving to the centre. I think that we have given you the wrong impression. The real advantage of the SCT going into NHS 24 is that we are talking about a national telemedicine system, and any national solutions to telehealth will need some sort of call centre technology to support them.

To be brutally honest, the conclusion of the initial discussions that we had during the Kerr report was that we should have been in NHS 24 and that that was the right place for us to be to deliver telehealth services because we would have been alongside a national telephony system. However, at the time, NHS 24's position was not particularly favourable so, instead, we went to where most of the work was being done, which was Grampian. The time is right for us to move into NHS 24, because it is now moving forward. Some people might say, "That work is being done by Grampian," but I see the move as aligning us with a national organisation.

Ross Finnie: I will get to the more substantial point—I am glad that we have moved away from the frippery. The committee is uncomfortable with your advisory role—that is not because of you but because of the difficulties that that role produces in relation to implementation. We might want to develop that point.

Let us say that we overcome some of those issues. What are the serious synergies between NHS 24 and you? NHS 24 became a huge, empire-building organisation, which is now having to be broken up. For example, the intention is to deliver my out-of-hours care not nationally but locally. Indeed, the way that things were going, I was going to need telehealth because that might have been the only way that I was able to access care—and that is not because NHS Greater Glasgow and Clyde regards Greenock as a remote and rural area.

I am interested in the synergies. You say that it is a telehealth thing. Okay, but that is not quite where it started. There is the question of making use of the technology, and I am interested in your views as to why you are moving and what the synergies are.

12:15

James Ferguson: I have always had a problem with NHS 24 because it uses only the telephone, which is a limited, if useful, technology. I see the SCT moving forward on the remote delivery of care using extended techniques. There are many multimedia systems out there. I have always had a problem with the fact that NHS 24 offers to phone you back. Why not offer to Skype, videocall or text you back? A variety of options should be available. At the moment, someone who calls NHS 24 can speak to a nurse adviser or, perhaps, a GP, be sent to the accident and emergency ward or have an ambulance sent out to them. There have to be other services to which that person can be referred.

We are very much about clinical delivery of services directly to the patient, and the question is how we can enhance that in NHS 24. Whatever happens, we need a national front-line triage service for calls that come through. At the moment, that is split between the Scottish Ambulance Service, NHS 24 and so on. We need a common input that will allow cases to be triaged and moved to the appropriate service, which can, hopefully, be delivered locally.

Ross Finnie: So NHS 24 would develop into an overarching, 24-hour-a-day service, rather than being an out-of-hours service. You had difficulty defining telehealth, telemedicine and so on. NHS 24 started life as an out-of-hours service, but your vision is that it would replace a huge amount of other work, as it would become the major call centre for 24-hour care.

James Ferguson: Absolutely.

Ian McKee: Earlier, Mary Scanlon spoke about the difficulty of getting people to take up advances that are acknowledged and proven. That is something that is well beyond the field that we are talking about. It has always been a problem in the NHS and, probably, in the health services in other countries. As I have said to Iain Hunter before, I was involved in a telehealth scheme years ago that was not taken up. The problem was not that the technology let it down, but that other clinicians simply were not interested and allowed it to wither on the vine.

Do you think that there is a bit of a risk that the perception of your centre—whatever the reality is—is that it is a place where people can park telehealth issues so that they do not have to bother about them? If there are specific problems in an area of the Highlands, for example, it should be the job of the heath board and the clinicians in that area to sort out those problems and to take up a telehealth facility that will help in that regard, if one exists; it should not be up to you to try to persuade them to take it up.

The other side of that coin is that clinicians can work away blithely providing a service that imposes immense strains on the community that they are serving. Often, the community does not complain about that much at all. I have seen people who have to go through enormous difficulties to get to a centre to be seen and often, therefore, refuse to go. A telehealth solution could sort out that situation, but clinicians sometimes seem not to be sensitive to those problems. Perhaps directly elected health boards will make a difference.

Should we, somehow or other, be putting more of an onus on clinicians to solve problems in their areas? That would make you the people who could help clinicians, rather than the people who try to impose technology on them.

James Ferguson: I agree with you 100 per cent. Many of the barriers that we face are around clinician engagement. Some of that is unwitting, as their working pattern has always involved patients coming to them for primary and secondary care and they assume that, because that has been the system for the past 50 years, there must be a benefit to it. Part of the issue is also that some people are not really comfortable with change.

