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Pàrlamaid na h-Alba

Official Report

MEETING OF THE PARLIAMENT

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Session 3

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[The Presiding Officer *opened the meeting at 14:30*]

Time for Reflection

The Presiding Officer (Alex Fergusson): Good afternoon. The first item of business this afternoon is time for reflection. Our time for reflection leader is Tina McGeever, who is one of the featured individuals in the Parliament's travelling exhibition, which encourages people to engage with the Parliament in various ways. Tina has become a wonderful ambassador for our public petitions system, and we are delighted that she is with us today.

Tina McGeever: In March 2006, my life changed for ever in one sentence. All future plans vanished in an instant. I then realised the difference between living and just existing. In fact, I did not see the point of being on this planet at all.

I was dragged out of that by the determination and resilience of the human spirit, which guided me gently by its support, protection and cajoling, and basically by giving me a kick up the backside, which came from close family, friends, colleagues, acquaintances, strangers and people in the Parliament.

I do not envy you your jobs. When you get it right, you are the bees' knees; when you get it wrong, you are consigned to room 101. However, being part of that tenacious human spirit, you—with all those others—have allowed me to sit and watch someone I loved belly laugh with an old friend over the outrageous antics that they got up to when they were younger, argue over politics and football, renew old friendships that we thought we had lost, gain new friendships that will last for ever, and just sit and enjoy the company of others and each other. If you asked me what the greatest achievement in my life was, I would say that it was having those extra precious moments with someone I loved.

I look at you as MSPs and I know that you go home sometimes and take off your MSP hat, kick off your shoes and breathe a sigh of relief. You are not being defined by your job; you are just being yourself with people you love. When you have to put on your MSP hat again and be an MSP, please remember who you are, the people you love, Michael Gray and all those who are in his situation today and in the future who may be given that extra opportunity through the tenacity of the human spirit.

I want to finish by reading a couple of verses from a poem by Maya Angelou entitled "When Great Trees Fall".

"Great souls die and
our reality, bound to
them, takes leave of us.
Our souls,
dependent upon their
nurture,
now shrink, wizened.
Our minds, formed
and informed by their
radiance,
fall away.
We are not so much maddened
as reduced to the unutterable ignorance
of dark cold
caves.

And when great souls die,
after a period peace blooms
slowly and always
irregularly. Spaces fill
with a kind of
soothing electric vibration.
Our senses, restored, never
to be the same, whisper to us,
They existed. They existed.
We can be. Be and be
better. For they existed."

E-health

The Presiding Officer (Alex Fergusson): The next item of business is a debate on motion S3M-7015, in the name of Christine Grahame, on the Health and Sport Committee's report, "Clinical portal and telehealth development in NHS Scotland".

14:34

Christine Grahame (South of Scotland) (SNP): Going by my helpful note from the clerks, I fear that I have 13 minutes for this speech. A pattern appears to be emerging of my having extensive time to speak on subjects on which I have restricted capabilities and knowledge. I believe that that is some kind of revenge on me, but I shall try not to share or spread that revenge round the chamber.

I deliver this speech with a health warning, in that I am most probably the least technological member of the Health and Sport Committee. I think that brass bands should celebrate when I successfully replace a fuse, and I am in persistent communications with the Parliament's information technology helpline; its number, 86100, is engraved on my heart.

I will reach the report, but first I commend the committee members, some of whom served on Monday and Tuesday on the End of Life Assistance (Scotland) Bill Committee. Some, who had not been sufficiently tested, proceeded to the Subordinate Legislation Committee. We then spent all this morning considering stage 2 amendments to the Alcohol etc (Scotland) Bill. The committee members are here this afternoon in body, if not in spirit.

So here we are. The report looks dull and sounds dull, but it is actually very worthy and important. "Worthy" is a most abused word, but the report is worthy, because its recommendations would assist in delivering a better health service not only generally, but individually for the patient by saving—a mot du jour—resources in staff time and financially.

In December last year, the Health and Sport Committee undertook a short inquiry into the development of clinical portal technology and telehealth in the national health service in Scotland. Members correctly felt that the issue was much neglected but had a great deal of potential. The inquiry's aim was to examine the current pace of development in the use of technology as a means of delivering a more efficient, responsive and patient-centred health service. The inquiry focused on two specific areas. The first was the development of a Scotland-wide clinical portal project by health boards and the role of the Scottish Government in co-ordinating that. The second was the level of use of telehealth applications by health boards and the role of the Scottish centre for telehealth in promoting their use.

The committee report was published in March 2010. Although we recognise the good work that some health boards have undertaken on portal projects—NHS Greater Glasgow and Clyde and NHS Tayside get the plaudits—and the use of telehealth systems by NHS Highland, the committee's overall view is that we need a much more focused and coherent approach to delivering the systems. The committee was also concerned that, a decade into the 21st century, a culture still seems to exist in the health service in which telehealth systems are regarded as Cinderella services rather than as core tools by which the NHS delivers health care in Scotland.

The report—as someone somewhere once said—is a game of two halves. If members are sitting comfortably and are still awake, I shall describe a clinical portal and then telehealth. To ensure maximum attention, there will be a question and answer session at the end.

On clinical portals, most data relating to the treatment of patients in the health service are collected, processed, analysed and stored electronically. For example, IT systems in the NHS allow patient X-rays to be stored and viewed by clinicians and general practitioners throughout the country. When I recently broke my foot—yet again—by the time I reached the consultant, he was busy logging on and we both had a good look at a rather dramatic fracture, which he understood and I did not.

In recent years, technology has been used to store and examine medical information relating to blood tests, prescription medicines and specific surgical treatments. The IT systems vary from health board to health board depending on the specific needs of clinicians in the area.

Here comes the bit that I think I understand: a clinical portal is a computer-based software system that provides an electronic gateway to allow easier access by health professionals to patient information that is stored in various systems. How proud my sons would be of me for understanding that. The trouble is that there does not seem to be a substantial degree of commitment or prioritisation in NHS boards to engage in the development of a clinical portal or, in other words, in a system that allows the individualistic systems of various boards to speak to one another, as it were.

The committee agrees with the Cabinet Secretary for Health and Wellbeing that to ditch existing data systems and to try to impose one

system would, frankly, be a disaster waiting to happen. Nevertheless, it seems appropriate that, when NHS boards are selecting systems, they might try to engage with one another in advance, so that there is a possibility of harmonisation of the systems.

We were also not too sold on the prospect of simply opting for Microsoft software as the basis for IT development, but I shall leave any technical development to others because I fear that I have already overreached my technical limits and will be found out.

The sharing of medical health data is, as my history teacher would say, a good thing, but it also raises the spectre of data protection—the security of who knows what, when, why and where about our medical history. Hot-desking—I am modern—and shared passwords are not unknown and failure to log out and so on all rightly give rise to patient anxiety. That is why patients should be right slap bang in the middle of developments and kept informed in order to allay their fears and suspicions. We make that clear in our report and we also call for proper staff training so that staff are aware that their duty of care does not begin and end at patient clinical care, but extends to patients' rights, the ability to track accessing of their records and privacy.

Telehealth is a term that is used to describe the use of modern technology to remotely deliver health care to patients via land lines, mobile phones and broadband services, often involving videoconferencing—of which, incidentally, Health and Sport Committee members are masters, as one would expect of such a talented bunch. The effective use of such services can improve the patient's experience of health care by reducing the need to travel to main urban centres and hospitals to receive care and treatment. It also allows patients to be proactive in the treatment and management of their conditions, which is important. As members can deduce, telehealth is particularly relevant, although not exclusively so, in remote and rural areas, which no doubt will be illustrated by committee colleagues.

The Scottish centre for telehealth, known, as members are probably aware, as SCT—I will be asking questions later—was established by the Scottish Government in 2006 to promote the use of telehealth by health boards in Scotland. It has now been absorbed by NHS 24, which we hope will give it more clout, and has changed from being just advisory to making change happen. There is no doubt that a more forceful approach to the use of telehealth by health boards is overdue. Change is not a welcome guest, and institutions as well as individuals within them like to stay in their comfort zones, fearful perhaps, and reasonably so, that change means a threat to their security of employment. However, telehealth has the potential to make much better use of professional skills. I vote for fewer chiefs and more Indians any day.

The committee received responses from the Scottish Government and Tunstall Healthcare UK Ltd, the major private sector provider of telehealth systems in Scotland, but I will refer to only a couple of issues in the Government response. I understand that the Government is currently funding a UK-wide initiative to develop a framework of competencies for postgraduate medical training in e-health. I would like to know how that is getting along, so a progress report would be handy.

Reference is also made in the Government response to the "NHS Code of Practice on Protecting Patient Confidentiality" to which I referred earlier and which was published originally seven years ago. The cabinet secretary's note of 4 May to the committee states that the code is currently being reviewed. Again, the committee would be pleased to hear of progress in that regard.

I am sure that other members will develop in a much more confident and informed fashion other aspects of the report. However, let me conclude—I said that I would not take 13 minutes—by restating that a report that appears on the surface to be as dull as the proverbial dishwater is actually full of wee gems, which if mined could enhance our health service and redirect staff time and funding elsewhere in the NHS, which is to be much commended in belt-tightening times.

However, I say to the minister that one of the wee gems is not "an architecture vision", which is not in our report but in the Government's response. It has nothing to do with hospital buildings, but as the committee knows, I will gleefully add the phrase to my compendium of banned phrases to join inter alia "virtual scenario", "direction of travel" and "landscape signature". In fact, I have an architecture vision of the landscape signature that I wish, as my direction of travel, to take me to the virtual scenario. It has been a long, long day, Presiding Officer, and I am in need of caffeine. [*Interruption*.] I concur with Mr Stone that it is getting longer by the second.

I move,

That the Parliament notes the conclusions and recommendations contained in the Health and Sport Committee's 3rd Report, 2010 (Session 3): *Clinical portal and telehealth development in NHS Scotland (SP Paper 399)*.

The Presiding Officer: I ask members not to follow the convener's example by not using up their allocated time, because we have a little time available.

I call Shona Robison, who has 11-plus minutes.

14:45

The Minister for Public Health and Sport (Shona Robison): I welcome this debate on the important role of information technology in improving the safety, effectiveness and efficiency of care. I hope that I will be able to address many of Christine Grahame's points and questions. She described the report as worthy, but she also said that it is important. The Scottish Government is clear about the value of investing in e-health measures and set out its agenda in 2008 with the launch of the e-health strategy. That agenda is developing to support the implementation of the quality strategy.

Our approach has been to build on previous successes in NHS Scotland, of which there have been many. For instance, a European Union review of the emergency care summary concluded last year that NHS Scotland's approach provides a lesson for all health services.

Our strategy is to make incremental change to support the progressive convergence of systems, while avoiding overcentralised approaches. Many members will have seen in reviews of health IT programmes in England the criticism that those programmes are highly centralised. I am pleased that the Health and Sport Committee broadly supported NHS Scotland's approach: the Scottish Government recognised the risks in the centralised approach.

The Health and Sport Committee took evidence on developments in the clinical portal and telehealth and published its welcome report in May. The report contained several recommendations and I will let members know what has been done to address them.

Christine Grahame offered a good definition of a clinical portal. I would describe it as a window on a clinician's computer that allows them to view defined information about their patients in a virtual electronic patient record that is drawn from information that is held in different clinical IT systems. I do not know whether that definition is better, but it is different. Perhaps the definitions taken together provide clarity on what we are talking about.

Our strategy seeks to avoid setting up a large national database of clinical information. Instead, the portal, or window, assembles relevant information for the clinician from different sources at the point when the information is needed. I have seen the British Medical Association's briefing for the debate: I am glad that we agree that that model is right. I am also glad that we agree that better access to such information will support improved care delivery and decision making, and that patients can be reassured that clinical staff have the information that they need to provide safe, effective and efficient care.

NHS boards fully support the development of the clinical portal. The fact that they are in different positions technically argues for a flexible and incremental approach to delivery. Boards have organised themselves into three regional groupings, two of which—the north and the west—include boards that already have portal investments. The south and east of Scotland boards commenced work on shared arrangements first and have developed a working portal prototype that was well received by clinicians. They are now developing the business case for procurement and an implementation plan. The west and north of Scotland boards have assessed the existing portal technologies in their areas and are working up proposals for sharing.

The committee's view was that there should not be a lot of different clinical portals. The Scottish Government and senior leaders in NHS Scotland share that view. We will look for the optimum path that produces results quickly, most cost effectively and with the maximum local support for implementation. We expect that to lead to a maximum of four technical solutions, including the two existing developments in NHS Greater Glasgow and Clyde and NHS Tayside, to which Christine Grahame referred.

The clinical change leadership group is considering standardising the presentation of information to clinicians. Increasingly, NHS Scotland solutions will use the powerful new integration tool Ensemble. That will provide the nationally agreed engine that will support sharing across NHS Scotland and initiatives such as the portal. I say "engine" because it is very much under the bonnet: the clinician will not see it but it will help to enable what they see.

The focus on the underlying integration of NHS Scotland IT systems will be a building block of future IT developments. It is important that if we need a reminder of how useful clinical portals are, we need only look at the growth in their usage. One example is the NHS Greater Glasgow and Clyde portal. Last summer, the portal was used to look up about 1,500 test results a week. In the first week of September this year, 180,000 documents were accessed and the portal had around 6,800 active users. That tells us that clinicians like it and, more important, that they are using it.

The portal is not intended as an access point for all the information about a patient that the NHS holds. A survey of clinicians was undertaken in which they were asked to rank the pieces of information that are of most use to them when seeing a patient. The clinicians identified consistently 14 types of key clinical information. Those first types of available information in the

clinical portal include such things as current medication, test results and clinical letters. Information items from the top 14 that are harder to get or are not held electronically at the moment will be introduced incrementally so as not to hold up clinician access to information that can be made available quickly. That way of working is entirely consistent with the e-health strategy.

Working incrementally, we are seeking to build on what is already available and take it forward in a pragmatic way that delivers value for money and is developed as close as possible to the front line. In recent years, all our major IT systems have been developed along those lines. For instance, the new patient management system is the product of NHS boards working closely together. That has produced strong board commitment to delivering the benefits of the investment. By working together, the solution was delivered more cost effectively than was predicted for a centrally led alternative approach.

A key issue for the committee was the strength of safeguards in the system to protect patient confidentiality and ensure that information can be accessed only appropriately. On many occasions, I have said that the Scottish Government regards safeguarding patient records and confidentiality as being of great importance. That is true regardless of whether information is held on paper or computer. Confidentiality is important not only because of legal and professional duties, but because it sits at the heart of the relationship of trust with patients that is vital for effective care.

The Scottish Government is developing an information assurance strategy in which we are building on successful existing work to improve information governance. It will bring together important issues about the availability of information and business continuity, and how we deal with confidentiality. It will retain a strong focus on awareness and staff behaviour: it is as much about pieces of paper and staff conversations as it is about accessing IT systems.

We have also revised guidance on records management: "Records Management Code of Practice" was issued to NHS boards in August 2010, and we are consulting on final revisions to the code of confidentiality, which I anticipate being made available to boards at the end of the year.

