HEALTH AND SPORT COMMITTEE

Wednesday 9 December 2009

Session 3

£5.00

Printed and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

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HEALTH AND SPORT COMMITTEE
32nd 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)

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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 GAVE EVIDENCE:

Catherine Clark (Scottish Government Chief Nursing Officer Directorate)
Derek Feeley (Scottish Government Healthcare Policy and Strategy Directorate)
Professor Andrew Morris (University of Dundee)
Paul Rhodes (Scottish Government eHealth Directorate)
Shona Robison (Minister for Public Health and Sport)
Professor Bill Scott (Scottish Government Primary and Community Care Directorate)
Dr Kevin Woods (Scottish Government Director General Health and NHS Scotland)

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Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 9 December 2009

[THE CONVENER *opened the meeting at 10:00*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning and welcome to the 32nd meeting this year of the Health and Sport Committee. I remind everyone to switch off mobile phones and other electronic equipment. Apologies have been received from Ross Finnie.

The first agenda item is to consider whether to take agenda item 5 in private. Do members agree to take that in private?

Members *indicated agreement.*

Subordinate Legislation

Pharmacy Order 2010 (Draft)

10:01

The Convener: Agenda item 2 is subordinate legislation. The draft Pharmacy Order 2010 is going through the Scottish Parliament and the United Kingdom Parliament at the same time. Because of the length of time that the Subordinate Legislation Committee spent considering it, we have only this meeting to consider the motion and to recommend approval, as we must report on the order by 14 December. That means that we must dispose of the order at this meeting.

We will take oral evidence on the draft order. Members have a copy of it and of paper HS/S3/09/32/1, which sets out the errors that the Subordinate Legislation Committee has drawn to our attention. The order makes provision for the establishment of a new general pharmaceutical council and sets out the arrangements for the council's regulation of the professions of pharmacist and pharmacy technician in Great Britain. The order also amends current legislation in respect of the regulation and inspection of registered pharmacies. Those functions are currently undertaken by the Royal Pharmaceutical Society of Great Britain.

The Minister for Public Health and Sport, Shona Robison, is present to give evidence. She is accompanied by Scottish Government officials, who are Catherine Clark, head of the regulatory unit in the chief nursing officer directorate; Professor Bill Scott, the chief pharmaceutical officer; and Kathleen Preston, a health and community care solicitor with the legal directorate. I welcome you all and ask the minister to make any introductory remarks.

The Minister for Public Health and Sport (Shona Robison): The Pharmacy Order 2010 will establish a new general pharmaceutical council as the regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain. It will separate the regulatory function from the professional leadership, which will remain with the Royal Pharmaceutical Society of Great Britain. For pharmacy technicians in Scotland, regulation is devolved, which is why the order has been laid for approval by resolution of the Scottish Parliament as well as both houses of the UK Parliament.

The order is the next step in the implementation of the programme of reform and modernisation of health profession regulation that was set out in the UK Government white paper "Trust, Assurance and Safety—The Regulation of Health

Professionals in the 21st Century". The programme is aimed at improving patient safety and the quality of services that are provided to the public. It addresses the public concern and doubts about the impartiality of regulators of the health care professions that came about as a result of high-profile cases—including that of Harold Shipman—and which threatened to undermine trust in our system of professional regulation.

The separation of professional regulation from professional leadership in pharmacy was signalled by powers that were taken in the Health and Social Care Act 2008. The order will bring pharmacy into line with the other regulated health care professions, whose regulatory bodies are separate from the bodies that represent the professions. The order will remove the conflict of interests that currently faces the RPSGB, which will now be able to focus on promoting and advocating for its professions. The changes will enhance public confidence in the ability of the pharmacy regulator to protect the public and deal with poor professional standards.

The order sets out the key functions of a professional regulator in the 21st century, governance arrangements and the core purpose, which of course is to safeguard patients and the public, particularly those who use the services of registrants. It sets criteria for entry to the register, educational requirements, the standards expected of those registered and the requirement that they continue to demonstrate how they meet the standards through continuing professional development. The order also sets out arrangements for entry to the register for those from the European Union and overseas. Fitness-to-practise procedures are set out alongside appeals and sanctions.

Schedule 5 contains transitional arrangements for the transfer of the regulatory functions from the RPSGB, which will ensure that no current student is disadvantaged, that fitness-to-practise cases already in progress can be completed and that the Transfer of Undertakings (Protection of Employment) Regulations 2006 will apply to affected RPSGB staff.

Before we proceed to discuss the order, members will want to be aware of some amendments that need to be made to the version before them. First, the Subordinate Legislation Committee highlighted the current reference in paragraph 2 of the preamble to

"the Secretary of State and the Scottish Ministers".

That will be replaced with "Her Majesty, with the advice of Her Privy Council", as this is an order in council that is ultimately for the Privy Council, following parliamentary approval. Secondly, the SLC also highlighted references in article 11(2) and 11(3) to article 11(1)(g), both of which are typing errors that need to be changed to refer to article 11(1)(f). Finally, three further small amendments to the order are now required as a result of the Lisbon treaty entering into force on 1 December. References in articles 21(4)(b), 22(2)(b) and 66(2) to "the Treaties" now require to be replaced by references to "the EU Treaties". All those changes will be made before final printing.

I am happy to take any questions on the draft order.

The Convener: Thank you, minister. I remind members that this is an evidence session, so I invite questions from them.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I very much welcome the order, which is clearly another step along the road to improving the safety of the public in respect of professional activities and ensuring that the professions are governed in an appropriate way instead of there being conflicts of interest, as was the case under the previous system.

To get a flavour of how the order will work, I want to know how it will affect a particular problem that we currently face. Currently, the RPSGB issues ethical guidelines to its professional group. Will the new general pharmaceutical council issue those ethical guidelines? I am thinking in particular of the current conflict between community pharmacists and producers—of which I know the minister is well aware—whereby the producers are effectively rationing drugs to community pharmacists because some export drugs in much larger quantities than previously. The ethical guidance basically says that exports should not take place unless it is clear that they do not affect patient care. However, the net result of a few pharmacists undertaking that in a way that the industry regards as inappropriate is that every community pharmacist now spends the latter part of almost every supply month rushing around trying to get the appropriate drugs for their patients.

That is a practical example. I realise that this is quite a technical question, minister, but will the new council have any powers to bring in those pharmacists and say, "What you're doing is actually putting the public at risk"? Ultimately, that whole situation is putting the public at risk.

The Convener: Who wants to answer that?

Professor Bill Scott (Scottish Government Primary and Community Care Directorate): I will take Dr Simpson's question.

The current code of ethics places a duty on pharmacists to endeavour to do their best for patients, which includes getting medicines for them. The new general pharmaceutical council will

publish its code of ethics. When it is seen that a pharmacist is adversely affecting patient care by their activity, they will be investigated.

Dr Simpson: Will the RPSGB continue to do that until the order comes into effect?

Professor Scott: Yes, it will be done through the RPSGB's inspectorate.

Dr Simpson: Will the council's powers be significantly different from those of the RPSGB? In the example that I gave, were someone to be arraigned in front of the council, would they—

Professor Scott: The powers will be transferred to the GPhC, which will determine whether an investigation should take place and what action should be taken against the pharmacist.

Dr Simpson: Finally, what right of appeal would that pharmacist have? Would they appeal to the Health Professions Council generally, or would the appeal mechanism be within the new body?

The Convener: Who will answer that question? You may answer collectively.

Catherine Clark (Scottish Government Chief Nursing Officer Directorate): The appeals mechanism is within the order.

Dr Simpson: And what is that? The order is a long document and I did not get to that point. Would the appeal go to the Health Professions Council, the central body, or would it be retained within the new body?

Catherine Clark: It would be within the new body. The new body will have its own fitness-to-practise investigating committee.

The Convener: Are you content with that answer, Dr Simpson?

Dr Simpson: I am slightly concerned about that. One problem with the GMC has been the fact that a number of cases that it determined—admittedly, before it came under the Health Professions Council—ended up in court and there was criticism of the process in the GMC. There was also criticism of the fact that the appeal mechanism was within the body that made the initial decision. I am slightly concerned that we are replicating that system for pharmacists.

Catherine Clark: Steps are being taken to address that. There will be a new adjudicating body for doctors, in the first instance, and opticians, which will be called the office of the health professionals adjudicator. That will separate the appeals process from the new body.

Dr Simpson: Will that eventually apply to pharmacists as well?

Catherine Clark: That will be considered once we have seen how it is working. The regulation of pharmacists is reserved at the moment. Once we have seen how the office of the health professionals adjudicator is working, the process will apply to other bodies, too.

Dr Simpson: So that is work in progress.

Catherine Clark: I want to clarify one thing. The body that oversees the health professions regulators is the Council for Healthcare Regulatory Excellence, not the Health Professions Council.

Dr Simpson: Sorry.

Catherine Clark: The CHRE will assess how each body is doing, and all the regulators will be called to account each year—there will be an annual assessment of how they are carrying out their duties.

Dr Simpson: Thank you.

Mary Scanlon (Highlands and Islands) (Con): I have a couple of questions on the Executive note. I was surprised to read:

"A recent study found that over 3% of items dispensed in community pharmacy were subject to a dispensing error relating to labelling or content."