The solution is in how we develop drivers in the NHS to push people forward. In the private health care sector people can be incentivised with the promise of more money, but that is certainly not how things work in secondary care in the NHS, where we are paid to do the job. We have to use drivers such as requiring reduced waiting times or giving people extra resource only if they can demonstrate that they have met targets or standards against which they can be held to account. There are various ways in which we could try to incentivise people, but we are just advisory. The issue is how we get the clinicians around the table. We have tried talking to them and showing them examples. Something that really got me was that, at every meeting on the 18-week target—and we went to all of them—everyone in the room was thinking about doing what they had been doing, but a bit more efficiently. They could have been thinking about doing things a bit differently by delivering some of the initial assessment and care out in the community and then supporting the practitioners in that community by using telehealth, but that is a completely foreign concept to the majority of secondary care providers in the NHS at the moment.

Ian McKee: My question is whether the pressure should come from the Scottish Centre for Telehealth, which should be, if you like, the saviour of practitioners. Should not the pressure come via local health board managers saying that the current situation is unsatisfactory and needs to be sorted out? Hopefully, practitioners would then come to you for solutions and you would not need to sell solutions to them.

Iain Hunter: Absolutely. We hope that we act as a catalyst to inform the debate, but health boards must ultimately take ownership of the situation in which they find themselves by looking for creative ways of redesigning services. I keep saying that we are an advisory body that does not have money to dish out to this or that project. We go out to cajole and persuade health boards of the concepts that we are talking about, which we try to get boards to implement wherever possible.

The Convener: We will take evidence next week from Dr Kevin Woods, Derek Feeley, who is director of health care policy, and Paul Rhodes, who is the e-health programme director. We will be able to raise our concerns about the business of driving change by encouraging NHS boards to be more proactive.

If members do not mind, Helen Eadie’s will be the last question on this item. We will then move on to other business, as we have had quite a long session on this issue.

Helen Eadie: Apropos the point that Ian McKee made, last Wednesday we had a series of events in the Parliament that involved skin care clinicians from all over Scotland. Between 60 and 70 people attended, including Mary Scanlon, Ian McKee and various others. The clinicians said that malignant melanomas, which are the type of cancer that has had the highest increase—42 per cent, I believe—in Scotland and the United Kingdom, are an absolute candidate for a telehealth solution. The problem is that it can take up to 130 days before the patient receives a diagnosis. If the appropriate triage that James Ferguson suggested was available, we could use digital imaging—provided that the consultant was appropriately scheduled at the other end of the camera—to ensure that the patient gets a faster diagnosis. We were told that that would cut the death rate fantastically.

Convener, I hope that our committee might help to drive that issue, given the clear message that we heard from the physicians, professors, specialist nurses and patients last week. Perhaps the witnesses might want to take that away and push for that. Professor Jimmy Ferguson, along with others such as Colin Douglas from the west of Scotland, really hammered that message home to us last week.

James Ferguson: I will speak about teledermatology at the meeting in the Parliament tonight. When I was making up my presentation, I found an old presentation from 2000 that cites evidence that telehealth solutions can reduce attendance by 85 per cent—

The Convener: Did you say 85 per cent?

James Ferguson: Yes, 85 per cent. That evidence has been around for a long time and is also available from Scotland. Teledermatology is perhaps the best example. We know that it works, but we have not implemented it. One could say that part of the reason is technological—we have problems with the infrastructure and so on—but, at the end of the day, the reason is clinician resistance. That is the best evidenced example of telehealth in the world, but we cannot get that system up and running. As far as I am concerned, everyone should be seen initially using a telehealth referral from the GP before we select which patients should come in—

Helen Eadie: I am sorry to interrupt, but the clinicians want it, so it must be the health boards or someone else who is resisting. Certainly, Jimmy Ferguson and all the clinicians at that event were desperate to have the system.

James Ferguson: With a name like Ferguson, obviously he is a good guy, but—

The Convener: Only if he has one s.

Helen Eadie: He is a Jimmy as well.

James Ferguson: Yes.

This is not specifically about dermatologists, but there is an element of people saying, “Yes, that is fantastic, we should be doing that, but I’ll go back to doing what I’m doing just now, thanks very much.” We have tried to facilitate the use of the system, but some clinicians are scared of the technology. If we can reduce referrals by 85 per cent, will we always need as many dermatologists as we need now? Any clinical body that represents clinicians has to please its membership. When we get advice from a dermatology group, a COPD group or whatever, they will always have one eye on what is in it for them. If we are suddenly to change systems, but not to the clinicians’ benefit, I wonder whether there is much incentive for them to do it. There is a lot of rhetoric, but nothing much has happened.