Of course, the e-health programme is also focused on improving IT systems. Plans to improve board capacity to audit and control access to IT systems on the basis of staff roles are well advanced. I referred earlier to the British Medical Association briefing. I believe that the BMA will be reassured that our actions in this area are exactly what it and other clinicians are calling for.

We are also addressing guidance information for patients. Health rights information Scotland has been commissioned to produce a leaflet and video clip for patients on e-health and its implications for the service that patients receive from the NHS, and on how their information is stored and shared safely. Related, extensive stakeholder consultation and user testing are under way.

I turn to the other theme of the Health and Sport Committee report: telehealth. Good progress is being made on telehealth-related activity. The committee is well aware of the work that the Scottish centre for telehealth undertakes. The centre was established in 2006 to provide advice to NHS boards as they sought to realise the potential of telehealth products. It has carried out a number of pilots. That said, the inquiry heard of frustration at the lack of conversion of pilots into mainstream services.

The Scottish Government shared those concerns and initiated a review, which was commissioned in January 2009 and reported in August 2009. A key recommendation of the review was to bring the Scottish centre for telehealth into NHS 24. That transition took place on 31 March this year. NHS 24, as Scotland's key telehealth provider, will use its expertise to provide a national focus for telehealth-related activity.

Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD): Will the 111 telephone number be utilisable in Scotland?

Shona Robison: We have said that we will look at the evidence on how the number rolls out, what it looks like and some of the learning from that before giving further consideration to it. That will be interesting, because there may be information and lessons for us to take from it and we may want to consider the matter further. That is how we will proceed.

One of the first actions that the review recommended was that a telehealth strategy be produced. That has been completed and focused on four programmes of work: stroke, paediatrics, mental health and chronic obstructive pulmonary disease. All of those programmes aim to deliver cost-effective solutions that can be rolled out on a national basis. The work will be co-ordinated by NHS 24, under a governance structure that includes appropriate representation from boards. Projects will be fully costed and supported by robust business cases.

Mary Scanlon (Highlands and Islands) (Con): Why did the minister decide not to set a health improvement, efficiency, access and treatment target for telehealth, as recommended in paragraph 87 of the committee's report? Why did she decide against setting health boards clear deadlines for the use of telehealth systems?

Shona Robison: As I am beginning to outline, we have decided to move forward on a phased basis, focusing on the areas that I have identified. Rather than ask boards to do everything at the same time, we have broken down the strategy into four programmes of work that we can take forward on an organised basis.

The first business case—for the telestroke programme—is scheduled to be considered for funding in November. Rather than try to do everything at the same time—which would not work—we are ensuring that the strategy happens on a planned basis and at a pace that achieves results. The telestroke programme will look to improve the treatment of stroke patients by developing a national network for increased access to urgent stroke thrombolysis-decision support, which will be delivered through a combination of videoconferencing and a facility for specialist consultants to access computed tomography scans from home.

I firmly believe that the possibilities that are afforded by the clinical portal, telehealth-related developments and, indeed, e-health generally provide us with significant opportunities to improve patient care and access to it. There are also opportunities to make the NHS more efficient, which will become more important in the years ahead.

I look forward to hearing what will be said this afternoon. All of us agree on the importance of telehealth and telecare. As I have said before, we have scratched the surface of its application. By prioritising the four areas that I have identified, we are proceeding in an organised way and taking a systematic approach to making the most of telehealth and telecare opportunities. That is important in the current financial climate, but it also provides a very good outcome for patients, especially older patients. Given the demographic challenges that we will face in the next few years, that will be even more important, if we are to keep health local to people and to keep people safe in their homes through the use of telehealth and telecare. There are tremendous opportunities not just for the health service but, importantly, for patients who receive services.

Thank you, Presiding Officer, for giving me the opportunity to respond to the Health and Sport Committee's report. I look forward to participating in this afternoon's debate.

14:59

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I welcome the debate. As the Health and Sport Committee's convener suggested, it might appear to be a dry subject, but it is also a very important debate. I thank her for her opening remarks, and I thank everyone who gave evidence to the committee. I thank the Scottish Government for responding to the committee, although the minister's speech today has been more helpful, in some respects, than some of the responses that were given to the committee, which were lacking in clarity; I do not have the skills to put that in the way that the convener did, in relation to some of the language that was used.

There is considerable consensus on this area of health care and on its capacity to deliver some important advances for Scottish health. In the first session, Labour set out to encourage work in telehealth, with an increase in the use of IT for the benefit of patients. The most notable development, as the Minister for Public Health has indicated, was NHS 24. The organisation has had its troubles over the years, but it is now making a considerable contribution to Scotland's health.

I visited NHS 24 at Cardonald shortly after being elected, and was impressed by the recognition there of the problems to be addressed. Telephone advice is not without its risks, but they are now being managed better. Moreover, the integration of telephone advice with other services, its increased connectivity with the Scottish Ambulance Service, its integration with mental health provision, including the development of a cognitive behavioural therapy pilot and the provision of more specialist nurses, are all helping it to evolve in a very useful way. The service has now been handed an additional and great responsibility through the merger with the Scottish centre for telehealth.

Before I discuss developments in the future, I will consider a few more of the important decisions that have been taken over the years and that have been followed through by the current Government. The Parliament reached a fundamental decision not to adopt the centralised national data spine. I hope that we can all agree that we should continue to adhere to that approach. The BMA referred to and welcomed that in evidence to the committee.

In about 2000, our colleagues in England turned their backs on what was happening there. Following Labour's time in Opposition, we developed concepts that were developed in individual hospitals and groups of hospitals for a dispersed system. Under my colleague Alan Milburn, who was Secretary of State for Health, it was decided to go for a grand, all-singing, all-dancing, centralised national database. It was to cost about £12 billion, and the current coalition is trying to rescue and repair it.

Scotland chose only two centralised concepts. One was the community health index, which is fundamental to data linkage in the long term, both between primary care and secondary care, and

with pharmacy, optometry and other community services.

The emergency care record was to be developed alongside suites of clinical software systems, which were eventually to be linked into the clinical portals, or electronic gateways, as I prefer to describe them—we all have our own names for it. Under three regional consortia there are now to be four different systems, as I understand it from what the minister has said.

One of the major concerns that has existed all along with data systems is patient confidentiality. In England, there have been suggestions that access to data from other Government agencies could be permitted. I ask the public health minister to indicate—either now or later—whether we have a form of declaration in general practice that precludes information being shared with agencies such as HM Revenue and Customs, the Department for Work and Pensions, the UK Border Agency, the Identity and Passport Service and even councils. That has been suggested in England.

We should remember that the systems were being developed at a time of declining patient confidence, following the issue of contaminated blood products, the Bristol cardiology scandal, the Alder Hey organ retention scandal and—more recently, in a Scottish context—the revelation that a doctor was accessing the emergency care record data of celebrities.

In England there are campaigns to encourage patients to opt out of the national system. That is not happening in Scotland.

The Health and Sport Committee's report makes clear our collective view that patients must be at the centre of all IT systems. That means membership of the clinical portal programme board, which is now occurring, according to the response that has been received. More important is that it should be ensured that patients retain control. That is fundamental to our system of dispersed e-health and e-care.

We have already established the fact that patients can access their medical records, but we now propose going further: we propose that patients should be given access to a credible audit and tracking system, by which they can see who has accessed their data and when it has been accessed. Access to patient records should be limited to clinicians and secretarial staff who need it to provide the patient with a service and, except in primary care and where specified because of the long-term nature of a condition, it should be time limited and specific.

In 2003, the Labour and Liberal Democrat Government introduced a code of confidentiality. I am pleased that the Government is updating it and would be grateful to know when the update will be published.

A case called I v Finland was completed last year after a long and winding contortion through the European courts. I will tell members a little about it. It concerned a nurse in a hospital in Finland whose HIV status was recorded without her knowledge on her clinical IT record in the 1990s. That record was then accessible to fellow health care workers. The question was not whether those workers would access the data but whether the data and the potential for access should have existed in the first instance. The European Court of Human Rights decided that it was inappropriate and a breach of the nurse's human rights. It is important that such decisions be taken into account when we develop our systems.

Presiding Officer, I am not quite sure how long I have. Do I have a minute or two more?

The Presiding Officer: You have a minute and a half more.

Dr Simpson: Telehealth is moving forward, but rather slowly. We have four systems—telestroke, telepaediatrics, mental health and long-term condition management—but, as Mary Scanlon said, there is no HEAT target, which I regret. Even with a Government implementation programme, there is no leverage for the introduction of the new national approaches. Without national approaches, we will not become a world leader, which we have the potential to do. Champions—they are mentioned in the Government's reply—and a new strategy are all very well, but without incentives to boards, we will not make progress in the present austerity climate.

The digitisation of radiology has been important and has saved a huge amount of unnecessary travel. The Grampian accident and emergency system, which is linked to peripheral minor injury units, has saved thousands of patients from travelling. Every minor injury unit should be linked in that way.

Dermatology clinics linked to the Western Isles and abroad have been established and, in NHS Forth Valley and NHS Lanarkshire, new digitised linked systems for triaging potential melanoma have been developed. Those should be picked up and rolled out nationally, because they tackle a major problem with waiting times in dermatology. There are other schemes, such as those in ophthalmology, to which my colleague Helen Eadie will refer.

We really need to take a grip and make progress on telehealth. It is no longer appropriate to have civil servants, however good they are, moving in and out of a unit that deals with the policy area; we must have people with proven

expertise in it really getting a grip of the issue. We have delayed and dallied too long; the time for action is now.

15:08

Mary Scanlon (Highlands and Islands) (Con): Much is said about consensus in the Parliament, although it tends to be lacking in many debates. However, the considerable consensus in committees—particularly when it comes to committee inquiries and reports such as the one that we are debating on clinical portals and telehealth—is often missed.

The ministerial response came in May, and I agree with Richard Simpson that Shona Robison's speech was undoubtedly much more positive in tone and content than the written response.

The report is the culmination of written and oral evidence taking. I hope that ministers have picked up the fact that it reflects frustration among committee members of all parties at the extremely slow progress that has been made in e-health in general and telehealth in particular.

The Scottish centre for telehealth merged with NHS 24 in April, so it is possible that parts of the report may already have been overtaken by events. Paragraph 87 highlights the lack of any progress on telehealth systems to date:

"The approach adopted by Government to encourage health boards in the use of telehealth systems, to date, has been largely unsuccessful. While many boards have undertaken effective pilot projects, there has been no real incentive to ensure telehealth development overcomes ... cultural resistance".

The committee welcomed the merger between the Scottish centre for telehealth and NHS 24, and the report acknowledges the intention to

"drive forward the telehealth agenda",

but notes that

"it is clear from the evidence received, that much of the work to establish a clear focus within NHS 24 on taking forward its new telehealth remit is yet to be undertaken and this needs to be addressed."

That sounds to me like more and more delay.

There is no doubt about the efficacy of telehealth. When Rhoda Grant and I met representatives from NHS Highland last week, they confirmed the 100 per cent reduction in hospital admissions as a result of the pilot telehealth study in Argyll. Given that telehealth systems lead to better monitoring of patient health and empower patients to self-manage their conditions better, it is unacceptable that such systems have not been rolled out elsewhere in Scotland. I hope that the increased focus on reducing emergency admissions to hospital and finding solutions that will benefit patients and save the NHS money will lead to the increased use of telehealth.

The Government's response to the recommendation for a HEAT target with deadlines for health boards on the use of telehealth systems is disappointing. Stating the need to establish the business case when there have been so many pilots is not encouraging. The Government states that NHS 24 and the Scottish centre for telehealth will

"contribute to appropriate events and activities covering a broad range of key stakeholder audiences,"

but that is best described as a Christine Grahame fudge. I hope that NHS 24 and the Scottish centre for telehealth will do that regardless of any committee report. However, more heartening was the Government's confirmation that

"technology offers opportunities to support healthcare in rural and remote communities"

and that it

"will continue to invest in these technologies and encourage these linkages".

I note that Liam McArthur is in the chamber, but I will take advantage of the opportunity to say that NHS Orkney is the only health board in Scotland that does not have a computed tomography scanner for stroke patients, which undoubtedly puts those patients at a disadvantage. I hope that the provision of a telehealth system will be a priority under the new stroke telehealth initiative.

The move to develop national services is encouraging, particularly in the areas of paediatrics, stroke, mental health and long-term-condition management. Although no timetable has been given, I hope that that approach will be prioritised in the coming months. Long-term conditions such as asthma, heart failure, diabetes, chronic obstructive pulmonary disease, hypertension, depression, drug and alcohol addiction, obesity, smoking and congestive heart failure can all be managed by telehealth products that are designed to benefit doctors and patients through time-saving monitoring and improved confidence. In addition, visits to GP surgeries, hospital admissions and social services visits can be reduced, while better information is gathered.

In parts of the Highlands and Islands, patients with mental health problems have been able to access cognitive behavioural therapy via NHS 24, and the feedback from patients and health boards on that has been very positive.

On clinical portals, evidence to the committee highlighted the fact that 15 per cent of hospitalisations are complicated by medication errors, one in seven hospital admissions occurs because care providers do not have access to previous hospital records and 20 per cent of

laboratory tests are requested because the results of previous investigations are not accessible. Although 94 per cent of GPs have electronic access to information about patients' current medication, only 12 per cent of hospital doctors and 23 per cent of hospital pharmacists have that information. Surely if the patient is at the heart of our NHS, the patient record should be electronic so that appropriate information is available to health professionals. Indeed, that should also be extended to pharmacists now that they have a prescribing role. Although having an emergency care summary is helpful, it is used only in emergency care.

Having heard all the evidence, committee members had no doubt that the aim should be

"the development of a single portal system across all health boards, rather than a range of differing systems across the NHS."

That point is made in paragraph 31 of our report. In paragraphs 47 and 48, we raise concerns that

"multiple portal systems ... will add to the time, complexity and coordination of staff being granted access to such systems".

Although the Government does not intend to develop a single database of patient information, I believe that its proposal to have a limit of three databases must be better than having 14.

In conclusion, it is important to put on record that we constantly check the NHS to determine whether IT, e-health and telehealth are being used in what we would hope is a modern and innovative health service in Scotland.

15:16

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): The motion asks us to note the contents of the Health and Sport Committee's report, which I do with great interest. I, too, thank the members of the committee and their back-up team for the work that has gone into it.

As others have said, clinical portal technology offers ways of accessing virtually all the records for a given patient at very high speed. That is a far cry from the situation in which a specialist who sees a problem is unable to know the best way forward because important information is held in a file somewhere else or because the pertinent information is held by another consultant even further away. Clinical portal technology offers total instant access at the tap of a key. Indeed, taking into account the caveats that Christine Grahame voiced, I was surprised that, after I underwent medical treatment at Aberdeen royal infirmary last year, I had to hand carry some of the information about my condition back to my GP. That is not to gainsay the excellence of the treatment that I received, but I found that surprising in this day and age.