Are pharmacies currently regulated or audited? Will that dispensing error rate of 3 per cent be reduced by the order?

Professor Scott: The number of prescriptions that are dispensed in the NHS in Scotland runs to more than 80 million, so 3 per cent is a significant number. However, those errors are picked up before they reach the patients. The premises themselves are regulated and any dispensing error is reported by the pharmaceutical inspectorate to the Royal Pharmaceutical Society of Great Britain. The new GPhC will have the same powers as the RPSGB and the pharmaceutical inspectorate, and it will regulate the premises. We will continue to promote good practice in pharmacies to reduce the number of errors as far as we can.

Mary Scanlon: Sorry, but you have not answered my question. We are told on page 16 of the Executive note, under the heading "Avoidance of serious misconduct incidents", that the errors lead to a reduction in life expectancy and the deaths of 20 patients. I hope that what is before us today will reduce the number of such errors. I am asking for assurance that that will happen, and I do not think that I have quite got that.

Shona Robison: I think that Professor Scott said that it is significant.

Mary Scanlon: It is significant, but I hope that the proposal that is before us today will reduce the number of those errors. I am not sure that I quite got that answer.

Professor Scott: That is something that we continue to work at. The GPhC, as well as the new professional body, will continue to put in place procedures to ensure that we reduce the number of errors to a minimum.

10:15

Mary Scanlon: I will leave that question there.

Page 6 of the same document says:

"The provisions in the Order focus on setting standards so that the public can be clear about what they can expect from the profession and the profession is clear what is expected of it."

Will you explain that to me? I am not sure that the public know what to expect.

Professor Scott: Draft standards have gone out for consultation. It is the intention of the GPhC to ensure that there are good communication strategies and that the public are aware of its function and how they can communicate with it if they are dissatisfied with the pharmaceutical service.

Shona Robison: In other words, it will ensure that the public are aware of how to make a complaint, if they want to.

Mary Scanlon: So the public will be more aware of how to make a complaint—not of what to expect from the service, which is what the explanatory memorandum says.

Shona Robison: It will be both. They will be more aware of what to expect and what to do about it if the standards are not achieved and they are not satisfied with the service.

Mary Scanlon: The memorandum says that they will be told what to expect.

My final question is for the minister. The Subordinate Legislation Committee says that it

"has considered the Scottish Government's proposal for remedying the error and considers that, in the circumstances, a full explanation of the errors and the intention to correct them should be provided to the whole Parliament prior to seeking its approval of the instrument."

What is the minister's response to that recommendation?

Shona Robison: I dealt with the errors in the order in my opening remarks. Whether the Parliament as a whole wants to debate them is a matter for the Parliament. I have come here to ensure that the committee is aware of the errors, most of which are technical; they have no fundamental impact on the order itself.

Mary Scanlon: Convener, it is unusual for the Subordinate Legislation Committee not to expect the subject committee to deal with the matter but to recommend that the whole Parliament deal with it. I wanted a response to that point.

The Convener: You have had that. The minister has put on the record fully how the errors will be remedied. If members of the Parliament are concerned, it is up to them to pay attention—as I am sure they do—to what the committee does.

Ian McKee (Lothians) (SNP): My question follows on from Mary Scanlon's point. The problem that faced the Subordinate Legislation Committee was the fact that one section of workers is covered by reserved powers and another is covered by devolved powers. That creates a problem when it comes to putting legislation right. I can think of one way in which that could be solved, but that is for another occasion. Sir Kenneth Calman has produced a report—which seems as if it might be adopted—that makes recommendations on the matter of reserved and devolved regulatory powers. How would that affect such a situation in the future?

Shona Robison: Calman's recommendation is that all health care regulation be reserved, which would be a retrograde step. It is important that the differences between the health systems be recognised and, in the current arrangements, the views from Scotland on health care regulation be listened to and taken on board. In the work in which we have all been involved through implementing "Trust, Assurance and Safety", it has been important for the Scottish view to be heard.

If all health profession regulation was reserved to Westminster, there would be no statutory role for the Scottish Government at all. Whether we would be listened to would be down to whether the Department of Health was inclined to listen to us, rather than any requirement on it to hear Scotland's views on how regulation may impact on the Scottish health service.

Despite its complexity, the current system works reasonably well. The current vehicle—the order under section 60 of the Health Act 1999—allows both Parliaments a role in the regulation of new professions. That works reasonably well and it would be a retrograde step to change it.

The Convener: As there are no further questions, we move to agenda item 3.

As no member wishes to debate the order, I invite the minister to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the draft Pharmacy Order 2010 be approved.—[*Shona Robison*.]

Motion agreed to.

The Convener: Thank you, minister. We will not have a break because we have just started, but we will pause to allow the witnesses to change.

e-Health Inquiry

10:22

The Convener: Item 4 on the agenda is a follow-up session on the evidence that we took last week on the development of the clinical portal programme in NHS Scotland and the current status of the Scottish Centre for Telehealth.

I welcome the witnesses who are representing the Scottish Government. Dr Kevin Woods is the director general health and chief executive of NHS Scotland; Derek Feeley is director of health care policy and strategy, and director of e-health; Paul Rhodes is the e-health programme director; and Professor Andrew Morris is director of the biomedical research institute at the University of Dundee, and a member of the Scottish Government's e-health strategy board.

I refer members to paper HS/S3/09/32/3, which covers last week's evidence session. I ask members and witnesses to give the meeting some structure by starting with questions on the clinical portal only; we will then move on to questions on the Scottish Centre for Telehealth and telehealth issues. With that in mind, we start with Helen Eadie.

Helen Eadie (Dunfermline East) (Lab): I am interested in the pilot portal and am particularly concerned about the content specification. Where might I find that? Is it published anywhere?

Dr Kevin Woods (Scottish Government Director General Health and NHS Scotland): Are you talking about Tayside and Glasgow?

Helen Eadie: Yes.

Dr Woods: I will invite my colleagues to add a bit in a moment but, if you will permit it, convener, I will make one or two preliminary comments that relate to the question because it is integral to the design that has been applied in those places.

We had three key considerations in mind: first, that we should build on what we have, and the committee will have seen some of that in the evidence that it has taken from Glasgow and Tayside; secondly, that clinicians should be involved and integral to the evolution of the systems; and thirdly, that we must ensure that the confidentiality of patient information is safeguarded at all times. Those considerations have been central to the thinking in Glasgow and Tayside. I invite my colleagues to give you a bit more information on that specific point.

Helen Eadie: Just to clarify, when I asked where it is, I did not mean geographically, but in terms of its progress.

Dr Woods: Where is it in terms of progress?

Helen Eadie: Yes.

Dr Woods: Oh, sorry—I misunderstood.

Helen Eadie: It is obvious where it is geographically; I am asking about where it is in terms of progress.

Dr Woods: I was thinking less in geographical terms and more about where you could access a document. That is what I was referring to.

Helen Eadie: I want to know about the document, but I also want to know where we are in terms of progress.

Dr Woods: We will try to deal with documentation and give a report on progress. I invite my colleagues to comment.

Professor Andrew Morris (University of Dundee): Good morning, it is a pleasure to be here. I understand that the committee heard last week from my colleague Dr Cliff Barthram, the clinical champion of the Tayside portal. Before I define what is in the portal specifically, I will take a moment to discuss the information landscape of the NHS, as that will put the portal in context.

The portal provides a real opportunity to draw information into a single site. We know that there is a high number of heterogeneous data sets in the NHS. Even in Tayside, where we are supposedly well joined up, we have up to 60 clinical systems to serve all the specialty groups. The data are less voluminous than those in other industries, but they are complex in their relationships. As Kevin Woods suggested, there are key issues around governance. The portal gives us the opportunity to pull all the information into a final port of call for clinicians. That does not mean only doctors; it is for all the health care team.

I read the *Official Report* of last week's meeting and found that there was a bit of misunderstanding about what a portal is. Probably the best example is the BBC website, which is a portal that allows people to retrieve information that is relevant to them. Importantly, they can configure the site based on who they are and their information requirements. Our initial work in Tayside is the first step in providing a rich functionality for the entire health care team.

On the content of the Tayside system, we provide information on past medical history, the current problem list, medications, allergies and alerts as well as information that is derived from the care of several long-term conditions such as diabetes, chronic obstructive pulmonary disease, asthma and thyroid disease. We should not see the portal as an end, as it is the beginning. The portal approach allows us to add in an iterative way to enhance functionality.

Helen Eadie: That does not really answer the question. I understand what a portal is—I claim to be one of the most enthusiastic of committee members on information technology and perhaps one of the most conversant technically. That is an assumption I am making, although perhaps wrongly. I want to know what the progress is and when the system will be rolled out across Scotland. Last week, we heard great frustration from everyone concerned that we still seem to be way behind and we are not making progress. The bottom line is that nobody is driving the process enthusiastically. That is what we need.

Dr Woods: Colleagues might be able to give more specific information on numbers of users in each place, which is an indication of the extent of the roll-out. There is great enthusiasm on our part for the portal. We see it as a way of supporting the integration of health care delivery. It brings potential benefits to the quality of clinical care and it is central to the development and implementation of our e-health strategy. I reassure the committee about the centrality of the work to our overall programme on e-health.