We live in a world in which we are supposed to base everything that we do on evidence. If I had evidence for a drug that could cure or help with a cancer that is at the level that we have in dermatology and I was not using it, I would probably be in court and struck off. We must ask whether going to a dermatologist’s consulting room and seeing them is of such better quality that it justifies waiting 130 days to be seen. How many patients who have cancer get worse in that period of 130 days? At present, nobody seems to address that. The approach seems to be that it is better for people to come and see the dermatologist. That is accepted, but I do not know what the evidence is for it, and I do not think that there is evidence.

Helen Eadie: Consultants are happy with the television system for diagnosis. Dennis Canavan’s son died from a melanoma. Everyone knows about the urgency and that if someone is diagnosed within two weeks that increases their chance of survival. In my opinion, the system is an imperative and it must be driven.

The Convener: We had some provocative comments towards the end. I thank both our witnesses for their evidence. On behalf of the committee, I give an assurance that we will not just watch the pilot succeed and then go away. The committee is determined to make progress on the issue and to bring it to ministers’ attention, either by a report or by an extensive letter. It might very well be a report, given the way things are going.

Petitions

Sleep Apnoea (PE953)

12:27

The Convener: Item 4 on the agenda is consideration of PE953, in the name of Miss Jean Gall, which calls on the Parliament to urge the Scottish Government to increase awareness of the problem of obstructive sleep apnoea and ensure that the health service is properly funded to treat the illness. I refer members to paper HS/S3/09/31/11, which sets out the details of the petition and the actions that the Public Petitions Committee has taken. I declare an interest, in that Miss Gall is a constituent of mine and I have supported her campaign for a considerable period—members will see that the petition has been going since 2006. I have also spoken at meetings of the Scottish Association for Sleep Apnoea.

While members are reading the paper, I shall make my comments. There are several issues that I would like the committee to consider. At the bottom of page 3, in annex A, a letter from the Scottish Government to the Public Petitions Committee states:

> “there is growing concern that driver fatigue plays a role in a significant proportion of road traffic accidents.”

Unfortunately, in many accidents in which there are fatalities, such as when an articulated lorry jackknifes on the motorway, one cannot tell whether the driver fell asleep at the wheel, but there is a growing body of evidence on that.

On page 4, the letter states:

> “The UK Medical Research Council ... Clinical Trials Unit, in collaboration with the Respiratory Trials Unit ... at the Churchill Hospital in Oxford, is currently conducting research relating to sleep disorders”.

I hope that the committee might agree to follow that up and to find out when the research might be concluded.

We are told that

> “The UK Department of Transport has also been conducting research on the potential use of fatigue risk management systems with the aim of developing guidance for those who employ drivers with fatigue-related risk factors.”

That is another interesting issue. The committee might consider asking the Department for Transport when that research will be published.

I also note that the chief scientist office within the Scottish Government would be

> “pleased to consider research proposals for innovative studies on the subject if these were of a sufficiently high standard.”

I am pleased to hear that. I do not know quite how one would go about approaching the chief scientist office about that, but perhaps our putting that on the record might alert somebody to the fact that, if they are pursuing such a project, that might be worth considering.

I would be interested in the committee’s comments. I know too much about the petition and do not want to develop it into a story.

12:30

Helen Eadie: I support the actions that you suggest, convener. I also support the suggestion that we write to the Scottish Government, the Scottish intercollegiate guidelines network and NHS Quality Improvement Scotland, seeking an update on the review of SIGN guideline 73. I cannot remember whether you were a member of the Public Petitions Committee in the first session of the Scottish Parliament, convener, but that committee was presented with the same issue. The issue has been raised over a long period and I am concerned that, after all these years, we do not seem to have made the progress that we should have made. It would be useful to pursue the actions that you suggest.

Ian McKee: I support that completely. That seems reasonable.

Mary Scanlon: I support that, too. I remember speaking on the subject in Kenny Gibson’s member’s business debate in the first session of the Parliament. Very little has been said in Parliament about sleep apnoea since then; therefore, I support Helen Eadie’s proposals.

Dr Simpson: I point out that the intercollegiate guidelines came out in 2003, so the initial actions of the Parliament were not without consequences. There is a pretty heavy work programme of revising the existing guidelines, and I think that SIGN has consulted on whether it is appropriate to update guideline 73. It is reasonable to ask the question, but I do not think that we should press SIGN to change its programme because of the petition.

Ian McKee: No, it is just information gathering.

Dr Simpson: Yes.

The Convener: We are just asking for an update on the review.