As the report points out, and as others have said, the health service has a poor track record in communicating to patients how their medical information is used and shared. Patient confidence in the recording, accessing and use of medical information is vital to the success of such IT projects, therefore the Scottish Government must ensure that patients are aware of how their personal information is being used and that development of the clinical portal is transparent.

Representing the constituency that I do, I am extremely supportive of telehealth technology, which can be particularly beneficial to patients in remote and rural areas. For example, in emergency care situations, telehealth solutions might reduce the number of trips to hospital for those who suffer from long-term conditions and could enable those at remote GP practices to see hospital consultants remotely.

In addition, telehealth technology can be hugely beneficial outwith remote and rural areas. Initiatives that monitor people's long-term conditions from home are empowering and give patients confidence in self-care and self-management of their condition. However, as the report stresses, we need to move on from the current situation, in which successful pilots and projects have not led to the mainstreaming of telehealth approaches. I agree with the committee's call for action to roll out successful projects.

The availability of high-speed, reliable broadband is vital to support telehealth services. The challenge of poor broadband connectivity affects many communities across Scotland as the digital divide continues to grow. That should be a worry to us all. Therefore, it is vital that both the Scottish Government and the UK Government work together to ensure that the peripheral parts of Scotland are not missed out as high-speed broadband is rolled out.

It will come as no surprise to hear that I believe that everyone in Scotland, including my constituents and anyone who lives in a remote area—no matter where—should have access to fast and reliable broadband. That is why my party has started a campaign to urge Jeremy Hunt, who is the UK Secretary of State for Culture, Olympics, Media and Sport—a long title—to choose Scotland as one of the areas to be covered by the three high-speed broadband connectivity testing projects that he announced recently. It is imperative that we all get behind that campaign.

Furthermore, although the opportunities that telehealth presents have long been recognised, it is the case, as the committee pointed out and as

others have said, that the mainstreaming of telehealth Scotland-wide has been far less successful than one would have hoped. Accordingly, the committee recommended that the Scottish Government should set a target of making Scotland the first country to establish national-scale telehealth services within three to four years at most. To fail in that endeavour is to let down patients, particularly those in the remotest parts of the country, who include many of my constituents.

Before I leave telehealth, I want to flag up a caveat. It is crucial that we set exactly where—I mean physically where—the balance should lie between an electronic, down-the-wire-and-through-the-ether approach and a real-face-in-front-of-you, hands-on approach. That is particularly true for areas such as the far north of Scotland, where remoteness and inclement winter weather can impose extra challenges when the time comes for real, hands-on treatment. For that reason, there must be a limit on the physical distance that separates health professionals and medical facilities from patients. I am sure that all rural members will understand my point; there has to be a balance.

I will conclude with a related issue that concerns all of us—data security. I recognise that things have come a long way since I was a lad, when I used to go to my surgery in my home town of Tain, where the receptionist behind the counter, who was a formidable lady, would demand of you, in front of all the other patients who were waiting patiently in the queue to see the doctor, "And what's wrong with you today?" If you said, "I would like to see the doctor," she would say, "No, but what's wrong with you?" That could prove extremely embarrassing, until a late and great friend of mine, Councillor James Paterson, who was known to many of us in the Highlands, replied, "I've got VD." After that, she did not ask the question again.

Perhaps I am wrong to make light of the issue. My point about data security relates to the fact that in the past two years, as we know, more than 300 laptops and sensitive files were lost by Scotland's public authorities. Items that were lost by NHS boards included six mobile phones, one of which had patient telephone numbers stored in it, and a memory stick with 40 clinical reports on 21 patients. Of the seven laptops that were stolen, one had on it details of approximately 5,800 patients, one had on it details of patients' names and another had on it some limited staff information. Another memory stick that was lost contained details of no less than 143 patients.

Although such accidents and examples of human error are understandable—we all lose things—each one only serves to undermine public confidence in clinical portal and telehealth technology. Such mistakes might be understandable, but they are, nevertheless, entirely unacceptable, and we must all do everything in our power to ensure that in future we minimise the likelihood of such events happening again. At stake is the confidence of the patient, which I believe is paramount.

The Deputy Presiding Officer (Alasdair Morgan): We now move to the open debate. I can allow members up to seven minutes each.

15:23

Ian McKee (Lothians) (SNP): As a member of the Health and Sport Committee, I am pleased to speak about our report. I begin by thanking our committee support team for their hard work in producing it.

My definition of a clinical portal system—I might as well join the rest of the team—is a system that allows clinicians, wherever they are in the health service, to access relevant information about a patient. I say "wherever they are in the health service" but, in fact, early developments of such systems have varied from health board area to health board area, with the result that they do not talk to each other. Furthermore, many systems exist only for select areas, so it may be possible for hospital information to be shared within a hospital but not with local general practitioners, for example. That is obviously less than adequate, and we on the committee suggested a national clinical portal system for Scotland. Also, we were disappointed that the general rate of progress seemed to be so slow, which is why I was pleased to hear some of the minister's reassurances in that regard.

We were concerned that members of the public are not more involved in what is happening. Knowledge is power, and it is important that the public are reassured that the ready and easy availability of personal information—sometimes very personal—cannot be abused.

Let me provide one example of where I have a worry. A hospital doctor seeking medical information needs to enter his or her password or personal identification number to gain access. It is therefore possible to track exactly who seeks information and whether they have the right to do so. However, as we have already heard today, there is a problem with that. Some locum doctors are often not given PINs for a few days, so they use that of another doctor—often the one whom they replace. Likewise, in busy wards, with perhaps a single computer, it has been known for one person to open the computer and for others then to access the information that they require. If the public are to be confident about the robustness of confidentiality arrangements, they need to know

how that real problem can be solved. Of course, it is important not to have the national spine with all information on it. A hospital doctor who needs to see an X-ray does not need to see GP notes on when the patient had, for example, an abortion or a sexually transmitted disease.

Telehealth has enormous potential, but it is potential that we have found difficult to tap into in the past. Committee members will recall that I took part in a telehealth scheme in Edinburgh as part of antenatal care as long as 35 years ago—almost a working lifetime—and yet we have scarcely advanced since then. The scheme lasted for five years, and what we did was quite simple. In the area where I worked, we had a problem with antenatal patients having poor outcomes. We found that a lot of them were not going to the hospital for their check-ups and so on. We decided to provide antenatal care in the area, and we used a primitive telehealth system—basically, videoconferencing—to deal with the consultant. We collected information in a previously agreed way, and at a prearranged time the consultant would come online. He would see the patients, we and he would look at the notes, and he would give us advice on how to progress. That prevented a large number of patients from having to go into the centre of Edinburgh to sit and wait in a queue at the hospital.

I am pleased to say that it is different nowadays but, as some members might know, in those days the antenatal clinic, certainly at the Simpson, used to be called the cattle market. At any one time, more than 100 women would be waiting to be seen, and when they were seen they were treated more like cattle than human beings. I am glad to say that those days are gone now, but using telehealth we were easily able to abolish those days for patients in a vulnerable area. After five years, however, the scheme was abandoned. The consultant changed, and other consultants did not want to take part. It was all given up.

That relates one message that I want to put across. Many telehealth projects have been the brain child of an individual or group of individuals. They have been introduced top down without securing the enthusiastic support of users or others who might use such a service in future. It is no use for a patient in the Highlands to appear in front of a camera, for example, if the consultant who should be at the other end is still on his ward round and unavailable. Telehealth projects should have grass-roots support, but that can happen only if the benefits are obvious to both patient and clinician.

Telehealth projects have been prime examples of what I call pilotitis. End-of-year money is available for a pilot scheme and a telehealth project is chosen, but whatever the result of the pilot no further funds are available to keep the project going, let alone roll it out. That situation is not unique to telehealth, of course, but telehealth projects seem peculiarly prone to pilotitis. The lesson is that no pilot should be initiated unless robust plans are in place to handle further development, should it be successful.

I am pleased to say that there is now light on the horizon as far as the dismal past record of telemedicine is concerned. The institution of the Scottish centre for telehealth means that projects will be co-ordinated nationally and it will be easier to choose winners. It remains to be seen whether basing the SCT in NHS 24 will increase health boards' exposure to telehealth and encourage them to take up telehealth as a major tool to improve the efficiency of the health service, but it is essential that that happens. We look to the Government to give a lead in the matter.

Although it is true, as I said at the beginning of my speech, that telehealth projects can succeed only if those who use them are adequately enthused, such enthusiasm can be kindled only if there is in place not only adequate and long-term funding but an educational structure to ensure that participants can cope with the technology involved. In that respect, it is good news that over the past few years there have been discussions between the SCT and NHS Quality Improvement Scotland on information technology developments, which have the potential to revolutionise the way that the NHS and other public bodies provide services and generally relate to the public. It is important to embrace those new technologies. In a sense, we are limited only by our own lack of imagination. However, we must realise that new pitfalls and problems lie ahead when we embrace new technologies.

Our committee's report gives some advice on how we should move forward in the field of clinical portal development and telehealth and what to watch out for. Education—

The Deputy Presiding Officer: Wind up, please.

Ian McKee: In summary, we could be on the brink of huge and game-changing developments in patient care, but only if we prepare carefully and fund sensibly. I commend the report to members.

15:30

Helen Eadie (Dunfermline East) (Lab): I am pleased to take part in what I consider to be an important debate that could help to unlock exciting developments throughout Scotland. I echo Christine Grahame's comments about the potential little gems—she is absolutely right. I also appreciate her remarks—I have a degree of sympathy for them—about whether those of us

who have attended four committee meetings this week and last week and have spoken in chamber debates both weeks are here in body, spirit and mind, but for this debate I am here on all counts, because telehealth is such an important issue.

It is true to say that when the Health and Sport Committee held its inquiry, every member expressed varying degrees of concern and their frustration that the Government was not doing more to develop an area that has great potential for delivering much-improved care and more targeted and efficient ways of spending public money. It is an understatement to say that there were "varying degrees of concern", because I think that we were hugely frustrated and hugely concerned. However, in this debate I want to tell Parliament why I have added my voice to support for a high-tech eye care initiative that is currently being piloted in Fife and why I shall join all those who are campaigning for it to be made available throughout Scotland.

I hope that the minister is listening carefully, because when I visited Queen Margaret hospital in Dunfermline in August to see the new electronic referral with digital images system, I was hugely impressed. The system has drastically reduced referral times by taking electronic photographs of people's eyes at high street opticians and instantly e-mailing them to the ophthalmology department at Queen Margaret hospital—60 per cent of opticians in Fife are now taking part in the process. It is the only system of its kind in the United Kingdom, and eye specialists say that it has revolutionised the way that people are referred to eye clinics and has already saved the sight of patients who required immediate treatment. However, calls to extend the technology to other Scottish health boards have highlighted a major dilemma in the current economic crisis: whether to freeze spending now or invest to save money later. The Scottish Government will consider that dilemma further at its programme board meeting in December. I ask the minister to please take a special interest in those deliberations.

NHS Fife has played a pioneering role in tackling preventable sight loss by drastically reducing the time between initial examination and specialist follow-up. Already, cases requiring immediate treatment have been identified. One gentleman was only hours away from a stroke, and his life was saved as a consequence of the use of this technology. I press the cabinet secretary—or rather the minister; I have just promoted Shona Robison—to introduce the system in other health board areas. We are on the verge of having a truly world-class eye care system in Scotland. We must not step back from that. Investing now will pay dividends later and may save the sight of many people.

Dr Roshini Sanders, who is a consultant ophthalmologist, is one of the lead consultants at Queen Margaret hospital. She told me that the electronic referral system with attached digital images allows them speedily to identify patients who require sight-saving treatment while also recognising long-standing pathology that requires hospital attendance. It also ensures that patients are sent to the most appropriate specialist clinic at first visit, thus giving a one-stop service at hospital. I am so glad that I live in Fife, with this service on the doorstep. Overall, the redesign of electronic communications makes excellent use of hospital resources for patients, ophthalmologists and optometrists.

A constituent of mine, James Taylor, a Lochgelly man who was featured on the front page of the *Central Fife Times and Advertiser*—that is my press release: I am taking a second bite of the cherry—was seen in hospital just 24 hours after referral by his optometrist at the specialist macular clinic. His digital images clearly showed treatable wet macular degeneration.

Mary Scanlon: Does the member agree that the public-private partnership between optometrists and the NHS is one of the best in Scotland and puts patients at the heart of the service?

Helen Eadie: I am not in a position to evaluate that, but if Mary Scanlon says that it is, she must be right.

Mr Taylor's digital images clearly showed terrible wet macular degeneration, yet he had intravitreal treatment and recovered his vision. Dr Sanders told me that if Mr Taylor had not been treated in time, he would have gone from being able to drive to being functionally blind. Mr Taylor told me that he went to the optician, who took a photograph of the eye and told him to come back an hour later because there was something that he was not happy about. He was then told that he was on the verge of losing his sight completely. The specialist nurse in the unit told me that one patient had presented at the optician and, when his photographs were taken and analysed, it was revealed that he, too, was only hours away from a major trauma—a stroke. That patient was sent straight to hospital.

The country's leading sight loss charity, the Royal National Institute of Blind People Scotland, has backed my call. The director of RNIB Scotland, John Legg, told me that the Fife system has significantly improved eye care services by reducing paperwork, ensuring correct appointment allocations and allowing e-diagnosis. A highly significant outcome has been the high proportion of patients who have been identified as not needing a hospital appointment, saving both time and money. In June, the charity published a report

that warned that the number of Scots with sight loss could double to almost 400,000 between now and 2030. It estimates the total cost to the public sector to be £194 million a year already, but that figure will increase significantly, because the elderly population is set to rise by 62 per cent over the next two decades. Already, up to one in six out-patient appointments at some Scottish hospitals is for eye care. John Legg has said:

"The annual cost of sight loss per person is around £17,600—roughly equivalent to ten hospital admissions."

The Deputy Presiding Officer: Wind up, please.

Helen Eadie: I make no apologies to anyone in the chamber for providing an intense case study, as it illustrates very well how telehealth can magically make a difference for people. I hope that that example will persuade others that we must invest in and be enthusiastic about telehealth.

15:38

Nanette Milne (North East Scotland) (Con): I join others in acknowledging the painstaking work of the Health and Sport Committee and its clerks that has led to the comprehensive report that we are discussing. I also share the concerns that are expressed in the report about the slow and inconsistent provision of electronic technology in Scotland over the past decade or so. Like Christine Grahame, I am a bit of a technophobe—I hope that I have understood correctly the report on clinical portals, especially as I am not a member of the committee that took evidence during the inquiry.

Given the undoubted financial savings and improved services for patients that would result from clinical portal technology and telehealth solutions, it seems inconceivable that progress towards their implementation has been so slow and patchy at a time of rapidly advancing technology. The speedy exchange of patients' health information—be that their medical history or information about their allergies and drug sensitivities or the medication that they are currently receiving—must be of immense benefit to patients, particularly in an emergency situation when they may be in the care of health professionals who are not familiar with their records. The rapid transmission of test results to a hospital or GP will help to ensure speedy diagnosis, treatment with appropriate drugs based on accurate information and the ending of the common practice—which Ian McKee, Richard Simpson and I know all too well—of repeating a barrage of tests every time that a patient presents in hospital. That will surely result in significant savings in junior doctor and laboratory time and costs.