Obviously, we must proceed with speed rather than haste, because one important lesson that we have learned on e-health is about the importance of securing and retaining clinical involvement. The clinical portal in Tayside and Glasgow has been a success because that clinical involvement has been achieved. The committee heard from previous witnesses about the arrangements that we have in place to achieve that.

We are very much committed to the portal, although, obviously, there are a number of important governance issues in relation to it. We have to get the confidentiality issues and a number of technical issues right. Nevertheless, we are clear that we want to invest in the portal, subject to rigorous business planning processes at the national and local levels to ensure that we get the very best value for money.

We hope that, following the work in Lothian—the piece of work that we call the discovery project—we will identify the more precise additional investments that we need to make and that, over the next two or three years, all parts of NHS Scotland will be able to embark on the implementation of the portal. I hope that that gives you some reassurance.

10:30

Helen Eadie: Are you saying that, within two to three years, the portal will be rolled out across Scotland?

Dr Woods: We hope that the portal will be in the process of being implemented in all parts of Scotland in that period. The development of the clinical portal does not have a simple start and finish. We can always add functionality to it. As Professor Morris described, we hope that better information systems can be accessed through the portal. To that extent, this is an evolution. Over the next two to three years, we want to make that start throughout the health service in Scotland.

Helen Eadie: You have told me what the timescale is and you have described the portal, but you have still not said whether the content specification is published anywhere.

Paul Rhodes (Scottish Government eHealth Directorate): The clinical change leadership group is discussing how the business specification should be set up. The group is taking material from NHS Tayside and NHS Greater Glasgow and Clyde on how they did it, and it is looking at how NHS Wales has been working in that area. The group will also determine specification issues such as role-based access. As the group produces that advice, it will be cleared by the clinical portal programme board and then published on the website. As the material is finalised and agreed, it will be placed on the website on an on-going basis.

The technical work will follow a similar pattern. There, the discovery project is more influential than the clinical change leadership group because it deals much more with the technical architecture and questions of availability of applications to build the portal.

Helen Eadie: Is there a timescale? How many portals will there be?

Paul Rhodes: The discovery project finishes this month, and we have a two-day session at the Beardmore in January to talk about its results and the implications for the future plan. We would expect agreements on a number of other soft infrastructure elements to come into place over the next six months.

Helen Eadie: How many portals?

Dr Woods: I can comment on that. We are clear that we do not wish to have a proliferation of different types of portal. That is an important point—I know that it has been of concern to the committee. However, we must acknowledge that there is a history of supporting different systems in individual boards. Many of those systems were procured some years ago, when we had trusts in Scotland and individual trusts pursued their own information technology strategy. Since then, especially in recent years, we have been moving to a more co-ordinated and consistent implementation of common IT platforms across the country.

We are clear—and so is the NHS, because we have discussed this with it and it has agreed with

us—that it is in no one's interests to have a proliferation of variants of a clinical portal. However, some variation will be necessary in what sits behind the portal. That is why the work that is under way in NHS Lothian is important, because it will enable us to identify precisely how much variation we need to tolerate in the implementation of the system. That work is not yet complete—it will be completed in the new year—but we are clear that we will not go for a proliferation of portals.

Professor Morris: I will follow up on what Dr Woods said. One cannot procure a portal off the shelf, but the work in Glasgow and Tayside is complementary.

I would argue that we are internationally competitive in this work. The project is ambitious as we are trying to track the journey of care not just in individual institutions but across primary, secondary and tertiary care. Last week, I was in the United States, which does not have many projects of such a scale and ambition across all the domains of care.

The department is being helpful because it is steering a map of convergence of portal activities throughout Scotland. From a Tayside perspective, I think that the work in Glasgow is helpful. Glasgow is majoring on various issues—a great strength is document management—and we will learn from the activity there. Likewise, Tayside is considering more granular information gathering from primary and secondary care, and I hope that colleagues elsewhere—

The Convener: What is granular information? I understand document management.

Professor Morris: I am sorry—I mean detailed information. That is my scientific language coming out.

I think that what Tayside is doing will add value to activities elsewhere in Scotland.

The Convener: I have noted that Richard Simpson, Rhoda Grant and Mary Scanlon want to ask questions. They are parked but noted.

Dr Woods: Professor Morris talked about our ability to implement the portals. It is important that the committee is aware that that rests on something that our predecessors got right—the implementation of the community health index number, which provides a unique patient identifier. Without that, it would be very difficult to develop the systems that we are talking about. It has been a success story. CHI numbers are in widespread clinical use, which gives us an important foundation for the work.

The Convener: Richard Simpson will be happy about that comment.

Dr Simpson: Some of the questions that I planned to ask have been answered. Colleagues are very aware of what is going on in England, which is taking a completely different approach—a centralised approach with a central spine—from the Scottish approach of building from the bottom up and having a portal to read the information that is available on systems, of which Professor Morris said Tayside has 60.

My first question has been partially answered. Will all 14 health boards have commonality in terms of the portal—with minor variations to accommodate the underlying software packages—so that if someone from Inverness goes to accident and emergency in Edinburgh, staff in Edinburgh can open the portal to study that person's information on the software and record packages that are available in Inverness?

The flip-side of that is the question how much work the central driving group is doing to ensure that all packages that are adopted now use a common architecture that will allow a common portal to access them. One problem in the past was that everybody went their own way. A nationally procured program was used in accident and emergency, but some boards were allowed to opt out of it, although some commonality was required. In the long term, we will surely have to bite some bullets.

Some of the software packages for long-term conditions such as diabetes or asthma or COPD have to be pretty much the same otherwise the system will be too cumbersome.

I accept and entirely support the basic philosophy, and I accept that it has caused a time delay. I believe that England is having its own problems, but at least it has a direct purpose. Are we going to get it sorted to ensure that no one will buy new software packages that are going to be incompatible with the common portal in the long term?

Dr Woods: There are a couple of points there on which I shall make one or two comments, and then I will invite my colleagues to add a little bit.

I understand the important point that if people move around to work in different places in NHS Scotland, we want them to feel comfortable using the interface that they find in the different boards. It is integral to the design of all this work that that should be achievable, just as we become used to the software packages that we use on our personal computers. The software will have what I am told is best described as an intuitive feel, and people will be able to find their way around it, even if what sits beneath it might be different because of legacy issues.

Richard Simpson gave a good example in respect of common supporting systems. Another

good example is the picture archiving and communications system, which we have rolled out across Scotland. For those who are not familiar with it, PACS is important in transmission of digital images such as X-rays, scans and so on. It has been a great success.

We are working to procure common systems in two particular areas. The obvious one is the work on the replacement of patient management systems, which are very important for the day-to-day running of hospitals. Our approach to that is designed to achieve precisely what Richard Simpson suggested. Derek Feeley or Paul Rhodes might want to comment further.

Derek Feeley (Scottish Government Healthcare Policy and Strategy Directorate): What we have is joined up at every level. We have agreed the strategy with the boards, and everyone is clear about what we are going to do and when. We have agreed with the boards what the e-health programme is going to fund. As Dr Simpson said, interoperability is fundamental to that—we are not going to fund things that cannot be joined up.

Although an incremental approach almost inevitably leads to having to deal with some of the legacy issues to which Dr Woods referred, we ought to be able to attain a common look and feel. People ought not to feel when they use the system in another health board area that it is alien to them.

The Convener: When did you stop funding systems that will not be compatible with others?

Derek Feeley: We did that when we agreed the strategy.

The Convener: When was that?

Derek Feeley: The strategy period runs from 2008 to 2011.

Dr Simpson: How does that change the ECCI strategy of 2000 and the e-health strategy of 2003? We did not just suddenly land on the planet in 2008.

Derek Feeley: The functions of ECCI have been subsumed within the new arrangements.

The Convener: I am going to have to ask another question. I have asked what “granular” means, so I might as well dig myself further in. What on earth is ECCI?

Dr Simpson: It is the electronic—

The Convener: I want the witnesses to tell me, if they can.

Dr Woods: I was hoping that Dr Simpson might be able to recall the acronym, because I could not. If I remember correctly, it was a pilot project that took place some years ago.

The Convener: I will ask Dr Simpson, in that case.

Dr Simpson: It was the electronic clinical communications implementation.

The Convener: Thank you. You will get an extra pie for that.

Dr Woods: In a sense, some of the thinking behind that is replicated in what we are talking about today. There was a period in the middle of this decade when people thought that there might be a single system that would produce an electronic patient record and that such a thing could be purchased. We looked into that carefully in the e-health strategy board. It became obvious that it was most unlikely that there was such a system that we could procure.

10:45

We had already embarked on the evolutionary approach, with some success. For instance, we had created the Scottish care information store and the emergency care summary. It became clear that the best way to proceed was incrementally, making the best use of what we had and integrating applications. That goes back to some of the ambitions of the ECCI. Of course, we have taken it to a rather more sophisticated level at which much more functionality is available to clinical staff.

Dr Simpson: I hope that we will get the clinical portal, that everything will be compatible and that the software packages that are not compatible will gradually be replaced by ones that are. One major IT-related problem for clinicians over the years has been that we have had paper and electronic records running in parallel. Except in one or two areas that we have heard about—such as digital transmission of images, which has been hugely helpful—there has been duplication, which has made things more, rather than less difficult.