Ross Finnie: Paragraph 5 of the clerk’s paper states that SIGN indicated that the review might take place in March 2009. We have gone quite a bit beyond that.

Dr Simpson: The response from the Scottish Government says that there has been consultation on whether there is a need to update SIGN guideline 73. If no new evidence has been produced since 2003—

The Convener: The issue of evidence is crucial, especially regarding road traffic accidents. I recall a recent one in Australia, when an elderly gentleman was driving his family and fell asleep at the wheel for just seconds and crashed into a concrete post, killing the entire family except himself. That is a horrendous life sentence for him.

Ian McKee: The issue is not just traffic accidents. Sleep apnoea poses other health risks.

The Convener: Indeed, but that gives the issue some urgency and extends the perception of it beyond its being simply a medical condition to its being something that causes huge issues in other areas.

Out-of-hours GP Services (Remote and Rural Areas) (PE1272)

The Convener: Item 5 is consideration of PE1272, by Mr Randolph Murray, who has been sitting patiently with his wife throughout our proceedings today. The petition calls on the Parliament to urge the Scottish Government to ensure that there is adequate out-of-hours GP coverage in remote rural areas. I refer the committee to paper HS/S3/09/31/12, which sets out the details of the petition. The petition was first lodged on 7 September 2009; however, as many of us know, the issue has been running within the community for a considerable time.

Ian McKee: It is an important petition on an important topic. We have acknowledged its importance by planning an inquiry into the subject for early in the new year. I do not think that further consideration of the petition is appropriate, as we have agreed to pursue the issues.

Helen Eadie: I agree with Ian McKee. Our visitors in the public gallery will know that the committee very much shares their concerns. They should not think that our closing the petition today means that we will not take any further action on it. We will take action on it and we are very sympathetic to the concerns that they have raised. I hope that they will go away with the clear message that we are supportive of their concerns.

Rhoda Grant: I agree, although we should perhaps make it clear that, even if we close the petition today, it will be fully considered as part of our out-of-hours health care provision inquiry. Closing it is a technical term; we would by no means be ignoring it. We would be taking it forward in another way.

The Convener: Yes. Closed does not mean put on the shelf to gather dust.

Mary Scanlon: I had been going to suggest that we keep the petition open, given that we will have an inquiry. However, we have a significant amount of information here, and we would have to make it clear to the petitioners that if, after our inquiry, they are not satisfied with any of our recommendations, they would be at liberty to submit another petition. The issue has been on the cards for quite a long time. I did not see the point in closing the petition, given that our inquiry will begin in January, but I will go with the flow.

The Convener: Closing it does not mean we are not doing anything; closing it simply means that, because we will deal with it as part of our inquiry, we do not need to keep it open. I believe that Mr Murray has submitted evidence on rural out-of-hours health care provision that will be included in our inquiry, as would any other evidence.

Mary Scanlon: Given that the inquiry is very much based on the concerns raised in the petition, I am happy to go with the rest of the committee.

Helen Eadie: I would like some clarification. Perhaps the clerks could advise us, but my recollection is that once a petition is closed, there is a specified period in which it is not possible for petitioners to come back with another petition. I cannot remember how long that is. There is also the issue of whether the petitioners will receive a copy of our report when it is published. I want to be sure that, if the petitioners are not happy, there is no mechanism to prevent them from bringing the issue back to the Parliament.

The Convener: I cannot give you an off-the-cuff answer about whether there is a time bar about coming back with a further petition. If you want, we can leave the petition technically open, although what we are actually doing is taking it forward into our inquiry. I am relaxed about that.

Helen Eadie: That is helpful. When I was on the Petitions Committee, one of the core principles was that you would always give the petitioners the opportunity to comment on the outcome. If we closed the petition, they would not have the opportunity to do that—that is the difficulty.

The Convener: I am happy with that. Also, I make it plain that the committee will send a copy to the petitioners of any report that comes out of the inquiry. The petitioners are a central part of the inquiry, so it is not as if they or the petition are being sidelined or parked in any fashion.

Dr Simpson: Will we consider first responders in our inquiry?

The Convener: We will come to that in our next item, when we discuss in private our approach to the inquiry. For the benefit of the petitioners I explain that we will go into private session to consider our approach to the rural out-of-hours health care provision inquiry. For example, we will consider which witnesses to call. The evidence that has been submitted is already part of the inquiry. It is normal practice to discuss such matters in private and the committee has agreed to do so. There is nothing untoward about it.

We have agreed to keep the petition open. It is part of our inquiry, which we will discuss in a moment.

12:39

Meeting continued in private until 12:54.

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