I fully understand the concerns of the BMA and others about the risks of breaching patient confidentiality and the need for a proper identity and access management system across the NHS. With that in place, and a reliable system to ensure the application of ethical standards of confidentiality, I can see only benefits from clinical portal technology in the NHS, although the caveats from Ian McKee and Jamie Stone cannot be ignored.

The committee appears to be somewhat at odds with the Government in recommending strongly that efforts should be directed towards a single portal system across all health boards, rather than the incremental approach towards a maximum of four portals that is currently proposed. Although there is a need for the speedy implementation of clinical portal technology, health boards are in different states of readiness for it and there are difficulties in merging existing systems into one national portal, as Dr Kelly, the Scottish Government's e-health clinical lead, explained to the committee. I therefore see why the Government has opted for a portal that draws relevant patient information from a variety of systems at the point that it is required by the patient's clinician rather than going with the committee's recommendation, although the Government states that it shares the committee's desire for more sharing and greater commonality of systems.

Cost and value for money are particularly important at this time of financial constraint and I welcome the committee's stated intention to focus on the financing of clinical portals when it considers the Government's draft budget for next year, given that information on the capital costs for the development and implementation of projects is not readily available.

I am appalled that telehealth and telemedicine are still not available right across the NHS in Scotland. I remember being excited about the possible applications of telehealth solutions way back in my early days as a doctor in Aberdeen when Nelson Norman, who was at the time a senior lecturer in surgery at the university, pioneered their use in connection—if I remember rightly—with the oil industry. He did so initially from a tiny room at the back of my husband's health centre.

Over the years, as technology has improved, and largely due to the enthusiasm and hard work of clinicians such as Jim Ferguson at Aberdeen royal infirmary, telehealth solutions have increasingly been used, in the north-east and elsewhere, in the diagnosis and treatment of skin disease, the management of epilepsy, the interpretation of X-rays sent from remote centres

and in empowering patients to manage their long-term conditions at home.

There are so many benefits for patients, particularly in remote and rural communities, and there is still enormous potential for the future, provided that the communications infrastructure—up-to-date broadband technology, in other words—is available, as Jamie Stone stressed in his contribution.

I visited the Scottish centre for telehealth with Mary Scanlon a couple of years ago, and I still remember Jim Ferguson's frustration at being hampered in the roll-out of services by what can only be described as the vested interests of senior clinicians who were afraid of losing their fiefdoms to modern technology. Surely patients' interests must come first, even if clinical empires have to fall by the wayside to accommodate them.

During the committee's consideration of telehealth development, it became clear that there was a lack of national assessment criteria on which to base assessment of the impact, effectiveness and cost sustainability of telehealth projects in the delivery of health care. For example, the potential benefits of telehealth solutions in providing GP out-of-hours cover in remote and rural areas are well recognised, but that is one instance in which the lack of national assessment criteria is proving to be a stumbling block in the transition of telehealth pilot projects into permanent delivery tools for health care across the country. A key element of the telehealth strategy must therefore include such criteria to allow for the effective analysis and delivery of telehealth solutions in the health service.

I very much hope that the incorporation of the Scottish centre for telehealth into NHS 24 will allow rapid progress to be made in realising the full potential of what is a magnificent technology. Patients deserve no less, and the pioneering work of the NHS personnel whom I have mentioned deserves no less. I was excited by the report that we are discussing and I hope that the Government will implement many of its recommendations, which I am sure will allow the best modern diagnosis and treatment to become available to patients wherever they live in Scotland and ensure best value in the use of our precious NHS resources.

15:44

Michael Matheson (Falkirk West) (SNP): I will not offer another definition of "clinical portal". Members have provided several definitions and I suspect that the members who still do not understand what a clinical portal is probably never will.

It is fair to say that clinical portals, e-health and telehealth make for a dry topic. I confess that I have never had a constituent come to my surgery to complain about problems with the clinical portal or e-health. However, constituents have expressed concern about the loss of medical records and their difficulties in accessing records. I have little doubt that an appropriate, effective clinical portal offers a key way to address issues that my constituents have experienced over the years.

When the public sector talks about being innovative and finding IT solutions to such problems, I am conscious that it does not have a great track record in the area. However, it is fair to say that the NHS has gradually introduced more and more IT into its processes during the past 25 years, which has revolutionised how many patients are treated. The challenge is to ensure that we continue to find innovative and effective IT measures that will improve patients' treatment in the NHS.

The key test of such innovation must be whether it improves patient experience. That is the principle. The committee heard that, rather than patients' interests being central to the matter, innovations have been stifled over the years by what appears to be professional self-interest. That is sad. I will return to the issue, which relates to telehealth more than it relates to the clinical portal.

Significant progress has been made in the development of an effective clinical portal, as members said. The main objective, however, is to improve patient experience and during the committee's evidence gathering I was concerned about the lack of patient engagement in that development process. I accept that the clinical portal programme board is trying to shape things and take the initiative forward at national level, but I am concerned that there is no permanent patient representative on that key body, which is largely made up of clinicians and IT experts. That in itself represents a failure on the part of some of the people who are leading the approach in the NHS to recognise that the clinical portal is about making life easier and better not just for clinicians, but patients. I hope that there will be greater engagement with patients in future, to ensure that the portal is designed to reflect their views.

We should not overplay the extent to which professional self-interest is stifling developments in telehealth, but nor should we underestimate the impact of such self-interest. When the committee started its inquiry, I was under the impression that telehealth had made significant progress over the years. I was disappointed to find that little progress has been made and that the progress that has been made has been relatively slow.

I acknowledge that progress is starting to be made in some areas, but there seems to be a pattern with telehealth. People will say, "Let's try a pilot in this particular field and see how it runs for a few years." If an initiative proves to be quite effective, we will hear no more about it. Ian McKee highlighted what happened with the telehealth programme that his practice developed some 35 years ago. I hope that one of the key objectives of the Scottish centre for telehealth with its move into NHS 24 will be ensuring that pilots and programmes that are developed are rolled out throughout the country so that good practice is spread across different health boards. We need to ensure that we capture the benefits that come from those pilots and do not lose them time and again. That appears to have been the pattern over the past two or three decades.

Professional self-interest, particularly in relation to dermatology, was highlighted to the committee. Greater use of telehealth in dermatology could probably be well developed, but it was suggested to the committee that the real inhibitor to that is that fewer dermatologists would be required to do the work that is currently done. It is not exactly in the dermatologists' interests to be too enthusiastic about the introduction of greater use of telehealth in that field and I have no doubt that elements of professional self-interest will creep in to undermine telehealth developments in other areas of health care.

To conclude, it is extremely important that we try to make greater progress in the use of telehealth, but we must also be prepared to confront professional self-interest when it arises. The key way to achieve that is through strong leadership in driving forward telehealth measures in the NHS. It is probably better to do that in the current economic climate than it has ever been.

15:52

Rhoda Grant (Highlands and Islands) (Lab): The subject matter of this debate is the use of technology, but the committee's report is really in two distinct parts. The first part considers a single patient record portal and the second part considers e-health. It could be argued that the first issue is very much part of the second issue, but they were separated because of the way in which we took evidence. I suppose that the first part is to do with an administrative system and the second part deals with direct patient care. As technology grows, we will need to look at all the various aspects of e-technology and perhaps break them down further into groups such as paediatrics and elder care.

I will talk about the portal first. I was struck by several issues, including the fact that there is a myriad of IT systems in the health service. There are different systems in use not just between health boards, but between departments in the same hospital. That means that information cannot be shared among local units, far less among health board areas. Important information being unavailable caused slow diagnoses and repeat tests. Sharing information among health board areas is desirable, given that people are more mobile and that such information could be life saving. We also need to look at the huge waste of resources that occurs when tests and results are duplicated because they are not accessible to different departments in the same hospital.

The evidence that we took shows that GPs appear to have the most comprehensive patient records, but even they do not form complete records and they are often held in paper form. Common sense says that there should be one system for the same health board and the whole health service in the country. England and Wales have taken that route, but we discovered that they had hit complications. The Scottish health service therefore went in a different direction.

A number of Scottish health boards have been developing versions of a portal that can interrogate different systems and pull forward certain essential information, but there are patient confidentiality concerns that relate to that model. Members have talked about shared log-in details and passwords. They are essential in our health service because of the time delays that there are in issuing new passwords and log-in details, given the use of locum and bank staff. We need to consider ways of eliminating those delays from the system.

The best audit process that I can see, having followed the evidence, is to give patients access to their records and to have those records include an audit trail of who has accessed them. Before we do that, we must be sure that the log-ins and passwords are not shared, that patient access is secure and that people can access only their own record. However, those problems should not be insurmountable. The situation would certainly not be tolerated in any other business, because of the inherent inefficiency of people searching for information and running duplicate tests.

That ties in with an issue that I have raised with NHS Highland regarding the transmission of laboratory results. Ideally, they should be transferred electronically in a format that can be incorporated into GPs' computer records automatically. However, currently, the results are transferred in paper form. They are printed out in the lab and posted to GPs, who then have staff inputting the results at the other end. I intervened and asked for the process be changed. I have been told that lab results will be scanned at the lab and sent electronically to GPs. That will speed up the transmission of the information, but it will not

create greater efficiency for staff, because someone in the lab will have to scan the information and someone in the GPs' office will have to put it on to the computer system in a way that can be interrogated to show patterns.

I move on to e-health more generally. It is timely that Liam McArthur will speak next, because I was up in Orkney recently and was shown round the Balfour hospital in his constituency. I was impressed by the videoconference facilities in its accident and emergency department. Local staff can pull in expert opinion that allows them to make decisions about a patient's further treatment. Remote areas are much keener to incorporate e-health, but they need buy-in from the specialists. That is happening, but it must become the norm.

Like Mary Scanlon, I am concerned that the Balfour hospital is the only rural general hospital in Scotland that does not have a CT scanner. As she said, such a scanner is essential for stroke care, but it can be used for many other problems. A scan can inform whether someone can be treated locally or should be referred for more specialist treatment at another unit. That can be done by sending scans electronically. When I was in the Balfour hospital, I was told that another benefit of a scanner is that it can inform staff if a patient is untreatable. In a remote community, that information can save patients who are in their last hours from being moved from hospital to hospital without their family around them and without the support that their friends can give them at that terrible time. It means that precious remaining hours can be spent with loved ones, rather than chasing round the country.

We need to use technology to reduce hospital stays. Pre-operation checks should be done as close to home as possible. DanMedical has pioneered equipment that can be used to carry out those checks at home. Doing so can shorten hospital stays and reduce the number of last-minute cancellations. Currently, in remote communities, pre-op checks might mean an additional day in hospital if someone needs to be checked the day before their operation and cannot return home. That leads to cancelled operations when there are complications. The use of technology could build efficiency into the system.

There are many more issues that I could talk about, such as care in the community. Mary Scanlon talked about Argyll and Bute. There are issues about treating people with Alzheimer's in the community and ensuring that people are safe at home. Helen Eadie talked about the eye screening pilot in Fife. I am glad that, after I raised that issue with NHS Highland, it agreed to consider whether it can implement such a programme.

We have some way to go with e-health. We began the journey many years ago, but we have not travelled far. The current IT systems are not fit for purpose, so making them appropriate for modern use must be a priority.

15:59

Liam McArthur (Orkney) (LD): I, too, am pleased to participate in this afternoon's debate. I congratulate the members of the Health and Sport Committee on what their convener celebrated as a dull but worthy report, but one that I found to be a thorough piece of work with some sensible recommendations.

The committee acknowledges not only that the issues addressed in the report have a bearing on the delivery of health care throughout Scotland, but that they are of particular relevance to rural and island areas such as the one that I represent. Jamie Stone, Nanette Milne and others also made that point.

A number of the points that I will make this afternoon will echo similar comments that I made in a useful debate that we had in the chamber in April last year, on a motion that was lodged by Dr Richard Simpson. As I did in that debate, I intend to concentrate on telehealth and telemedicine. First I will touch briefly on clinical portals—without offering any definition.

The benefit of providing clinicians with timely access to relevant information on patients is self-evident, but the committee is absolutely right to flag up concerns about transparency and data security. Probably all of us can cite examples of where IT systems have been promoted as some sort of panacea when in fact issues to do with cost, reliability and the way in which they are used are held up to insufficient scrutiny from the outset. From my postbag I know of the problems that can and do arise within the health service as a result of poor communication with patients on how their medical information is to be used and shared. As a number of members have said, it is vital that effective steps are taken to increase public understanding and thereby confidence, while still enabling the benefits of such clinical portals to be secured. I am pleased that that point is made strongly by the committee in its report.

That public confidence is unlikely to be safeguarded by the creation of an uber database of personal information. The minister is correct in her response on that point. The committee highlighted that there are potential concerns about the decision to proceed with developing multiple-portal systems. Although I am not intuitively a fan of a one-size-fits-all approach, it strikes me that the committee is right to flag up issues that arise from the promotion of different systems across the

NHS that might impede access to clinical information. Ian McKee offered some insightful comments on that.

In Orkney's case, although most patients who require to be transferred will head to either Aberdeen or Inverness for treatment, a not insignificant number can find themselves sent to Glasgow or Edinburgh. That involves interaction with three separate regional consortia, and I would welcome the minister's assurance that appropriate access to relevant clinical information will not present difficulties as a result.

As I made clear previously, I represent and was brought up in a part of the country where the development of telehealth and telemedicine can have and is having an impact. Until recently, patients in Orkney who were suspected of having suffered a stroke would have been referred to Aberdeen for a consultation with a stroke physician. That would have involved cost, inconvenience and probably no little discomfort, as Rhoda Grant said. Invariably, however, it would also have involved time—the thing that suspected stroke patients can least afford after the onset of symptoms. Current evidence suggests that the first 24 hours are critical and that appropriate secondary prevention treatment ought to start immediately. For logistical reasons, that has simply not been possible for Orkney patients in the past. However, since July 2008, telemedicine has enabled some of those problems to begin to be addressed. Dr Macleod, the clinical leader in Aberdeen, and Bob Hazelhurst, the GP lead in Orkney, have been instrumental in developing the stroke telemedicine service in Orkney.

Through video consultations, access to specialists is now possible for my constituents without their needing immediately to leave the islands. The technology that allows that to happen is now in place in GP practices across the islands and at the remote consulting site at Aberdeen royal infirmary, which I have had the privilege to visit. The results to date have been hugely impressive—so much so that the team has already picked up the innovation and improvement award at the Scottish health awards.

There is undoubtedly potential to do more—we are already seeing that in the management of long-term conditions. In that regard, clinical reviews have been carried out in the past 18 months of cases involving diabetes, cancer, epilepsy, neurology and rheumatology.