I would also like to know about the ability to make inquiries of the data for audit and research purposes. How will ISD Scotland be able to link into the systems to interrogate them and to extract data for governance purposes? If we get the data linkage right, the potential for us to exploit that commercially is absolutely huge.

Dr Woods: We have a strong track record on which to build. We are one of the few countries in the world that can do the data linkage to which Richard Simpson refers. I return to the point that the community health index number is vital. I defer to my technical colleagues on audit functionality. Mr Rhodes might comment on that.

Paul Rhodes: I will begin by commenting on the first part of the question. ISD was represented on the programme board for the patient management

system that Dr Woods mentioned. It had an opportunity to go through the bids to ensure that its data linkage and transfer requirements could be met by any of the bidders. We will continue to take that approach.

On audit more generally, rather than on providing secondary-use information, several of the more modern systems enable audit. For instance, the emergency care summary has a good audit and logging facility, but that is not so easy with some of the older systems. One solution that we are producing is the identity and access management system, which is currently in testing in NHS Tayside. That product helps in authentication of individuals in relation to their rights to see particular data. It also provides much better audit facilities, so that access to records can be checked. We envisage that all boards should implement that in the next couple of years, as part of the national infrastructure, to improve the audit capability.

Dr Simpson: Within a decade—let us be practical and not too ambitious—will clinicians be able to audit patients more holistically, rather than simply within their own narrow specialty? Might they have information fed back to them if that is appropriate for their clinical management of a patient or group of patients?

Derek Feeley: The simple answer to that is yes. As Dr Woods said in his introductory remarks, we are starting by making the key data available to as many clinicians as possible. However, we will not be finished at that—we will continue to develop the system.

In our third phase, we talk about clinical dashboards, which will provide the functionality that Dr Simpson referred to. They will present for clinicians information that enables them to take a more holistic view. Some of that work is already possible. I am sure that Andrew Morris can talk about it.

Professor Morris: Dr Simpson is absolutely right. The opportunity for Scotland in records linkage for secondary-use purposes—whether it be audit, governance or research—is very exciting. There is a good example of that. Fifteen years ago, Scotland led the way in a clinical trial in the west of Scotland on the role of statin drugs in reducing heart disease. It finished in 1995 and was published in the world's best journal—the *New England Journal of Medicine*. Because it was a very intense study, it cost about £30 million to run, but it showed us that statins are beneficial in reducing heart attacks and strokes. Through Scotland's records-linkage capabilities, the same investigators were able 15 years later, using routine information, anonymously to see what had happened to the patients in the trial. They demonstrated an important public health message—that the benefit of statins was maintained. The second study was possibly the more important. It cost £60,000, which shows how we can derive important information inexpensively—we can get great value for money.

If we can address the ethical anonymisation issues—as we are trying to do—there is huge potential for secondary use of information that has been collected in Scotland. ISD is looking at that. A thing called the Scottish health information service—SHIS—will provide that functionality with good governance based on information that it holds. A consortium of NHS Scotland and universities has been awarded a large grant from the Wellcome Trust and the Medical Research Council because they recognise our potential, which does not yet exist down south. This is a real opportunity, not only for the health of the nation but, potentially, for the wealth of the nation.

Dr Simpson: I think I am right in saying that apart from Western Australia, no other state, country or region has such provision to the extent that we have and are likely to continue to have. Western Australia, however, has big problems with its primary care data because it does not have the sort of system that we have.

Professor Morris: That is correct. Western Australia and some of the Scandinavian countries are on a similar competitive level to us.

Rhoda Grant (Highlands and Islands) (Lab): On patient confidentiality, we were given a fair amount of quite reassuring information last week about the use of individual passwords and how those would be tracked through the system. We also heard about on-going work on programmes that will audit the system and throw up anomalies in order to trace people who look up records when they should not.

Two questions flow from that. First, given the sharing of passwords in the health service, what steps can be taken to ensure that people have one password, and that they use it rigorously and do not leave it open to anyone else to use it? Any tracking system will be wholly dependent on that.

Secondly, the best audit of any system is whether it empowers patients and allows them to view their own notes. A patient would very quickly be able to identify whether someone was accessing their notes who had no right to do so. If they had that kind of access, it would create confidence in the system and empower patients.

Dr Woods: I ask Mr Rhodes to comment on the safeguards that are being built into the design of the systems. We take those issues extremely seriously.

Paul Rhodes: The clinical change leadership group is considering standards in that area—the

committee took evidence from three members of the group last week. The views that you found comforting are the views that are being built into the system design. There is a question here about education. I think that that was also mentioned last week.

An element of trust will be built into the system. How people deal with that and how well they understand the role in which they are placed and the consequences for them of failing to operate as they are meant to operate will be important. The leadership group is giving quite a lot of thought to educating staff about their duties and roles and about the consequences if an audit shows that they are not behaving as they should.

The desire to move in the direction of patient access is long-standing. That will be more technically feasible in the next few years, as the new and more modern systems that we are buying are implemented. Some other jurisdictions are considering using similar tools to those that we are buying and we expect to share experience with them. We are keen to facilitate patient access to some material.

Rhoda Grant: If patients had access, would they be able to monitor who accessed their records?

Derek Feeley: Patients can already ask for information about who has accessed their records, but I suspect that you are looking for something more proactive and straightforward for them to do. We are considering the patient equivalent of the clinical portal—a patient portal. Work in NHS Ayrshire and Arran is going positively and has been well received by patients, who appear to be deriving significant benefits from it.

We will consider whether we can make available to patients through the patient portal a view of who has accessed their records through the clinical portal. We will investigate whether we can link together the portals so that patients can view at any time who has accessed their records. That might or might not be technically feasible, but it is certainly on our agenda.

I reinforce what Mr Rhodes said about confidentiality. We take it incredibly seriously. The identity and access management system work in Tayside to which Paul Rhodes referred is a fundamental bit of the portal. The two aspects sit side by side and interlock: we cannot have one without the other.

Professor Morris: The question is good and the topic is important. It is arguable that we are talking about the programme's most important feature, which we must get right. We have an audit log of access that tells us who accessed a record and when. We audit in order to try to verify a legitimate clinical relationship. If I access an ECS record—I am sorry; I must stop using acronyms. What does ECS stand for again?

Dr Woods: Emergency care summary.

Professor Morris: Well done. If I access a patient's emergency care summary, we can cross-check whether that patient has a record on the patient administration system or the accident and emergency system in the hospital. We use the information that is available to us from multiple systems to define legitimacy of access. If any isolated access points without supporting evidence are identified, that focuses our investigation.

I subscribe to Rhoda Grant's view that the best way to move forward is to create an inventory of access for each patient, which the patient can view. Small international examples of that exist in Denmark and in some US systems—particularly Intermountain Healthcare. We are not there yet in Scotland, but that is the direction of travel that we must take.

Rhoda Grant: It would make a big difference if someone who might view a patient's record wrongly knew that that patient would see their name and that that could land them in a lot of trouble. However, such a system depends wholly on people having and working with their own log-in names and passwords. Otherwise, someone could walk up to a computer that someone else was logged into and look at anybody's record under that other person's name. The person who was logged on to that computer is the one who would be pulled up about it, but they would have no way of proving that it was so-and-so who wandered in from another ward, saw the opportunity and decided to look at their neighbour's records, or whatever. That has to be monitored very carefully, and training, penalties and the like will have to be put in place.

11:00

Dr Woods: We agree with that. One of the advantages of such systems is the electronic footprint, which we do not have at the moment. In a sense, there are some added safeguards in the system.

The Convener: I have a point of clarification about patients' access to their records. I understand absolutely about accessing and being able to see who has looked at a record. I might be wrong about this, but if a patient can access all their records and see everything that is written about them, will that not inhibit what is put on the record? The general practitioner might want to share with someone else a concern about someone's mental wellbeing, for example, but if the patient read that, it might have an adverse impact on them or on the relationship. Do you see what I am getting at? A GP or someone might

want to put on a record something that might have an adverse impact or unintended consequences if the patient saw it.

Professor Morris: You are touching on very important issues relating to clinical practice. The pendulum is shifting towards clinical communication in anticipation that everything will be shared with the patient. For example, in some services, clinical out-patient letters are copied to the patient, and that is probably the direction that we are going in.

The Convener: Therefore what is added to a patient's notes has to be written with the knowledge that, although it might express medical or clinical concerns, the patient might read it.

Professor Morris: I think so.

The Convener: That is important.

Ian McKee: Can I act as a witness, convener?

The Convener: Why not?

Ian McKee: It has been about three and a half years since I was in general practice, but patients have been able to see their records for quite a long time. However, there was always the stipulation that the GP would look through the records first and would be justified in not allowing the patient to see things that would harm the patient or give information about a third party. There might be information in a patient's notes about their husband being unfaithful, for example, and the GP would not really want to pass that on to the patient. I do not see why it should be any different with an electronic system.

The Convener: It was important to clarify that and to put it on the record that there are issues. One wants the GP to be honest when they are writing things down, but I did not appreciate that there was a circumstance in which they might properly edit the notes.

Ian McKee: The GP would have to be able to justify it.

The Convener: Thank you for clarifying that.

Mary Scanlon: I would like to ask a couple of questions about "Better Health, Better Care: Action Plan" that I asked last week but which were not appropriate for that session. The clinical portal is quite new to my knowledge, but I wondered about the intention to

"Launch a Managed Knowledge Network in April 2008 to provide patients and carers with resources to support self management."