Unfortunately, as Mary Scanlon rightly said in her speech, which was echoed by Rhoda Grant, and as I have made clear on numerous occasions in the chamber, the continued absence of a CT scanner in Orkney is now a source of serious concern. That prevents thrombolysis following a stroke and undermines the scope for undertaking locally many other procedures within the timeframe that is set out in strict guidance. My concern remains that when any cost-benefit analysis of a CT scanner in Orkney is carried out, no account can be taken by the board of the resulting cost savings to NHS Scotland and the Scottish Ambulance Service. The reduced costs in relation to transport, admissions, overnight stays and emergency transfers are all savings that would accrue outside NHS Orkney's budget. However, I understand that the board would still bear the full capital and on-going costs of a locally based scanner. The minister was right to acknowledge that using telehealth technology to access CT scan information is helpful, but the scans cannot be performed remotely. Access to a scanner would deliver far more.

Telemedicine can deliver and is delivering more in supporting access to professional advice and development for health professionals who operate in some of the smaller islands in Orkney and throughout the remoter parts of the country that Jamie Stone and I represent. The benefits for staff and patients are obvious and significant. However, I urge caution again about ensuring that the public are fully engaged at every stage. If the technology is seen as a means to centralise services, it will meet understandable resistance. The population is ageing and is dispersed across many smaller islands, so the use of such technology is fundamental.

Orkney health and care—the model that brings together social care and NHS services in my constituency—is developing a variety of telehealth and telecare solutions. The model will help in dealing with dementia and falls monitoring and will provide call alarms and more sophisticated equipment that can monitor a patient's blood pressure and oxygen levels. I welcome those pilots, but I was interested to note Ian McKee's observations about what might be called pilotitis. I echo him and Michael Matheson in saying that we might need to look again at how that situation can be improved, perhaps by accepting the committee's call for HEAT targets on mainstreaming the use of telehealth in health boards.

I support the committee's observation, which Jamie Stone reinforced strongly, that without the availability of high-speed broadband access, the development of telemedicine and telehealth will inevitably be inhibited. In the areas in which such innovation could lead to the most dramatic improvements in care, the quality and reliability of broadband are often at their poorest. NHS Orkney, the local council and their partners are seeking to address that, but I hope that the minister will accept that different boards' needs vary and must be taken account of when funding is allocated.

I congratulate the committee on its report. Rarely can dishwater, as Christine Grahame described it, have proved so worthy of closer inspection.

16:07

Dave Thompson (Highlands and Islands) (SNP): As I represent Scotland's largest parliamentary region, which contains hundreds of large and small communities in remote glens, peninsulas and islands, I am very much aware of the challenge that our health professionals face in delivering the care and support that our constituents need. In the past, that health care was delivered by innumerable village doctors and community nurses who were scattered throughout the Highlands and Islands, who made themselves available to their patients whenever the need arose.

Times have changed and individual doctors are no longer available to serve their patients 24 hours a day, so we must consider new ways of delivering the ever-more complex benefits of medicine and nursing care to patients throughout our rural and island communities.

In that context, modern information and communications technology comes into its own. It allows medical staff to spread their expertise over a far greater area than used to be possible by jumping into a car to pay a personal visit to a patient's home or requiring a sick highlander to make their way to Inverness, Broadford or Fort William for what was often an urgent medical appointment.

In recent years, improvements in communications technology have allowed some of our more experienced doctors—in Inverness, for example—to use telemedicine to have consultations with patients in Caithness, Skye or the Western Isles by using a videoconferencing link and to make an informed diagnosis of a patient's condition and create an individual treatment plan.

However, not all remote health care needs to involve consultants. At another level, it can involve an elderly or infirm patient wearing a sensor to alert staff in a sometimes distant care centre of any change in their condition. Sometimes that is as simple as a button on a box hanging around the patient's neck that can be pressed in an emergency, but advances in such telecare technology have allowed that simple alarm button to be supplemented with a range of sensors to monitor breathing, blood pressure or heart rate.

Between those two extremes is telehealth. Increasingly, it allows health professionals to access a growing range of vital details about the changing condition of patients who have long-term conditions, such as diabetes, or a history of heart failure without the need for patients to leave their homes and be brought into often distant hospitals that are many miles from their local support network of family and friends.

Health care managers and enterprise chiefs in the Highlands and Islands have adopted e-health enthusiastically, and not just for its benefits in spreading care to remote and isolated communities. A cluster of related businesses has been built to help progress and test e-health developments in exactly the type of environment in which they are most needed.

Capitalising on this new sector of health care was a key driver in Highlands and Islands Enterprise's decision to invest £24 million in the creation of the new centre for health science beside Raigmore hospital in Inverness. E-health companies are being encouraged to congregate at the centre to allow cross-fertilisation of ideas and knowledge in a manner that is similar to that used in silicon valley in California, where great advances in computing have been seen in recent decades. The cluster of cutting-edge researchers who operate from the centre for health science has helped to establish the region as an internationally recognised centre of excellence in this pioneering area. Indeed, the strategy is already bearing fruit. So far this year, some of the world's leading communications and telehealth experts have gathered twice in Inverness for major e-health conferences.

Although current developments in telehealth require only a relatively conventional mobile phone or traditional land-line telephone connection to operate, there is growing concern that the patchy provision of broadband in rural areas will have a limiting effect on the next generation of e-health developments in the areas where those developments are needed most. Other members have mentioned that, and the committee touches on the issue in paragraphs 78 and 79 of its report:

> "A key piece of infrastructural development necessary to support such telehealth services is the availability of high-speed broadband internet access. As with many other aspects of the public services, broadband access is especially important in remote and rural areas.
>
> In our view, the forthcoming telehealth strategy must clearly set out how such services will be delivered and how this links with the Scottish Government's broadband development policy."

Unfortunately, responsibility for Scotland's broadband infrastructure is reserved to Westminster, although the Scottish Government has done what it can to support the roll-out of vital new communications technology into communities where it is needed desperately.

Westminster's approach to broadband roll-out often appears to be that it should be driven purely

by commercial considerations. Regrettably, the businesses with a role in delivering the telecommunications infrastructure that is needed for modern broadband access will always concentrate on areas of high population, not scattered communities in large regions. Government intervention is needed to help with that. We must do all that we can to encourage Westminster to ensure that Scotland's rural and island communities catch up with the provision that is taken for granted in the rest of the UK—provision that allows people to benefit fully from the important developments that are taking place in e-health. Jamie Stone and Liam McArthur touched on the problem, but we do not need yet another Liberal Democrat campaign and petition. I say to them, "You are in government now, gentlemen." Jeremy Hunt must deliver broadband for the Highlands and Islands, too. We need no more petitions, political games and spin from Jeremy Hunt and the Lib Dems in London; we need real progress.

Jeremy Purvis: I am sure that the member is aware of the pathfinder north project under which schools got broadband connections. The project was fully delivered by the previous Scottish Executive. What prevents the Scottish Government from doing the equivalent in health?

The Deputy Presiding Officer (Trish Godman): You are in your last minute, Mr Thompson.

Dave Thompson: Okay. Thank you, Presiding Officer.

Mr Purvis will find that the Scottish Government has done many things with its limited powers, but that does not change the fact that responsibility for broadband infrastructure rests primarily with Westminster. If it rested with us in this chamber, the Scottish Government would have no problem in getting all members to agree to do something serious on the matter. Jeremy Hunt and the Lib-Cons in London have the power and control of the purse-strings through a Highland MP called Danny Alexander. If Mr Purvis wants to influence broadband improvements, including in the Highlands and Islands, he should get on to his MPs.

16:14

Angela Constance (Livingston) (SNP): I congratulate the Health and Sport Committee on its inquiry into clinical portals and telehealth development in Scotland. I do not have the privilege of being a member of the committee. However, having listened to committee members' comments in the debate, I can see that they are a rather feisty and incisive lot. I listened to Dr Ian McKee's speech, in which he spoke about what he was doing in telehealth 30 years ago, and I suspect that some of them are a bit longer in the tooth than some of us.

Jamie Stone: It was 35 years ago.

Angela Constance: I stand corrected; we must get our facts right.

The committee has correctly assessed the huge but as yet largely untapped opportunities for portal care, e-health and telehealth. We cannot and must not underestimate the potential to deliver more effective and efficient health care and medical research and a more truly joined-up 21st century health service. Telehealth has given us the opportunity and means to revolutionise the service, with prompt, accessible and preventive health care.

The committee is right to aspire to see Scotland as a world leader in e-health and the first country to establish a national-scale telehealth service. I detect its impatience in its report. It is good to be impatient and to demand the best—sometimes that is the only way of moving things forward. Of course, Government must balance a good pace with good footwork, to ensure delivery. As the minister indicated in her speech, good progress is being made and there is a shared vision, not least in the desire to mainstream telecare.

Although I understand and accept the minister's decision on HEAT targets, I urge her to consider such targets as a weapon to be retained, if there is a need to cut through the cultural resistance to which Mary Scanlon referred, the pilotitis to which Ian McKee referred or the professional self-interest to which Michael Matheson referred. The financial climate in which we live at present is very challenging—that is probably an understatement—but with every crisis there are opportunities. There are opportunities to develop a shared approach to services, not least in information technology.

I reiterate that telehealth is about taking health care to patients, where and when they need it, and not an excuse to centralise services; on that point, I concur with Liam McArthur. I reinforce the remarks that other members have made this afternoon about the great value of technology for remote and rural areas. I know that Livingston is just off junction 3 of the M8 and will not be considered remote or rural, but my constituency is mixed and has a large rural component, where public transport is rather poor. There are also areas in West Lothian where broadband access remains rather elusive. The committee was right to highlight in its report the relationship between the roll-out of broadband and that of telehealth, and the need for those strategies to co-operate.

Given that many members have raised the issue of digital participation, I highlight the fact that there is a cross-party group on the subject, chaired by

my friend and colleague Willie Coffey, who assures me that the group is working hard to address some of the issues that have been mentioned. I am sure that members are welcome to attend meetings of the group.

I confess that initially I came to the issue of telehealth as a bit of a sceptic. I am the sort of person who would rather speak to someone than send them an e-mail. My initial concerns were probably epitomised by the sketch in "Little Britain" in which a woman sits behind a computer and, irrespective of the customer's question, always gives the answer, "Computer says no." I became a convert when I became aware of the good work that is being done in West Lothian. NHS Lothian, in conjunction with West Lothian community health and care partnership, has been participating in one of the biggest telehealth projects in Europe—a £700,000 project that focuses on the use of telemetry in tackling chronic obstructive pulmonary disease, high blood pressure, diabetes and stroke.

To my surprise, the technology is extremely popular with patients, who have the equipment in their own homes. Carers are reassured that their loved ones have more immediate access to health care, and the approach has been proven to improve a patient's confidence and their control over their illness.

I will quote one patient who said in an evaluation of the project:

"My Doctor phoned me up to say that he had been monitoring my health system and wanted to visit me as he thought I had become unwell. It was great, as I was just about to phone him and ask for an appointment anyway - the system works."

Mind you, that sounds a bit more like telepathy than telehealth, so we should perhaps be careful as to what we aspire to.

There is huge potential in clinical portals, telehealth, telecare and telemedicine. As has been highlighted in the report from the Health and Sport Committee, we have to grasp the moment and not waste the opportunity to revolutionise health care in this country and turn around the poor health of our nation.

16:21

Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD): Not many committee reports have been introduced to the Parliament by the convener with the words "looks dull, sounds dull." However, not many committee reports will affect every health service and care user in the country. This will be an issue of huge importance over the next decade, and if wrong decisions are taken now, it will set back our health and care services considerably.

Members have taken the opportunity this afternoon to raise some of the difficulties. Technology has been simply too slow to allow patients and users of care services to gain the potential benefits. Some vulnerable constituents of mine, who are at risk of falls, have discussed their particular difficulties with me. They made a request to link their mobile phones to the care alarm system, so that if they had a fall in their garden or outside, they could use the system that is already in place without necessarily having to call an ambulance.

Some deaf and hard of hearing patients have also approached me. They were unable to text or e-mail the audiology department at their local hospital. I was taken aback to find out that the audiology department allowed deaf people to get appointments only by making a telephone call. It seems extraordinary, but that was the case up until earlier this year.

Mary Scanlon highlighted the practical benefits of using telemedicine and telehealth better, especially for people who are more liable to be admitted to hospital. Patients wish to access information about their health or lifestyle; they seek advice and support; they want to improve their awareness of their health condition; they wish to receive reminder messages for appointments, or the health service wishes to provide them—and the Ambulance Service is starting to deliver that; and patients wish to monitor their medicines more closely.

This has not been raised much in the debate, but telehealth is also of critical importance to carers, who can use the technology to support those for whom they are providing care. It provides opportunities to identify and treat people who have suffered strokes, and it supports people in stroke rehabilitation, where there have been innovative solutions although they have not been sufficiently mainstreamed. There are huge opportunities for health.

I was recently on a school visit and we were speaking about health services in the context of the work that I do. It became apparent that one of the key sources of advice and information on health for young people is now Google. When it comes to using the internet and resources and technology that young people are familiar with—texting questions, or using the phone or the internet—we have been far too slow to catch up.

There are positives. When my dad started working as an ambulance driver in 1978, he would not know any information about the incident or patient that he was about to attend, nor would he have the ability to send the hospital data or information about the patient and their condition. By the time he retired a couple of years ago, technology had advanced—albeit too slowly—to

allow the transfer to the hospital of information on patients. That saves lives.

Last week, I spoke to users of the Broomhill day centre in Penicuik at their annual general meeting. The guest speaker was Dr Begg, who had started his career in 1981, which is more recently than Dr McKee. It was interesting that most of the questions from the elderly users of that day service were about matters such as their rights to information, how their carers or loved ones could use that information, how other users of the day service with early-onset dementia would be able to have access to such information and how their pharmacist was able to access information from their doctor. I was surprised that information was uppermost in their mind. The reason why I asked the minister about the 111 number was because I was asked whether we are getting that in Scotland. People are asking about it and are interested.

I turn to the committee's recommendations on delivery. The minister did not refer to the work by the Cabinet Secretary for Finance and Sustainable Growth to revise the procurement of information and communication technology in the health service. The committee has identified many of the potential drawbacks with a single ICT system. It is not only that there are concerns about the security of data and information in a single system but that a single procured contract does not necessarily gain best value for the health service. Jamie Stone highlighted the valid issue of data loss. Those issues go together. I agree with Mary Scanlon that it is not good enough that it is two and a half years since a review of data security within the health service started. The ability of health officials to uphold consistency and security needs to be made much clearer.

Dave Thompson made some specific points on the Highlands and broadband. His analysis was correct. I, too, represent a rural constituency and, unless there is some form of Government intervention over the next decade, 40 per cent of that constituency will not receive superfast broadband. If we are to reap the benefits of telemedicine and telecare, we need that.

It would have been interesting to have heard the Scottish Government's response on that, rather than simply being pointed to another Government. In fact, it would have been particularly helpful if the Government had responded to the committee's recommendation on the matter. Dave Thompson spent more time highlighting the issue with the UK Government.

Dave Thompson: Will the member give way?

Jeremy Purvis: I will be charitable.

The Deputy Presiding Officer: No, I am sorry, there is no time, you are winding up.

Jeremy Purvis: I apologise that I cannot give way to Dave Thompson, as I was referring to him. I am sure that he simply forgot to highlight the fact that, in its response to the committee, the Government neglected to respond to the recommendation on broadband. Before we start talking about the UK Government, let us first ask the Scottish one what it is doing.

16:28

Murdo Fraser (Mid Scotland and Fife) (Con): I apologise to the committee convener: due to my late arrival at the debate, I missed her speech, which was clearly a sad loss on my part. As I intimated earlier to the Presiding Officer, I had another appointment that unavoidably detained me elsewhere. Nevertheless, I have gained the flavour of the convener's remarks from complimentary comments that other members have made and I look forward to reading her speech in the *Official Report* tomorrow.

The convener was probably a little unfair to say that the report was dull. Perhaps we could characterise the debate as worthy but dull, and I was grateful to Mr Thompson for enlivening it a little with his speech.

Christine Grahame: It was a little tongue in cheek to call it dull. In fact, I said that it was full of little gems.

Dave Thompson: Including the convener, of course.

Murdo Fraser: I will step back from describing the convener as a little gem and move swiftly on to the substance of the debate.

The background to the report is the experience of large IT systems in the NHS and other areas of government. It is fair to say that that experience has not been universally positive. Indeed, there are examples north and south of the border of a great many problems being identified with large IT systems that are intended to provide patient information to the NHS, which everybody would agree is an entirely desirable objective.

I recently wrote to the Cabinet Secretary for Health and Wellbeing to raise with her concerns that one of my constituents has raised with me about IT systems within NHS 24. Having been contacted by individuals who work in the sector, my constituent was concerned about the fitness for purpose of the IT systems that are being commissioned by the health service. When we are dealing with large-scale, public sector IT projects, it is almost inevitable that a large number of things will go wrong. Perhaps that is a function of the scale of those projects.

We can all agree on the importance of a clinical portal and how valuable it would be. My local

health board, NHS Tayside, has made the most progress on that, along with NHS Greater Glasgow and Clyde, and we can learn lessons from that. As the report says,

"The advantages of a clinical portal to improve the treatment of patients are clear".

Health professionals believe that there is a great benefit to be had from

"having immediate access to up-to-date patient information"

and that that

"is especially true in emergency care situations".

There is some concern about patient confidentiality, which is always a concern when large amounts of information are being transferred to an IT system that is accessible at different points by a variety of individuals. BMA Scotland raised that point in its briefing for today's debate, and Ian McKee, who clearly has some experience in the field, went into the issue in more detail, raising concerns about the sharing of user names and passwords.

The Government's response to the committee's report states that patients should be given access electronically wherever possible, perhaps through the future development of a patient portal or other digital medium, and I encourage the Government to go down that road.

Telehealth is an area in which I have a greater personal interest. There are tremendous benefits to be derived from it for the NHS and for patients. During the debate, we have heard a number of examples of how it could be of benefit, and I was particularly taken by Helen Eadie's contribution on her experience with eye treatment in Fife, which has clearly been a great success. On a personal level, I pay tribute to the Airlie silver surfers, who are based near Kirriemuir in Angus, for the work that they have done to promote telehealth. I have seen them do a demonstration of telehealth in practice. Despite their age, they are real enthusiasts for the technology.

Telehealth is a real benefit, particularly in rural areas. In parts of rural Angus and Perthshire, which I represent, journey times to local hospitals or health centres can be long. Members will know of my interest in health provision in highland Perthshire, particularly in and around Kinloch Rannoch, where for many years there have been concerns about the removal of out-of-hours GP cover. Part of the reason for that concern is the long distances that would have to be travelled by local residents if they had to visit a hospital, and journey times, particularly in winter, can put patients at risk. A quality telehealth product would certainly make a difference and help to alleviate some local concerns.

In avoiding unnecessary journeys, a proper programme of telehealth would undoubtedly mean a cost saving to the NHS. According to the briefing provided by Tunstall Healthcare, a leading provider of telehealth services, there is evidence that the average reduction in admissions to the NHS can be 30 per cent to 40 per cent over all long-term conditions. That means a better quality of care being provided to patients of the NHS in Scotland and a substantial cash saving, which must be welcomed in the current climate.

There is one important prerequisite for telehealth use, which is good-quality broadband—and a number of members have raised that point. Over the years and on numerous occasions, I have raised my concern that rural areas in Scotland suffer from second-class broadband services compared with those available in urban settings. I was interested in Mr Thompson's contribution, which was no doubt made with an eye on a not-too-distant election in the Highlands and Islands. To Mr Thompson I say gently that it is not helpful to pass the buck entirely to Westminster on that issue. The Scottish Government has the opportunity to take the initiative to extend broadband in rural areas. It has already done that. We all know about the Avanti contract, which I believe had serious flaws and was not fit for purpose in many rural areas; I have the mailbag to testify to that.

Dave Thompson: Will the member give way?

Murdo Fraser: Do I have time, Presiding Officer?

The Deputy Presiding Officer: Very briefly.

Murdo Fraser: I will give way briefly.

Dave Thompson: Surely the member agrees that the major responsibility for broadband development rests with Westminster. It has the real power to deal with the issue of telecommunications. There was a proposal was there not—

The Deputy Presiding Officer: That is enough, thank you. Mr Fraser.

Murdo Fraser: Perhaps Mr Thompson and I can agree that what is needed is a partnership approach, in which the Scottish Government does its bit and the Westminster Government does its bit as well. That would be to everyone's benefit.

The Government's approach to encouraging health boards to develop telehealth has not been a great success so far. More could be done. Having seen the Government's response, we need to question whether the Government is addressing the issue with sufficient urgency. Michael Matheson pointed out that the issue requires leadership, but from the evidence thus far I am not convinced that leadership is being provided. The

one clear message that comes out of today's debate is that the Parliament is unanimous in the view that telehealth is worth supporting. However, we require leadership from the Scottish Government. I look forward to hearing about that in the minister's response.

16:35

Dr Simpson: I will start with the issues on which we are all agreed. There is fairly universal disappointment about the speed of progress on the issue. We all agree that the correct approach is to build up the clinical portal system as gateways to individual suites of software, but there are clear concerns that, in rejecting any sort of centralised system, the procurement should proceed quickly and there should be a decision on which of the four systems in use is likely to be the most effective. We should narrow that down as quickly as possible. Both Christine Grahame, who spoke on behalf of the committee, and the minister agreed that having a uniform centralised system is not appropriate, but we need systems now that share data. As Rhoda Grant said, the inability to share data creates all sorts of problems.

An important point that has not been mentioned is the use of open-source software. Procuring commercial software that is based on a particular operating system can be very restrictive, whereas open-source systems can be developed jointly by all the clinicians with an interest and can be cheaper at the end of the day.

Ian McKee and others raised the linkage with primary care systems, such as the out-of-hours system that Nanette Milne mentioned. What worries me is that the GP, having entered the general practitioner system, will need to come out of that system and go into another system to enter the clinical portal. That is not good. We all get irritated by slow access, so requiring people to close down one system and open up an additional one is really not satisfactory. That needs to be dealt with.

Mary Scanlon talked about the general frustration at the lack of progress, as did Ian McKee, whose comments on pilotitis highlighted the fact that we have plenty of pilots that seem to work but do not make progress. For example, the NHS Highland and Argyle and Bute Council project seems to work, but is it being rolled out to other rural areas? Nanette Milne referred to Dr Ferguson's frustration about A and E telemedicine, from which NHS Grampian has saved massively on patient travelling, but such facilities are not yet available across the country.

Although some sort of heart failure monitoring has been rolled out—the West Lothian project to which Angela Constance referred is one of the best examples—given that the savings in patient admissions and in time and money are absolutely massive, we need to develop that sort of home-care e-care system much more. We have not mentioned prisons, but that is another area in which such data linkage could be of great importance.

The national service development is welcome, but I still think that we need incentives to overcome what Michael Matheson graphically described as the professional self-interest that often acts as a barrier to proceeding. He and I share a concern that the good work that has been done on using telehealth in dermatology in the NHS Forth Valley area—and the slightly different system in NHS Lanarkshire—has not been rolled out. Perhaps that is because dermatologists feel under threat from it.

Michael Matheson also mentioned his constituents' concerns about records being lost. With good electronic systems, such losses would be reduced.

A number of members—Jamie Stone, Ian McKee, Rhoda Grant and others—spoke about the need for patients to be at the centre and about the importance of patient confidence and confidentiality. Others spoke of data security. Has progress been made on the encryption system that was promised two years ago? Is every single case record that is on a disk or USB stick or hard disk now encrypted? Can the minister guarantee that everything is now encrypted and that if a stick is lost—again—it will not be accessible? That should be happening, because it is a simple piece of progress to make. The technology has been there for years, so the matter should have been dealt with.

Rhoda Grant and I mentioned tracking for patients. Patients should have access to their own records instead of audit and tracking, as that puts them in control and at the centre.

Jamie Stone, Dave Thompson, Murdo Fraser and many others said that broadband was essential to underpin telehealth, telecare and interconnectivity. Unless that is developed, we will face real problems.

Mary Scanlon, Nanette Milne and others gave a particularly good example of why telehealth is necessary—the repetition of lab tests. The three of us who are doctors went through the phase of being junior doctors, when we had to keep asking for tests to be repeated because the results had been lost or had come from another department or another hospital, or the GP had done the test and we did not have access to the result. If 20 per cent of lab test results are being lost, we do not need to look much further for evidence of the massive

efficiency gains that must be driven into the system.

I will give the minister another example from a case study that I did in West Lothian on an individual who had alcohol-related brain damage, which is an area that expert committees have considered and on which a lot of information has been provided. The man in question had 11 different case records, none of which was linked. He kept coming to see accident and emergency, the psychiatrists, the gastroenterologists, the social workers, the housing department and the police with whom he was involved. All those services had separate records on him and they were all doing their best, but no one had thought to tag the records and to give a single point of connection. Once I added my telephone number, we stopped the process. The next time that he came to the gastroenterology department, instead of being admitted for three days and then discharged, he was held for 10 days before being admitted to an alcoholism unit. Unfortunately, he was there for 10 months while he waited for a guardianship order and his health was permanently damaged. In West Lothian alone, 16 other cases of that particularly severe condition were identified, in which records needed to be tagged and co-ordination was required.

Christine Grahame: Will the member take an intervention?

The Deputy Presiding Officer: Sorry, but there is no time.

Dr Simpson: I have only 30 seconds left.

If they are successful, pilots should be rolled out. We heard a new word today: pilotitis. Let us see whether we can strike that from the medical lexicon as quickly as possible by rolling out pilots.

Helen Eadie gave the wonderful example of the ophthalmology triage, screening and follow-up service, which works extremely well and has prevented people from going blind, but it is a data-linkage work-around system that is not totally secure. It is fairly secure; those concerned have done their best, but the business case needs to be tackled quickly.

The Deputy Presiding Officer: You should be finishing now, Dr Simpson.

Dr Simpson: We need much more determined and informed leadership. We need a HEAT target and other specific targets that give health boards incentives. In that way, we can make the faster progress that all of us desire, which will enable Scotland to fulfil its potential as a world leader in this field.

16:43

Shona Robison: I thank members for their useful contributions to what has been an interesting debate on an important topic. It is evident from what has been said that the clinical portal and telehealth offer significant scope for improving health services for patients, and I am heartened by the progress that has been made in Scotland in developing the clinical portal for a comparatively modest amount of money—£15 million has been set aside for it in 2010-11 and 2011-12.

I turn to a number of the points that were made in the debate. Christine Grahame asked about an update on education for clinicians in e-health. I can tell her that a national working group has been established, which is chaired by an e-health clinical lead. It is working with the Academy of Medical Royal Colleges, which hopes to get a report on the progress that the group is making by the end of the year.

Dr Simpson raised a number of points, which I will take in no particular order. He called for a credible access audit to be available for patients. We recognise that patients being able to see audit logs electronically can help with the important issue of trust in the health service. That is certainly an aim, perhaps for the longer term, and it will form part of the wider consideration of the future of patient involvement in e-health. Yes, we want to get there, but it will take some time to reach that position.

Dr Simpson also asked about encryption. The Scottish Government issued mandatory guidance about the encryption of mobile devices and allocated £1 million to support its implementation. He also asked about the viewing of patient data by Government departments, both devolved and reserved. The clinical portal is a clinical system for the NHS and its staff to support patient care. There are obviously some advantages in looking at access for a single shared assessment, for example with social work, so there are issues that would be of benefit to telecare. However, there is no plan to enable information to be shared with the Department for Work and Pensions or others, as that would not be at all appropriate.

Christine Grahame: The example given by Richard Simpson, which I tried to intervene on him about, was a good one, but I have concerns about information sharing. The minister gave an extreme case as an example, in which housing and other departments would have access to medical records, which might be a grey area. However, I want an assurance that there is protection for individuals and that it would have to be in specific cases, after a specific application, that there would be such sharing of information.

Shona Robison: Absolutely. I can give that reassurance. My point about telecare is that information sharing may be appropriate. There would obviously have to be safeguards and, in the example of telecare, permission by the patient and carers. We could imagine that, for dementia patients, important information could be shared in the crossover between social work and health, but there must be safeguards. I hope that I have given Christine Grahame the assurance that she was looking for.

Mary Scanlon said that there is no timetable for taking telehealth forward. I hope that I outlined in my opening remarks that we are setting out a national implementation plan around the four programmes. We could attempt to do everything everywhere, but I suggest that that would not be the best way forward, which is why we have agreed the four programmes. They are going forward, and telestroke is scheduled for consideration for funding in November. There is a clear timeline.

Ian McKee was right to warn us against pilotitis—I have probably warned against it myself over the years. That is why it is important that the four programmes go forward in a planned and systematic way rather than on the basis of pilots that we have seen in the past. I do not think that anyone would disagree that we need to act on a far more planned and national basis.

Helen Eadie raised some important points. She rightly paid tribute to the important optometry initiative in Fife. The issue was discussed yesterday at the e-health programme board, which agreed to give it priority. Boards have been asked to come forward with improvement plans, agreed with optometrists in their area, and funding decisions will be made later in the year. I hope that Helen Eadie will agree that that is good progress, and I hope that she and other members will welcome the development.

Michael Matheson raised a number of important issues. He and Richard Simpson rightly paid tribute to the very good dermatology service in Forth valley. I have seen it for myself, and can say that it is very good indeed. We need to be aware that, as Michael Matheson rightly highlighted, professional interests are not always aligned with those of patients. We have to ensure that the patient interest is always of paramount importance in taking these matters forward.

Michael Matheson also asked about patient involvement in the clinical portal programme board. The board has two patient representatives, one of whom is the chair of the Long Term Conditions Alliance Scotland. It was recently agreed with the board that the LTCAS would ensure that patient groups are involved in patient portal development. I hope that that will address some of the concerns about the matter.

A number of other important issues were raised. The vast majority of NHS sites have broadband access via the N3 contract with BT. The NHS is working hard to improve the situation within the parameters of the available infrastructure. Murdo Fraser probably got the balance about right. There is more for the United Kingdom Government to do and I am sure that there is more for the Scottish Government to do. We will take that work forward as we can.