Has that been done and does it fit anywhere with the clinical portal?

Secondly, the Government said that it would

"Develop an integrated National Health Information and Support Service by April 2009"

with

"clearly signposted access points where people can get support to find the information they need"

and

"to become an active partner in their own care."

Has that also been done, and are those two projects part of the clinical portal?

Derek Feeley: They have both been done. The first project is about getting information to clinicians and the second is much more about getting information to patients. "Better Health, Better Care" spoke about knowledge management for self-management, but we have decided that it is much better for patients to get all their information from a single place rather than have to go to two places, so the NHS information service, which will be called NHS inform, hosted by NHS 24, is where patients will be able to get all their information about services and information to help them to manage their own care. Although they are not explicitly part of the portal, they are very much linked to it. Information about good clinical practice, for example, will certainly be valuable to clinicians as they use the portal.

Mary Scanlon: Is the

"Managed Knowledge Network … to provide patients and carers with resources to support self management"

that is mentioned in "Better Health, Better Care" the information that will be hosted on NHS 24?

Derek Feeley: Yes.

Mary Scanlon: Was that launched in April 2008?

Derek Feeley: I cannot swear to the date, but it has certainly been launched.

Mary Scanlon: I think that we need more information on those targets, convener. What about the

"integrated National Health Information … Service"

with

"clearly signposted access points"?

Derek Feeley: The development work on that has been launched.

Mary Scanlon: Development work?

Derek Feeley: Yes.

Mary Scanlon: Although the whole thing was supposed to be in place by April 2009, it is still being developed.

Derek Feeley: NHS inform is not yet actively available to patients in its joined-up form. At the moment, they can access all the information that it will carry but only by going to different places.

Mary Scanlon: So there are no "clearly signposted access points" blah-de-blah—they simply do not exist.

Derek Feeley: Not as they will exist when we get NHS inform up and running.

Mary Scanlon: Given that all this was going to exist 18 months ago, then six months ago, I wonder whether the witnesses would mind putting what they have said on paper.

The Convener: What were you quoting from, Mary?

Mary Scanlon: I will tell you exactly what I was quoting. It is a Government target in the section on technology in "Better Health, Better Care".

Last week, I was shocked to discover that, in what is supposed to be Scotland's modern NHS, only 8 per cent of clinicians have access to treatment or care plans and only 12 per cent of hospital doctors and 23 per cent of hospital pharmacists have access to electronic information. I think that I am right in saying that the e-health budget is increasing by £100 million—or as near as. How will that money be spent in the next year? How will it benefit patients and clinicians and how will it ensure that more of those clinicians, doctors and pharmacists get a little bit more information about their patients?

Dr Woods: Your question raises two central points. First, on the development and the functionality of the underlying systems, we obviously continue to support and invest in the pharmacy system, the laboratory system and so on. However, the portal is intended to bring all those systems together, which of course is what we are primarily talking about today.

I am not familiar with the precise numbers that you have referred to or what they relate to, but I am very happy to look into them in rather more detail, if that would be helpful.

The Convener: They are in a written submission from Dr Docherty and Dr Kelly, who gave evidence last week. All the information is in the committee papers.

As we are talking about the clinical portal this morning, I wonder whether I can follow up Helen Eadie's question and ask how the clinical portal will be advanced in the next financial year, given the huge increase in e-health spending. Will that bring things forward faster? Where is the money going?

Dr Woods: I think that it will bring things forward faster. As we have explained, important discovery work is under way in NHS Lothian and we have set up two developmental sites in Tayside and Glasgow. When that discovery work is completed, we will, subject to appropriate business planning and approvals, wish to ensure, over the next two years, that each board is in a position to really get started on implementing the portal. That is where some of the money is going.

Of course, the total e-health budget is not solely devoted to the portal—

Mary Scanlon: I appreciate that.

Dr Woods: It supports a whole range of things. Perhaps Mr Rhodes will elaborate on some of its components.

Mary Scanlon: Will some of that budget be allocated to the advancement of the clinical portal, to bring it together and co-ordinate it?

Dr Woods: Yes. Mr Rhodes can indicate the size of next year's planned spend on that in the context of other items in the overall budget.

Mary Scanlon: In the budget document, it is one line. We do not have a breakdown.

Dr Woods: I appreciate that. We have been asked to give level 4 details, which we have done. Nonetheless, we can help you here today.

The Convener: Focusing on the clinical portal, Mr Rhodes, can you give us an idea of how the money is allocated?

Paul Rhodes: The additional money in the next financial year is largely focused on the completion of the 2008 to 2011 strategy. There are some larger items, such as the signing of the contract for the patient management system—a large investment that is mentioned in the e-health strategy. Beyond that, the largest single item will be clinical portal work. We anticipate that the likely spend next year to take clinical portal work forward will be around £6 million revenue and £2 million capital. The data that the committee were shown by the clinical change leadership group indicated that, although substantial progress has been made with GP IT over the years, joining up systems within the acute sector remains a priority. That is where the clinical portal investment will help us to move forward much more rapidly and, in a similar manner, to help with staff who work in community settings, who have more limited access to some of that information.

The Convener: Just to clarify, the spend for the clinical portal is £2 million capital and £6 million revenue.

Paul Rhodes: Yes, although, as Dr Woods indicated, that is subject to the outcome of the discovery work and the business case. However, that is the anticipated allocation of the money next year.

The Convener: That will be allocated after you have done your discovery work and appraisal.

Paul Rhodes: Yes.

The Convener: When will that be?

Paul Rhodes: We would be looking for a sign-off from the strategy board in about March.

Dr Woods: It is all subject to parliamentary approval.

The Convener: We just want some details—granular information. I like that expression. I think that I will practise it.

Mary Scanlon: My final question again concerns the paper from Dr Docherty and Dr Kelly. They say:

"The most challenging information set to deliver is likely to be the patient health summary."

Why is that so challenging, given that GPs hold 94 per cent of medication and patient information?

Paul Rhodes: Some of the challenges relate to how structured the data are. Data such as medications data are easier because there is a structure to them—in IT terms it is a lot easier to move them about. When data are essentially free text, there is a greater set of technical issues.

Professor Morris: It is important to ensure that the quality of clinical coding is of a very high standard before sharing information. That has been our experience in Tayside. We want to share very accurate information, so our GPs, who have been fantastic in leading that work, have looked at ways of enhancing the quality of the information. We should commend our general practice community for being at the forefront of considering how to share information. However, we do not want to rush into this precipitously; we want to do it in an incremental way that maintains the support primarily of the public but also of the professions.

The Convener: Next up is Ian McKee. We have not moved on to telehealth yet—we are still on portals.

Ian McKee: My ears pricked up when I heard you say that the developments could contribute to Scotland's wealth. A lot of the technology is not very transferable because other countries might not have the same organisation of their material in primary care and so on. However, I would imagine that when what you are doing is more mature, it will be of enormous benefit to people doing research projects in this country, including pharmaceutical companies. No doubt there could be quite a bit of income from that, especially with anonymised data coming later on. Are you planning for that? There will be drawbacks to that activity as well as advantages.

11:15

Dr Woods: I will offer some preliminary comments and Professor Morris can then add a little bit about experience in Dundee.

I return to the point that was made about the value of the information systems that we have and the ability to link them. That ability provides a good platform for the research community in Scotland to be competitive in trying to win research funds, which has been quite important in our thinking about our research strategy as a whole. In recent times, we have created the Scottish academic health sciences collaboration, which brings together the universities with medical schools and the health boards that host those medical schools to work constructively and collaboratively to utilise the capacity and intellectual resources in those institutions. That work is proving to be very beneficial, and it also has potential commercial applications, of course, subject to the appropriate safeguards. Professor Morris is best placed to comment on the developments in that area in Scotland.

Professor Morris: Life sciences, I am told, are one of Scotland's top seven industries.

The Convener: I do not know what we are to read into the phrase "I am told".

Professor Morris: I think that they are.

The Convener: Okay. I thought that that was a caveat.

Professor Morris: No. I am in the sector.

Dr Woods: Professor Morris is being modest.

Professor Morris: They are also a creative rather than a distributive industry, such as banking.

Ian McKee: Banking is quite creative at times. [*Laughter.*]

Professor Morris: That is very good.

To use Dundee as a case study, we estimate that up to 16 per cent of its local economy is driven by the life sciences. We need to replicate that throughout Scotland.

The Scottish academic health sciences collaboration, which Ministers Swinney and Sturgeon officially launched in June, is a significant step forward, because it has brought together into a single entity NHS Scotland and the four clinical medical schools in Edinburgh, Glasgow, Aberdeen and Dundee. If we are to compete internationally, we can leverage opportunities in the life sciences sector only with that critical mass. The research income of the grouping that I mentioned is greater than that of the institutions in Oxford and Cambridge and the individual London institutions. Our chief scientist, Sir John Savill, is successfully leading the programme.

The translational medicine research collaboration with Pfizer—it was with Wyeth, but

Wyeth has been consumed by Pfizer—provides an example of the work that is being done. On Friday, I was in Connecticut to meet the Pfizer board to discuss translational medicine opportunities in Scotland. The company came to Scotland for three reasons: our excellence in biomedical research, with Philip Cohen and Ian Wilmut, and the Edinburgh BioQuarter, for example; the network of clinical research facilities across Scotland and the willingness to present Scotland as a single research site; and, perhaps most important, the fact that the NHS works alongside the universities and our patient population is willing to subscribe to clinical research. That alignment represents an exciting opportunity for Scotland. We have demonstrated value in the TMRC, and we are having similar discussions with other industry partners. Subject to having transparency and good governance, that approach is certainly worth exploring.

The Convener: That is not the purpose of the clinical portal, although it is an interesting by-product. However, I agree with you.

Ian McKee: I totally accept what has been said. However, it strikes me that, when the clinical portal and all the systems that have been talked about have been further developed, Scotland will be a popular place for research. That means that the people of Scotland will have much more research done on them. That is not always entirely beneficial, and there have been examples of populations that have had too many research projects carried out on them. Is that a possibility? Are you planning how to control development in a way that ensures that people do not suffer through the research that is carried out?

Professor Morris: As you are probably aware, clinical trial activity in the UK is haemorrhaging to eastern Europe and south-east Asia. Last year, there was an 11 per cent decrease in trial activity, and that has important implications. Trial participation is voluntary, but I argue that, if we have good information systems, we can be more competitive in running clinical trials efficiently.

Good information systems also allow us to consider safety, particularly drug safety. The number 1 mantra of medicine is, “First, do no harm.” We have a great opportunity to ensure that the therapies that we prescribe do not have unanticipated detrimental effects. There is evidence that people in clinical trials have better long-term outcomes—arguably, because of the placebo effect. In any case, we need an honest discussion about participation in trials. Many individuals in Scotland are very enthusiastic and come back for more and more.

The Convener: Thank you for that interesting line of questions and answers. After questions from Michael Matheson, Helen Eadie and Richard Simpson, I want to move on to discuss telehealth.

Michael Matheson (Falkirk West) (SNP): I will pick up on an issue that I raised with witnesses last week. The value of a good-quality IT system can be undermined if staff are not sufficiently in tune with how to maximise its potential and how to utilise it properly. As you develop the clinical portal and the various IT programmes, what plans are there to ensure that staff are sufficiently proficient in using the system effectively, so that we can gain the maximum potential benefit? What was the experience of staff in Tayside and Glasgow? What were their training requirements for using the clinical portals that are in place there? Have lessons been learned from the experience that has been gained in those areas?

Derek Feeley: One of the strengths of our approach is that it has been clinically led. It is not something that is being done to clinicians; it is being done with them. The role of the clinical change leadership group is important, as is the input from professional bodies and other organisations. If we involve clinicians in the whole design of the system, we are much more likely to secure utilisation downstream than we are if we just land the system on people and say, “There you go. Here’s a new bit of kit. Go on and use it.”

We are conscious of the need for good training to support the implementation of the projects. The degree of utilisation in Glasgow and Tayside has encouraged us to think that the product is fairly straightforward for people to use. To give you a sense of the increase in use, there were about 1,400 views of the clinical data per week when the system started in Glasgow; by August there were 18,000 views of the data a week, and the figure will have gone up further since then. Clinicians seem to use the product and get value from it. I am sure that you heard from Malcolm Gordon and other witnesses last week about how useful it is.

The keys to success are continuing clinical engagement and a continuing focus on the purpose for which the technology is being used—better clinical care—rather than a focus on the technology itself.

Michael Matheson: It was made clear to us in the evidence last week that there will not be a single clinical portal and you have re-emphasised that there will be different systems in different health board areas. One concern is that staff need to be able to use the clinical portal when they transfer between health boards. For example, a locum who is working in NHS Greater Glasgow and Clyde on the Friday may be working in NHS Lanarkshire on the Saturday. It strikes me that a key issue is for them to be able to log into the system. We have already heard from Rhoda Grant about the importance of professionals having a unique log-in identity so that they can get into the system when they need it. How do you overcome

the practical problems of staff transferring at very short notice between different health board areas that may be operating different portal systems and at the same time ensure that the health board's system is able to respond quickly to give the person a unique log-in identity so that we can ensure that the necessary audit trail operates effectively?

Dr Woods: I will invite my colleagues to comment on the latter part of your question, which is to do with the allocation of appropriate authorisation when people move, but I want to be clear that we do not expect there to be a proliferation of portals. We expect there to be some variation, as it were, in the underlying functional content, because of the legacy systems that sit behind the portal, but the whole idea of the portal is that it should be something that people find easy to use. That is the kind of convergence that we are trying to pursue. It is important to get that point across at the outset. If people move from health board A to health board B to fill a locum post and they need access to these systems, the question is how, through the authorisation procedure, people will be given access to that specific clinical portal's data while they are serving that board. Mr Rhodes might wish to comment.

Paul Rhodes: There seem to be two aspects to the issue. One is about training and the other is about the responsiveness of the systems. The growth of use in Glasgow that Mr Feeley talked about shows that the clinical portal there is quite intuitive and, compared with some other types of system, has fewer problems in that regard, although there is anecdotal evidence from NHS Greater Glasgow and Clyde that more training effort would be helpful because—

The Convener: I understand the word "intuitive", but it might be helpful to members of the public who are interested in this and who might be concerned about who will be looking at their records if you explained a little bit more about what an intuitive system is.

Paul Rhodes: The portal presentations from NHS Tayside and from NHS Greater Glasgow and Clyde look different to me, but to clinicians they do not look all that different. The pieces of information that they expect to see are there and it is not hard for them to find their way around. Because there is a benefit to them as individuals doing their job, they are willing to do the work to become familiar with it quite quickly; it is not particularly hard. A number of information technology systems require the user to do a number of steps.

The Convener: I come back to Professor Morris, because I quite like the BBC website idea. If I am a punter outside, I understand the BBC website, so when you say that it is intuitive—

Professor Morris: If you went to the BBC website and looked up international news and then went to the CNN website and looked up international news, you would be able to find your way to the information that you require. That is intuitive; the information is presented in a way that is consistent.

The Convener: So if one of Michael Matheson's people moved from—

Michael Matheson: I understand what "intuitive" means, so you are on your own.

The Convener: If they moved from NHS Lothian to NHS Greater Glasgow and Clyde and went on to the portal site, what would they then do?

Professor Morris: I think that we will see a consistency of information provision. For example, drugs and allergies will be shown consistently across both sites. We should move away from talking about systems and start to think about information services and information provisioning in a consistent way. That is what the portal will allow us to do.

Mary Scanlon: Why will we not have one portal? If it is consistent information that we are after, why are we still talking about having three, four or five portals? If we want consistent information with underlying functionality and an intuitive approach, why do we not have one system that is compatible throughout Scotland?

11:30

The Convener: That is a matter for the committee to discuss. In evidence, it has emerged that we might not be starting from where we wanted to be starting from.

I wish that I had not started this, but I want to get back to the practical example. I will take a deep breath and start again. Let us say that I am a GP in NHS Lothian who is doing locum work for NHS Greater Glasgow and Clyde. I want to use the portal to find out about a patient who has walked in with a very bad headache. I do not know them at all and they are from another NHS board area. How do I get into the system? How do I find out about their history using the portal? I want you to imagine that you are talking to a very dumb student in one of your lectures. How would an ordinary person understand the portal concept?

Professor Morris: One way of explaining it is that some systems are national, such as the emergency care summary and the radiology PAC system, and the information from them will be displayed consistently. We must recognise that because of where we have come from, many boards have systems that are peculiar—that is not the right word; I mean "particular"—to them. The portal will allow us not only to display consistent

information from the national information services but to gain best value from the local systems that are particular to individual boards. That is why we need to map convergence, because we do not have clinical systems consistency across Scotland.

I am not frustrated about whether we have one portal or two. The key is that we are mapping convergence. When there are national systems, the information will be displayed consistently. When there are local systems, we will try to use the information from them to add value to the quality of clinical care.

The Convener: I will not pursue the point—I am now Mrs Smith with the headache.

Dr Woods: For me, the issue is ease and simplicity of use. The user will not have to worry about what lies behind the system. They will not need multiple passwords and they will not need to know about the intricacies of the underlying systems. Just as you have described, they will be able to approach the portal as though it were a web browser, which, these days, we can all find our way around extremely easily. That is what we are trying to communicate. Therefore, a doctor who moves from one place to another will be familiar with the material even if there is some variation in the underlying systems. Provided that they are an authorised user and the local board has arrangements in place to enable them to obtain an appropriate password rapidly, they will be able to enter the portal and get the information that they need to care for the patient. That is what we are trying to do through our portal work.

The Convener: You will be pleased to know that I understood that.

Dr Woods: Thank you.

The Convener: I am sorry about that—my team is looking grimly at me.

Have you finished your questioning, Michael? I interrupted because I was getting lost on what an "intuitive" system was.

Michael Matheson: I have some anxieties about people's ability to log on to the system. My practical experience in the national health service, local government and even this Parliament tells me that getting initial access to mainframe IT systems can take some time—maybe days. We have clinicians who work in different health board areas, and I am highly conscious that the position can change within hours. Issues such as confidentiality, the audit trail and so on are all tied into people's ability to log on. I am not persuaded—and I do not know whether it is possible for you to persuade me—that our health boards will be able to respond quickly to the need for staff to get unique ID numbers and passwords so that they can log on. If that ability is not in place or cannot be provided, we will undermine the system and some of the safeguards that are meant to be built into it.