Murdo Fraser also talked about leadership. I hope that, in my opening and closing speeches, I have given a sense of getting on with the job and making progress, but we cannot do that by taking a scatter-gun approach. We cannot do everything at the same time everywhere, because that is not realistic and things are likely not to happen if we try to, so by agreeing the four programmes we have set out a sensible and systematic way of taking forward four important programmes in a planned way across the NHS.

The Health and Sport Committee recommended that an annual report be provided to the Parliament on the direction of progress on telehealth. That is a very good way to proceed.

I talked in some detail about the stroke programme. A lot of work is also happening in paediatrics, on chronic obstructive pulmonary disease and on mental health.

The debate has been useful, as it has been helpful to hear members' comments, which I am sure will be fed into the board so that it can reflect on them. I hope that I have been able to give a sense of real progress that will lead to real change for the benefit of patients throughout Scotland.

16:52

Ross Finnie (West of Scotland) (LD): It was a tragedy that so few members were in the chamber when the Health and Sport Committee convener opened the debate. Not only did they miss a very skilful and succinct summary of a difficult and technical report, they missed a masterly exposition of the convener's knowledge and understanding of information technology. Those who heard the speech will not be surprised that Christine Grahame was among the first of the MSPs to write to our IT department congratulating it on adopting Windows 7 architecture and on the introduction of Microsoft Office 2007. Equally, those who heard the convener will not be surprised to hear the rumour that, since they were installed, the convener has not turned her computer on.

I do not think that this is either a dull or a worthy report; it addresses a very serious issue, which

could impact on the whole of the way in which health care is delivered in Scotland. Although the report was written some months ago, its relevance is heightened by the need for us all to examine how we can deliver services better, more efficiently and, in some cases, with less expense. I am sure that the minister would agree that the report is a genuine and constructive contribution to that process. It lays out a whole series of recommendations that point to areas where, if we all worked at it, we could improve efficiency and delivery while, at the same time, reducing the pressures on cost.

As the convener pointed out, the report is in two distinct but related parts, the first of which concerns clinical portals. Dangerously, the convener began a definition contest that, sadly, the minister immediately joined in order to trump her. She was followed by Ian McKee, who tried even harder. Mercifully, Michael Matheson and Liam McArthur declined to enter the contest. Later on, the convener also attempted to define "telehealth". She began by telling us that it would enable us to remotely deliver, which I found slightly distressing, as I would have preferred it if she had told us that it might enable us to deliver remotely and that, therefore, modern technology would not corrupt the English language.

There are serious issues behind all these points. Ian McKee went back 35 years, but I go back to my early days as a minister in the first Scottish Executive, when I took part in a visit to Canada, part of which involved examining how services in Canada are delivered in remote and rural areas. A striking aspect of that visit was the extent to which the Canadians were embracing the principles of telehealth. The committee heard a tremendous amount of evidence of the benefits of telehealth, and many members this afternoon have pointed to important examples of those. Helen Eadie gave a splendid example of a case study involving the application of telehealth to optometry; Michael Matheson gave an example from dermatology; Liam McArthur talked about the service in a remoter area; and Angela Constance and Murdo Fraser also provided excellent examples. Those simple examples served to demonstrate what we are missing in our failure to engage the technology in a better way.

I share the view that members have expressed that we have been encouraged by the more positive response that the minister gave in both her opening and closing remarks, which contrasted to the slightly stuffy formal response that we received earlier in the year. I am glad that she has been able to reflect on that. All members were pleased that she was able to make a more positive comment. I am also pleased that, in the course of the debate, she has been able to give us some assurances and comfort on the education of clinicians, encryption, patient data, telecare, the timetable for telehealth, the issue of pilots being assessed before new pilots are introduced, the application of telehealth to optometry, patient involvement—the need for which was stressed by several members—and the need for broadband, recognising the role that it plays.

On the last of those issues, the committee made its recommendations in the clear knowledge that it is a matter not just of whether one has responsibility but of who is to engage with the private providers of the broadband services. Under the previous model in education, it was the Scottish Government that was able to speak to the providers because it commanded most of the services. That is what the committee had in mind when it made its recommendations in paragraphs 78 and 79.

The committee is in no doubt that the inquiry has proved to be an important exercise. In the case of the clinical portal, we have pointed out that the portal was well intentioned and well designed but that progress has been far too slow. We have pointed to many areas in which we are pleased to have prompted the Government into a positive response that might lead to the matter being taken forward at a better pace. We are concerned that telehealth must become more integrated into the delivery of health services across the NHS in Scotland at a much faster pace. We are pleased that we have raised all those issues and made recommendations that are receiving a positive response from the majority.

However, we must say to the minister that an investment of her time is required—as she has acknowledged—in leading the programme. Although it is clear from this afternoon's debate that we all agree on the benefits that could accrue from implementing a more integrated system of telehealth, we are not yet able to say that we are getting those benefits throughout Scotland. It is important for the whole of Scotland, and certainly for the remote and rural areas, whether they are in the Highlands and Islands or in the Borders.

We know, and the minister knows, that the committee has reported on difficulties in providing out-of-hours care services, and we all acknowledge that there is no single bullet—no one answer—to improve that situation. However, one thing that is certain is that telehealth can play an important part in improving the current position. Murdo Fraser made that point in relation to a case in his constituency that has been the subject of much controversy. Out-of-hours cover could be an area in which telehealth would be very beneficial indeed.

The committee is grateful to all those who have taken part in the debate and responded positively to the recommendations in its report. We are

particularly grateful to the minister who, in her opening and closing speeches this afternoon, has taken up many of the issues that the committee has raised. We certainly hope that the minister will find a way, perhaps without the need for a further debate, to report back to the committee and the Parliament on further progress in this most important area.

Business Motion

17:01

The Presiding Officer (Alex Fergusson): The next item of business is consideration of business motion S3M-7041, in the name of Bruce Crawford, on behalf of the Parliamentary Bureau, which sets out a business programme.

Motion moved,

That the Parliament agrees the following programme of business—

Wednesday 29 September 2010	
2.30 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Ministerial Statement: Broadcasting
followed by	Standards, Procedures and Public Appointments Committee Debate: Commission on Scottish Devolution
followed by	The Scottish Parliament (Disqualification) Order 2010
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 30 September 2010	
9.15 am	Parliamentary Bureau Motions
followed by	Scottish Conservative and Unionist Party Business
11.40 am	General Question Time
12.00 pm	First Minister's Question Time
2.15 pm	Themed Question Time Justice and Law Officers; Rural Affairs and the Environment
2.55 pm	Scottish Government Debate: Administrative Justice and The Future of Tribunals
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Wednesday 6 October 2010	
2.00 pm	Time for Reflection
followed by	Parliamentary Bureau Motions
followed by	Stage 3 Proceedings: Legal Services (Scotland) Bill
followed by	Business Motion
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business
Thursday 7 October 2010	

9.15 am	Parliamentary Bureau Motions
followed by	Scottish Government Business
11.40 am	General Question Time
12.00 pm	First Minister's Question Time
2.15 pm	Themed Question Time Finance and Sustainable Growth
2.55 pm	Scottish Government Business
followed by	Parliamentary Bureau Motions
5.00 pm	Decision Time
followed by	Members' Business—[*Bruce Crawford*.]

Motion agreed to.

Parliamentary Bureau Motions

17:02

The Presiding Officer (Alex Fergusson): The next item of business is consideration of three Parliamentary Bureau motions. I ask Bruce Crawford to move motions S3M-7042 to S3M-7044, on approval of Scottish statutory instruments on the Loch Lomond and the Trossachs national park and the Cairngorms national park, en bloc.

Motions moved,

That the Parliament agrees that the Loch Lomond and The Trossachs National Park Designation, Transitional and Consequential Provisions (Scotland) Order 2002 Modification Order 2010 be approved.

That the Parliament agrees that the Cairngorms National Park Designation, Transitional and Consequential Provisions (Scotland) Order 2003 Modification Order 2010 be approved.

That the Parliament agrees that the Cairngorms National Park Elections (Scotland) Amendment Order 2010 be approved.—[*Bruce Crawford*.]

The Presiding Officer: The question on those motions will be put at decision time.

Decision Time

17:02

The Presiding Officer (Alex Fergusson): There are two questions to be put as a result of today's business.

The first question is, that motion S3M-7015, in the name of Christine Grahame, on the Health and Sport Committee's report on "Clinical portal and telehealth development in NHS Scotland", be agreed to.

Motion agreed to,

That the Parliament notes the conclusions and recommendations contained in the Health and Sport Committee's 3rd Report, 2010 (Session 3): *Clinical portal and telehealth development in NHS Scotland (SP Paper 399)*.

The Presiding Officer: I propose to put a single question on motions S3M-7042 to S3M-7044. If any member objects to a single question being put, they should please say so now.

As no one objects, the next question is, that motions S3M-7042 to S3M-7044, in the name of Bruce Crawford, on approval of Scottish statutory instruments, be agreed to.

Motions agreed to,

That the Parliament agrees that the Loch Lomond and The Trossachs National Park Designation, Transitional and Consequential Provisions (Scotland) Order 2002 Modification Order 2010 be approved.

That the Parliament agrees that the Cairngorms National Park Designation, Transitional and Consequential Provisions (Scotland) Order 2003 Modification Order 2010 be approved.

That the Parliament agrees that the Cairngorms National Park Elections (Scotland) Amendment Order 2010 be approved.

Richard Demarco

The Deputy Presiding Officer (Alasdair Morgan): The final item of business is a members' business debate on motion S3M-6732, in the name of Linda Fabiani, on Richard Demarco, 80 years young. The debate will be concluded without any question being put.

Motion debated,

That the Parliament notes and celebrates the 80th birthday of Richard Demarco, one of Scotland's leading figures in art promotion and an advocate for contemporary art for decades; further notes that he has promoted cross-cultural links, taking Scottish artists abroad and bringing other European artists here, making a particular contribution to the understanding of Eastern European art between 1968 and 1989 with his journeys behind the Iron Curtain, that he was a co-founder of the Traverse Theatre in 1963 before going on to found his own gallery and the Demarco European Art Foundation, that he has been involved with the Edinburgh Festival Fringe in one way or another since its inception and that he has made a contribution to the academic understanding of Scottish and European culture through his lecture work, including his professorship at Kingston University in London; also notes that his drawings, paintings and prints are held in more than 1,200 collections and that his 80th birthday will be marked by a major exhibition in the Royal Scottish Academy (RSA) from 28 November 2010 to 17 January 2011, highlighting Mr Demarco's collaboration with other artists and featuring works from Magdalena Abakanowicz, Marina Abramovicz, David Mach, Alistair Maclennan, Gunther Uecker, Ainslie Yule, Joseph Beuys, Tadeusz Kantor, Mario Merz and Paul Neagu; further notes that this honour afforded by the RSA comes on top of other honours bestowed on Richard Demarco, including the Polish Gold Order of Merit, the Cavaliere della Republica d'Italia, the Chevalier des Arts et des Lettres de France and a CBE; congratulates him on his achievements to date; looks forward to more to come, and wishes him many happy returns on his 80th birthday.

17:04

Linda Fabiani (Central Scotland) (SNP): I welcome Richard Demarco to the public gallery of Scotland's Parliament. [*Applause*.]

I thank all members in the chamber this evening who signed the motion, which celebrates the fact that Richard Demarco became 80 years young in July. The number of signatures is a mark of the respect that members of the Scottish Parliament have for Richard Demarco and his work. I proffer apologies from Patricia Ferguson, who was upset when she found out that it would be impossible for her to be here for the debate.

I found it difficult to write the motion. How does one condense achievements such as Richard Demarco's into a paragraph? Similarly, how can I do justice to Richard Demarco and his career in just a few minutes in this debate? I am sure that all members feel the same as I do.

One could list just a few milestones in Richard Demarco's career. He launched the Traverse theatre and gallery in 1963, and he opened the Richard Demarco gallery in 1966. One can mention his long tenure as director of contemporary visual arts exhibitions for the Edinburgh international festival, his directorship of Sean Connery's Scottish International Education Trust, and the establishment of the Demarco European Art Foundation and the incredible Demarco archives.

During his long career, which continues, Richard Demarco has been at the forefront of Scotland in Europe. He has promoted cross-cultural links, taking Scottish art abroad and bringing other European artists here. He has not done so in a timid or safe manner. This is a man who has always taken what others would perceive to be risks—he would perceive his actions to be the right and necessary things to do. His contribution to the understanding of European art between 1968 and 1989, through his journeys behind the iron curtain and his related lecture work, is immense. His drawings, paintings and prints are held in more than 1,200 collections.

One could also list the honours that have been bestowed on Richard Demarco, aside from his honorary fellowships: chevalier de l'ordre des arts et des lettres de France, commander of the British Empire, Polish gold order of merit and the freedom of Łódź, and professor emeritus of European cultural studies at Kingston University. Of course, I am particularly pleased that he is a fellow cavaliere della Repubblica Italiana.

Richard Demarco is a Scot, a Scots-Italian, a European and an internationalist whose worth is recognised the world over. His current work with the foundation and archive has been recognised by the University of Zürich and Washington State University, as well as by educational institutions from Blackhall primary school in Edinburgh to the Rose Bruford College of Theatre and Performance in Kent.

That brings me neatly to the educational resource that is the archive, most of which is currently housed in Craigcrook castle in Edinburgh. The castle might be said to be an ideal location. It has had a great history, not least during the 19th century, when it was used for literary soirées attended by Scott, Dickens, Eliot and Hans Christian Andersen. It was the home of Francis Jeffrey, editor of the *Edinburgh Review*.

I used the word "currently", because Craigcrook is just one of the locations that has been used for the archive over the years. I am in awe of the tenacity and dedication of Richard Demarco and his team in keeping this national resource together. The archive has not benefited from local or national funding but has been maintained by people who have a love of art and who recognise its importance to Scotland and to the family of nations to which Scotland belongs. Richard says that art is a language that links everything. The archive is a unique resource that links Scotland and Europe through many artists: Abakanowicz, Mach, Beuys, Maclennan, Yule and countless others.

What a gift to the Scottish nation. What an opportunity for a national institution to cherish and maintain. It is sad that if we are to keep the archive housed it might be necessary to sell some of its assets—unless something is done. I am glad that the Minister for Culture and External Affairs acknowledged the archive's importance and worth when she visited Craigcrook recently, by assigning officers to look into the funding of archivists. I am sure that she recognises the importance of keeping the Demarco archive in Scotland and I look forward to hearing her response to the debate. Richard Demarco might be only 80 years young, but he should be able to devote himself to promoting and enjoying the archive, rather than having to spend so much time raising money to maintain it.

When Richard Demarco is honoured later this year by the opening of the Royal Scottish Academy exhibition that will mark his 80th birthday, the collection at Craigcrook will be complementary to the exhibition at the national gallery. I hope that some security for the archive can be achieved now that it has received long-overdue recognition.

I urge everyone here and beyond to attend the RSA exhibition, which opens at the end of November and runs through to January. I also urge everyone to visit Craigcrook castle and the imminent exhibition of artists associated with the history of the Traverse gallery, the Demarco gallery and the Demarco European Art Foundation from the 1960s to 2010. I had to take a deep breath to say that long title, which reflects Richard Demarco's long career.