Dr Woods: I think we agree that, if we have smart systems that do the things that we are talking about, we must have smart administrative processes to enable people to access those systems—we fully accept that. I do not know whether my colleagues have anything to add on the experiences in Tayside and Glasgow.

Paul Rhodes: It is well understood in the e-health community that there will need to be some adjustment in this area. In many cases, IT systems, particularly the core ones, have not had a major clinical impact in the past and have been supported as administrative systems. As we move to a situation whereby clinicians will increasingly rely on being able to access certain data flows, the underlying systems that enable them to do that will need to be improved, which includes giving clinicians credentials that allow them to get on to the systems in the first place. The identity and access management system that has been procured and is being tested is part of that improvement, as will be projected improvements around boards' human resources systems. However, the key is that the systems will be supported by individuals who can make system changes, often at short notice and outside normal working hours. It is understood that we need to be able to move the support arrangements into a different place from where they have been to date.

Dr Woods: It is important to add that the identity authorisation system to which Mr Rhodes referred is a single national procurement that will be common across NHS Scotland—I know that the committee is concerned about that.

The Convener: Helen Eadie is next, to be followed by—it is Richard Simpson. Sorry, I cannot read my own writing now. I am turning into a doctor.

Helen Eadie: You will be pleased to know, convener, that I have a question on telehealth. First, though, I want to pursue with Professor Morris the issue of codes, which he spoke about earlier. In visits to GP practices across Scotland that the British Medical Association organised, GPs raised with me a particular issue. They stated that, when the NHS announces new programmes, the codes are not issued timeously. The GPs therefore have to invent local codes, but they have to unravel all of that when the NHS codes are ultimately issued. They must employ staff to ensure that the codes for costings and so on accord with the NHS codes as opposed to the codes that they had to design locally. There is therefore an issue about ensuring that coding information is introduced timeously for GPs.

Professor Morris: That is an important point, which emphasises the rich and complex nature of clinical information. In many ways, our GP colleagues have led the way by adopting a coding system for clinical information called Read. What Helen Eadie alluded to is that, if a Read code is not available, there can be local improvisation. We tend to use different coding systems in hospitals; they are OPCS-4 and SMR—sorry about the acronyms.

The Convener: I am going to ask for a glossary next time.

Dr Woods: The codes are national standards.

Professor Morris: Yes. The code issue is being addressed not just in Scotland but internationally. We realise that the more we code consistently, the better the information for not only patient care but all other uses, including audit. That work is on-going. I know that Mr Rhodes is working with colleagues in NHS National Services Scotland to improve our national approach to coding.

Helen Eadie: That is helpful. GPs expressed great frustration to me about the issue. They said that it cost them a tremendous amount of money when they ultimately got the right codes.

You will be pleased to know, convener, that my other point is on telehealth.

The Convener: We are moving on to telehealth shortly, but we have one more question on clinical portals.

Dr Simpson: The problem in general practice is that you record symptoms, as well as diagnoses, which leads to a coding problem.

I have concerns about the underpinning architecture, whether it be Microsoft or open source. I gather that at the moment there is a licensing agreement with Microsoft for what has been described to me as an eat-as-much-as-you-like buffet—we have paid a fee to Microsoft and can use its systems as much as we like. My concern goes back to the committee's original questions about security. Microsoft systems constantly have to be patched. Earlier systems also stop being supported—after a certain amount of time, that will happen to the 97 system, for example.

Given the variety of systems that are in place in the health service, there must be security worries about the accessibility of information related to those systems. What consideration has been given to moving ultimately to an open source system, which is free and more secure? Alternatively, what consideration has been given to ensuring either that we move to new Microsoft systems, at great cost, or that patching continues?

Paul Rhodes: When work was done to create the e-health programme strategy in 2008, one change was the establishment of an architecture and design division. There is a group of people who have design authority and are charged with designing the future path for applications and technologies in NHS Scotland. We take seriously the issue of how everything fits together.

We do not have an enterprise agreement with Microsoft at present—the previous agreement ended in the summer. There are on-going discussions with Microsoft about our future relationship with it. At the moment, if people want to buy Microsoft kit, they do so in the same way as people who do not have an enterprise agreement—through a software reseller.

One issue that the architecture and design group is considering is our dependence on particular brands or types of technology. The patient management system, which is at preferred bidder stage, is not a Microsoft piece of technology—it is built on other technologies. At the moment, we do not have a plan to move towards having a single supplier, whether it be Microsoft or others. We think that some plurality in the area could be helpful and could enhance our ability to negotiate the best deal for NHS Scotland.

You mentioned the requirements to patch. The architecture and design area includes key issues relating to security and information assurance. We are talking to boards about those issues, to ensure that material continues to be patched.

The use of open source technology for some back-end systems is being discussed. Work is being done in Tayside on whether products such as OpenOffice, instead of the Microsoft Office suite that is typically deployed, could be used in some cases. Since the previous arrangement ended, there has been discussion and debate about what our future strategy ought to be and how much of it will involve strong relationships with one supplier or another.

Dr Simpson: Those comments are extremely helpful. A number of countries are moving towards open source technology. In America, radiology systems are going open source; a lot of work is also being done in the area in France and Switzerland. I am glad to hear that we are in a more open frame of mind going forward, having come out of the previous agreement, and that we can look at the potential of open source. I know that open source is not free at the higher levels and must be supported. However, it has enormous potential, because it engages all of the clinicians who have an interest in the area in developing the system. We do not get that from Microsoft. I welcome the approach that you are taking and will watch developments closely.

11:45

The Convener: Gentlemen, you will be pleased to hear that I have no intention of asking what open source and patching mean. I lost the will to live during that technical discussion, but I know that somebody here understands it. No doubt they will enjoy it when we come to compile our report.

We are running a bit late. We move on to questions on telehealth from Helen Eadie, to be followed by Mary Scanlon.

Helen Eadie: When we talked about telehealth last week, both witnesses and members expressed some frustrations. There was a feeling that we perhaps have vested interests in Scotland. That was given as one reason why there might be resistance among many clinicians to the development of better telehealth. The issue of cultural resistance is another aspect that came up. Would you like to give us your thoughts and opinions on that?

The best example that I have heard involves dermatology—it was mentioned in this room two weeks ago, and I shared the example with the committee last week. The consultants, patients and other experts who were here believe that dermatology is one of the best examples of an area of work in which telehealth can be developed in a big way. Girish Gupta, Jimmy Ferguson and various others who were here said that dermatology is a classic area in which there could be a vast improvement in diagnosis. I think they said that the wait could be reduced from 130 days to 14 days just by getting faster screening of patients. That could save lives. However, we have not seen any developments in the area, and I want to know why not. What is your perception of what is wrong, and how can it be changed?

The Convener: The points about cultural resistance and the example of dermatology are in the public papers for today's meeting. I am not just picking on you, Helen, as I think that all members could ask shorter questions. I remind members that our witnesses have had the opportunity to read the papers. I ask everyone to ask shorter questions so that we can get through today's business.

Who would like to comment on cultural resistance, and perhaps also self-interest?

Dr Woods: I will answer initially in general terms, if I may. The matter is important. We share the committee's view that a more strategic approach to the implementation of telehealth is desirable. If we go back a little while, we created the Scottish Centre for Telehealth in, I think, 2006 because we felt that there was a need for more co-ordinated action. With its advisory and support role, the centre has undoubtedly done some useful things. However, like the committee, we feel that there could be more impetus in the area, which is why—following a review, which made it clear that people supported the idea—we decided to locate the centre as part of NHS 24. As you know, NHS 24 is a telehealth service in many ways. We share the desire to put more emphasis on and impetus behind a strategic approach to telehealth, which is why we are developing a specific telehealth strategy as part of the centre's transition to NHS 24.

Against that background, we have all seen applications that have potential, but the general point that we would make about investment in any technology is that we need to ensure that there is a sound business case for the investment and that the local organisations that are party to the development review the service delivery context within which it will sit. I do not know whether that is the cultural resistance to which you refer, but we share the ambition of the committee and indeed the witnesses to have more impetus and a more strategic approach to the development of telehealth. That is why the move to NHS 24 builds on some of the work that has been done in Aberdeen so far.

Helen Eadie: I would assume that what is needed is a sound patient case rather than a sound business case, but I understand what you say.

Dr Woods: You understand the point.

Helen Eadie: Yes.

Ian McKee: It seems to me that what you have suggested today, which was also suggested to us last week—that we develop telehealth first and then see where it fits—would mean doing things slightly the wrong way round. I would have thought that we first need to put pressure on health boards and clinicians to improve services in certain areas, especially rural areas where patients sometimes have to go to enormous lengths to keep out-patient appointments, visit hospital for various reasons or see their GPs. If pressure is put on the clinicians and health boards to provide better services, they will take up telehealth as a tool. In other words, telehealth will be demanded at the grass-roots level instead of our trying to force telehealth on unwilling participants, which so often seems to be the case.

Dr Woods: I do not think that we are trying to force unwelcome technological interventions on anybody. We have talked about this in committee before. The arrangements that we have for the performance management of waiting times in NHS Scotland, for example, create a strong incentive for people to redesign the ways in which they do things. I have seen examples—I am sure that the committee has, too, on its visits around NHS Scotland—of applications that people have

developed that are intended to shorten the journey times for individual patients. We welcome those applications; the question is whether NHS Scotland can develop them more systematically. We accept that there is a case for that, and we believe that making that a function of NHS 24—which has experience in other aspects of telehealth—will help us in that endeavour. Nevertheless, you are quite right to say that health boards and clinicians, and other people who are employed by the boards, will be required to value the potential of those applications.

Ian McKee: We have seen examples of good projects failing because there has not been co-operation at the grass-roots level. That leads one to feel that the projects have been grafted on instead of being developed as tools to meet needs that everyone who works in the area recognises.

Dr Woods: There may be particular issues that need to be carefully addressed in those situations—I do not know exactly to which projects you refer. We need to help people to identify the problems and overcome them. We accept that we must do more in the business-case process of evaluating how a specific initiative should be implemented—what the costs and benefits are and how it fits into the overall delivery of services and the use of people's time.

Mary Scanlon: I have a question on exactly that point about the business case. Last week, I cited the example of the telecare system that supports people in their homes in Argyll, which won an award at a recent event that you attended. When I gave that example to James Ferguson last week, he said that the problem is simply in implementing such projects. He said:

"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."—[*Official Report*, *Health and Sport Committee*, 2 December 2009; c 2488.]

We have some phenomenal projects that have proved their worth. I understand that the one in Argyll has reduced the number of emergency hospital admissions in that patient group to zero while there has been an increase in the number of emergency admissions among the over-65s elsewhere. It has also brought other savings, greater patient empowerment and so on, yet there does not seem to be any means of appraising such projects. There are some excellent pilot projects, but there seems to be no appraisal mechanism or leadership in assessing them so that people know how wonderful they are and so that they can be rolled out across Scotland. We have great pilot projects but, when they finish, everyone just reverts to what they did before. That is not what I would hope to see in a modern health care system in Scotland.

Dr Woods: What I said a few moments ago was an acknowledgement of the desirability of doing as you have just suggested. We will have a national organisation—NHS 24 is a national special health board—with expertise in telehealth and a national telehealth strategy that is shared and understood across the whole health service. When evaluated implementation possibilities are identified, we will work collectively to roll them out, subject always to the requirement that they demonstrate good value for money and provide the best use of resources for solving the particular problem involved.

I invite Mr Feeley to talk about the particular example that was referred to.

Mary Scanlon: Let me just add that, last week, the people from the Scottish Centre for Telehealth kept telling us, "Yes, I know that these projects are excellent, but we are only an advisory body." As the Scottish Centre for Telehealth is being taken into NHS 24, will it have much more responsibility for appraising and putting forward the business case for projects and for rolling them out? Will it be more empowered and not purely advisory?

Dr Woods: As an integral part of NHS 24, the Scottish Centre for Telehealth will continue to provide advice to many people but its work will be guided by the strategy that is being developed. My expectation is that NHS 24 will be right in the middle of trying to ensure that we maximise the use of those applications that are shown to have value.

Mr Feeley might be able to help with the specific example that was referred to.

Derek Feeley: We are aware of the initiative to which Mary Scanlon referred, which will be evaluated by the UHI Millennium Institute. The telecare programme as a whole has an independent evaluation built in. We also have a randomised control trial of a telehealth intervention in Lothian, which is one of the first of its kind in the world. We are gathering the evidence.

Members are absolutely right that what has been missing so far is a means to turn such projects into action. That is what the telehealth strategy needs to set out. We will consult on the strategy in the early part of the new year, with a view to having the strategy in place when NHS 24 takes over responsibility for matters. However, no one is resting on their laurels. It is already being said that there is potential in 2010-11 for a move to full national implementation of telehealth in two areas—telepaediatrics and telestroke—with more areas to follow.

Mary Scanlon: Once the telehealth strategy is published around spring next year, will there be leadership on, commitment to and enthusiasm for rolling out a telehealth system in Scotland or will the strategy just make a nice little

recommendation to which the boards will say, "No thank you"? Is that where we are going? Will there be real leadership?

The Convener: I think Richard Simpson is right: the issue comes down to what the incentive is for boards. Perhaps there needs to be money in it for them.

Dr Simpson: What are the carrots and sticks to persuade boards?

As I mentioned last week, Fife NHS Board has just built a wonderful new community hospital in St Andrews that has a minor injuries unit with no linkage to the hospital in Kirkcaldy. I find that incomprehensible, given that James Ferguson has for years been involved in a telehealth solution. The evidence shows that such solutions can provide massive numbers of saved patient journeys, so we are talking about a proven system that has been used in Scotland for some time. How can we build a new community hospital with a minor injuries unit without a telehealth linkage? The attitude is, "Oh, we will think about that and it might happen later." Given that we are building lots of community hospitals—for example, in Midlothian and in Clackmannanshire, although I do not know whether the latter has a minor injuries unit—and given that a telehealth system is being developed, why are we not taking on the systems and technologies that are being developed? Why are boards so resistant?

Dermatology is another area in which telehealth could be used. The increased number of cancer referrals creates a huge stress, yet there seem to be no plans to roll out the published and proven services that have been developed in Lanarkshire and Forth Valley, even though they would save enormous amounts of waiting time. The alternative, I am afraid, is that we appoint more consultants to do more of what we were doing before.

The Convener: I have lost the battle for short questions.

The key issue to address is how we incentivise boards to buy into telehealth—as Richard Simpson said, we need a carrot and stick—rather than impose telehealth solutions or allow developments to be lost in the long grass. There should be something in it for boards. Given that boards are required to make efficiency savings and are allowed to keep the money saved, perhaps there might be something like that. We are asking what will make boards say, "Well, we will try that solution; it is worth going into."

12:00

Dr Woods: I am trying to emphasise that we accept the case for greater impetus towards a more co-ordinated approach to telehealth, which is why we are putting it into NHS 24. You talk about leadership—Dr George Crooks, the medical director of NHS 24, will play an important role in the development of telehealth.

However, we would want to be sure, if we are to implement any technological intervention or revised means of delivering our service, about its clinical and cost effectiveness. Examples are emerging in which that is the case, and we will look to NHS 24 to provide the leadership in partnership with our territorial boards to exploit those technologies that demonstrate both clinical and cost effectiveness.

Dr Simpson: I still do not know whether—

The Convener: I am not hearing how use of telehealth would be incentivised.

Dr Woods: There are strong incentives in relation to the performance challenge that we construct for our boards.

Dr Simpson: But if boards find another way of doing it, and they say that the traditional mechanism—

Dr Woods: If they find a way that is more cost effective—

Dr Simpson: I do not believe that it will be more cost effective in the long term. There is a failure to adopt the technology, and boards simply go on doing what they are doing. James Ferguson made that clear at the committee last week: people would rather go on doing what they are doing, irrespective of the evidence that is presented to them, because there is no incentive—for example—to put in the capital to underpin the technology.

Even if it is slightly better to use the technology, the capital to support it is not available, the necessary training is not available, and the system is new, which makes things difficult. There are a lot of issues about change and innovation that are just not being addressed.

The Convener: I think that Rhoda Grant has a question about getting boards to buy into telehealth—she has waited patiently.

Rhoda Grant: My question is along the same lines; it is about national guidelines and patient pathways. A set of guidelines is one of the tools that are available: if telehealth was built into those guidelines and they were issued to health boards, the boards would have to comply and use the technology. It needs to be mainstreamed. We are all hugely frustrated because although we have been hearing about telehealth for a long time, nothing seems to happen unless somebody has a personal interest in it.

You say that you do not want to force or impose telehealth on anyone, but I think that the time has come to force and impose, and to use some of the levers that you have at your disposal. Those can involve not only the production of guidelines, but a consideration of what can be done through colleges and universities to ensure that training on how to use telehealth is built into general training for new physicians and doctors, and into continuous personal development for existing staff.

Dr Woods: I hear what the committee says and I sense your frustration that we are not making as much use of the technology as we could. I will not repeat the points that I have already made, but I think that the picture in Scotland is perhaps a little better than people might believe from our discussion. I invite Mr Feeley to say a little about how the progress that we have made in Scotland compares with that in other countries.

The Convener: I agree that that is important, but it will take you only so far with the committee. We will hear about it anyway.

Derek Feeley: We have never had a telehealth strategy before, so it is potentially an important step forward. The fact that NHS 24 is anticipating that strategy and already committing to national-level work in two areas is a positive step forward.

I will share with you a comment on that issue, not from me, but from Richard Wootton, who is the outgoing director of the SCT. In a report that he produced for us just before he left, he stated:

"If the work described here is ultimately successful, then Scotland could become the first country to establish national-scale telehealth services."

We know that we are behind the game in this area. Every country that has developed telehealth solutions faces the same type of issues that we are facing. What Dr Woods and others are trying to say is that we believe that we are headed in the right direction to deliver some of the things that the committee wants us to deliver.

The Convener: We are not laying the blame on any particular Government. It is simply frustrating. The Parliament has been in existence for 10 years and we are living in a modern age, but some of us who have been MSPs for a while realise that things move very slowly in the Parliament. I am content to stop there for now, if everyone else is. I thank the witnesses for giving evidence today. As agreed, we now move into private session.

12:05

Meeting continued in private until 12:13.

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