It was difficult to begin this speech, and it is difficult to end it. I have already made it clear how highly I regard Richard Demarco in a professional sense, but my motivation for requesting this debate to honour his birthday was personal as much as professional. He is quite simply one of the most inspiring and delightful human beings I have ever had the pleasure of knowing and spending time with. My respect for him is immense. He has travelled many roads. May he travel many more in his search for Meikle Seggie.

17:11

Ted Brocklebank (Mid Scotland and Fife) (Con): I congratulate Linda Fabiani on securing this timely debate.

It is hard to believe that Ricky Demarco is 80. People such as him do not grow old like the rest of us. I see him as a kind of life force—a diminutive Don Quixote who constantly tilts at the windmills of the Edinburgh arts establishment and a man who is in many ways lost between the two shores of Scotland and Italy, but is immensely proud of his links with both places.

I seem to have known Demarco all my working life, although I guess that we have met on only two or three occasions. I once interviewed him for a film about Scots-Italians. One of his answers ran for more than 20 minutes. As the film had only a half-hour slot, members can imagine the problems that I had in cutting him down to size.

The truth is that Ricky Demarco cannot be cut down to size. I liked what he said recently about the Scottish Arts Council's decision decades ago to cut his funding because he had, it claimed, "dishonoured art". The unrepentant Demarco quipped:

"Who'd have guessed that I'd still be around when the Arts Council itself is no more".

Linda Fabiani and others have listed Ricky Demarco's many achievements, such as his role as a co-founder of Edinburgh's Traverse theatre, his seminal role in developing the festival fringe, his tireless promotion of the arts in Scotland, and particularly his efforts to present those arts in an international context. However, as a long-time journalist and broadcaster, what I have always liked about him—apart from his joy in deflating the unco guid—is his ability to grab a headline. Many of the 60 Edinburgh festivals that he has attended over the years would have been dull affairs indeed without his special publicity skills. His publicity has, of course, always included a hefty amount of self-promotion. It has to be said that he has never suffered from any sense of false modesty.

Ricky Demarco is descended from that remarkable group of Scots-Italians whose forebears came from the Tuscan village of Barga. Indeed, he is the doyen of that remarkable line, which includes such talented Scots-Italians as Nicola Benedetti, Mario Conti, Tom Conti, Peter Capaldi, Daniela Nardini, Jack Vettriano and the pop star Paolo Nutini. Think about it: a place no bigger than Dingwall has produced arguably Scotland's most gifted young musician, one of our foremost churchmen, three of our best actors, the nation's best-selling artist, our current top pop star and, of course, the country's most versatile arts impresario, Ricky Demarco.

We owe a huge debt to our immigrant communities. In paying tribute to Ricky Demarco, I make no apology for linking his contribution to that of the wider Scots-Italian community, including, of course, that of Linda Fabiani, who is an exemplar of that lineage in the Parliament. It has been estimated that more than a third of Scotland's Italian population has roots in Barga. People first started to come from there towards the end of the 19th century, and they sold the figurini that they had crafted in their Apennine hill villages. Figurini are religious statuettes that were popular in Scotland's growing Catholic community at the time.

These days, the Italian contribution to Scotland is too often caricatured as being ice cream and fish and chips, and we in Scotland have not always been the best of hosts. Italian cafes and restaurants were ransacked in several Scottish communities when Italy came into the second world war on the side of Nazi Germany, despite the fact that many of those who were attacked and eventually interned had been born in Scotland.

It is true to say that one of Demarco's inspirations was the Leith-born artist and sculptor Eduardo Paolozzi, whose father, uncle and grandfather all drowned when the steamer Arandora Star, carrying Scots-Italian internees to Canada, was torpedoed by a German U-boat. Happily, in the years after the war, the Italians persevered and prospered all over Scotland. From cafes in places such as Portobello, Paisley, Kirkcaldy and Kilmarnock, Demarcos, Nutinis, Di Rollos, Zavaronis, Beltramis and Macaris have risen to the top of their respective professions.

I wish Ricky Demarco many more years of puncturing pomposity and opening our minds to his encyclopaedic knowledge of European art and architecture. As a native of St Andrews, I remain convinced that Demarco had the most imaginative proposal for Scotland to celebrate the millennium—to replace the roof of the ruined St Andrews cathedral. It was ransacked during the reformation, but in its day it was God's greatest house in Scotland. When some thought that erecting an up-market tent called Our Dynamic Earth was a suitable way of commemorating the millennium, Demarco wanted to restore the biggest religious building north of York. With that kind of vision, he should have been in this place, and knowing Ricky Demarco, even at 80, that is by no means impossible.

17:16

Christopher Harvie (Mid Scotland and Fife) (SNP): I, too, am grateful to Linda Fabiani for securing the debate. I express my warmest congratulations to Richard Demarco on his 80th birthday and to that remarkable community, the Italian Scots, which they both represent. Despite "Collar the lot," and its humiliation, and despite the Arandora Star, they have come through and carried us with them.

In the course of his career, Richard Demarco latched on to European culture of the highest, most challenging and deepest qualities. How did he do that from somewhere that was regarded as hidebound? Nevertheless—which for Muriel Spark was the essential Edinburgh word—Scotland and Edinburgh possessed their own magic. The Edinburgh festival was Demarco's decisive inspiration, especially the magical content of its first years. I remember seeing as a kid the stunning show on Diaghilev's Russian ballet in the art college and an early performance of Tyrone Guthrie's staging of David Lindsay's "The Three Estates", which was what Brecht was all about. That was the high European culture that Hitler had tried to crush. It brought the festival and it blessed Edinburgh with it.

Demarco knew that Edinburgh had to reciprocate from within for that annual gift, which was made out of our dour Calvinism, just as the 18th century enlightenment was. The festival was Edinburgh unbound—the Edinburgh of the lords of misrule and the abbots of unreason, as Tom Nairn has termed it. For a month every year, it became the world capital of culture.

Demarco found modernism in Yves Klein, the Dadaists, surreal movements and the bookshop small press revival. I remember Jim Haynes lurking behind the rhinoceros head of the Paperback Bookshop. Only a couple of weeks ago, I had lunch with John Calder, who is 86 and still no quieter and who was at the writers conference in the 1960s. The highest achievement reclaimed the soul of the religious spirit in people such as Joseph Beuys, Tadeusz Kantor and thousands of others across all fields, practices and disciplines, from Sean Connery—an art school model munching his way through the classics from Ibsen to Shakespeare—to the hard man Jimmy Boyle.

Demarco's life of the arts has been dedicated to bringing people together from a' the airts, as well as the arts and, most important, across the chasm of the cold war, which he crossed 90 times. He has bound together north and south Europe and his homelands of Scotland, Ireland and Italy. There was also that vital linkage with England. There, too, were wounds to be healed for Scotland to be truly itself and European.

The Demarco story has teetered on the verge of disaster and bounced back, with never a dull moment. Let us treat ourselves to the great collection at Craigcrook—and remember that it will not cost a fraction of a Celtic or Rangers 11. Those are the guys, we might remember, who only just managed to beat plucky little Liechtenstein, just as they managed to beat, I believe, San Marino. It would cost only an infinitesimal part of the Fred Goodwin bequest.

This is the man from Barga—the Ross County of art. We must remember that what he presents is not about size, but about the soul, the mind, journeys and meetings; it is about tragedy alongside comedy, neither separated nor alone. It is far from mere entertainment, sport, tourism or leisure, but it is never remote because it reawakens the sense of another Scots Italian, John Ruskin, and that great phrase,

"There is no wealth but life."

17:20

Mr Frank McAveety (Glasgow Shettleston) (Lab): Due to my usual reticence and quietude I had not noticed that this debate was on the agenda for today, but the brief encounters that I had with Richard Demarco in my brief period as a culture minister indicated what members have already expressed—not just the depth of affection for Richard but a sense of the contribution that he has made and will continue to make not just to the Scottish cultural scene but to the European cultural scene. I will touch on that in a moment. I am not too sure whether an Italian likes to be compared to Don Quixote, but we can have a wee discussion about that. When I saw that this was Linda Fabiani's debate on Richard Demarco, I thought that it was a Bertolucci movie with some name changes.

In my experience, there are two issues, and I am sure that the minister concurs. One is that perennial in the Scottish cultural scene: not "What do we do with our high arts?"—opera and ballet—but "What do we do with the Richard Demarco collection?" That is something that everyone who has sat in the minister's position has had to address.

What I found in the discussions that I have had with Richard and also the roles that many of us have played with him both informally and formally was his absolute passion for ideas. The compelling drive that he brought and still brings to the arts is the willingness to generate new ideas—not conventional ideas, not ideas that are easily accessible, and not ideas that people would see as orthodoxy. In fact, in a curiously perverse way, he challenges all of those with some of the productions. Any of us who have been persuaded by him to go to some of the productions know that there are some fantastic productions—but there are some others about which you politely say, "Thanks for the recommendation, Richard, but I'll maybe not make any comment on what I thought of that." Again, that is part of the drive and the enthusiasm that he has brought to his activities on the fringe.

The fact that Richard is being recognised in this evening's debate in the Parliament is an important

development. Ultimately, the real test is how we formally recognise the contribution that he has made and continues to make to the Scottish cultural scene. With the major exhibition at the Royal Scottish Academy, we have a fantastic opportunity to showcase the diversity that he has exemplified and the number of years for which he has made that contribution.

Ted Brocklebank mentioned the community that Richard came from, the links that Barga has had with Scotland and the contributions that have been made by individuals who have come to Scotland from Barga. They have made an incredibly disproportionate contribution to the cultural experience of our country.

Perhaps people have heard this before, but at the time when I had what one would call an occasionally turbulent period as culture minister, I was once described in *Scotland on Sunday* as a philistine. I remember saying to the audience at an arts event a few days afterwards, "I've been described as a philistine. I've looked that up in the dictionary and I can't see it under F anywhere." [*Interruption*.] I think that Richard understood the gag. In fact, the gag is so good that he has laughed twice for me—I appreciate and respect that.

What Richard brings is the experience of individuals who have come from different parts of Europe, the recognition that people in post-war Europe need to understand one another much more effectively, and the idea that one of the key unifying factors is art and culture, however it is expressed, whether it is through performance art, visual art or the whole variety of arts that he has pioneered. It is the idea that everybody has a contribution to make. Sometimes an idea that, in its time, might not seem wonderful ends up being an important piece of the contribution to the cultural fabric that makes Scotland such a player in the international arts field.

I know that Richard is celebrating his birthday. No doubt this is a quiet celebration compared with what his family and others have in mind for him, but I hope that the contribution that we can make is, in a sense, to put the pressure on and identify the ways in which we can ensure that the collection that he has put together is something that future generations of Scots and Europeans can properly appreciate. [*Interruption*.]

The Deputy Presiding Officer: Order. Unlike in theatrical performances, our rules do not permit applause or other interjections from the gallery.

17:24

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): I congratulate my good friend Linda Fabiani on securing the debate. Like Frank McAveety, I missed its inclusion in the *Business Bulletin*. As we wended our way through a long afternoon on the clinical portal and telehealth report, seeing in the *Business Bulletin* that the debate lay before us was like a flash of lightning.

My speech will necessarily be brief, because it is being made on the spur of the moment. I will give two reasons why it is really special that Ricky Demarco is with us today.

Nobody in the chamber knows that, through an accident of artistic mistake, I was the poetry convener of the 1976 St Andrews arts festival. The event was dowdy—it involved tweedy people from the county of Fife and young students doing orthodox arty things. On to that scene burst Ricky Demarco, who brought us the most amazing exhibits, one of which I have never forgotten. He had a young woman come into a hall and sit in a sort of mobile sandpit—I remember it well. She lay down, tied herself up "Gulliver's Travels" style with wee bits of string, and then set the bits of string on fire, which I can assure members was an event in itself—we students were agog. She stepped out and left the print of her body and the wee bits of burned string in what became an exhibit. That was avant-garde and was totally challenging for all of us—students and people living in Fife. I have never forgotten that and nor has anyone else who was there—I guarantee it.

That event taught me something that is hugely important about Ricky Demarco—in art, we must dare and we must challenge. What I described has stayed with me since I was a young man, and I say the first of my two thank yous to him for that.

We fast-forward to a time when most of us here were MSPs and some of us—Linda Fabiani and I—were involved in building the Parliament building. A lot of flak was flying around. Looking round the chamber, I can say that everyone here was kindly disposed, for which I thank them, too. One or two individuals out there in the community in Edinburgh and elsewhere in Scotland had the courage to say, "Actually, this is a really good artistic statement—I am proud of it. I don't care what flak is flying about or what brickbats are landing—I'm going to stand up and say this is good and we should be proud of it." I have never forgotten and never will forget for the rest of my days that Ricky Demarco was one of those people and I am deeply grateful for that.

When Ricky Demarco came to look at the art here when this place was complete, some of us—Linda Fabiani, others and I—went up to a committee room on the top floor. It was the room that faces inwards—I can never remember which way round committee rooms 2 and 6 are. It was night-time. He took us over to the big window, which looks down to the top of the garden lobby and across to Queensberry house, and said,

"Look—that is the waterfront of Barcelona at night-time." He took a new look at the building, which I can never see at night-time in any other way.

My speech was short and off the cuff. I give Ricky Demarco my sincere thanks and wish him a very happy birthday.

17:28

Jamie McGrigor (Highlands and Islands) (Con): I congratulate Linda Fabiani on securing this important debate. I, too, put on record my good wishes to Richard Demarco on his 80th birthday. My first encounter with Ricky was back in the 1970s, when he took foreign students round the ancient archaeological sites in my native Argyll and stayed at the renowned establishment of Lunga house at Ardfern, which was run by his great friend and fellow thespian, Colin Lindsay-MacDougall. I was immediately struck by the feeling that here was someone very notable who would make a difference, and I was not wrong.

Other members have, rightly, referred to Richard Demarco's wonderful encouragement of young people—people with talent who wish to become involved in the arts sector. I can vouch for that through experience. In 2008, my daughter Sarah McGrigor put on a play—it was called "Forgive Me Father"—at the Edinburgh fringe. I approached Richard, who was a tower of strength and encouragement as she put on her controversial work in the Demarco Roxy art house. He gave us the benefit of his deep knowledge and experience, which were invaluable.

In the past, Richard has spoken passionately of the importance of the Edinburgh international festival and fringe to the lives of countless young people at school and university who, in some cases, travel many thousands of miles to present their love of theatre. None of us can overstate the importance of the festival and fringe and Richard Demarco's contribution to them since their inception. The festival and fringe attract hundreds of thousands of visitors to the most dynamic and diverse arts festival on the globe. They bring millions into our economy. The fact that the festival and fringe continue to enjoy such a reputation and that they are still seen as innovative is thanks in no small part to the efforts of Richard Demarco.

I cannot overstate the importance of Richard's archive. It represents 60 years of non-stop collecting. It portrays Scotland in relation to 52 countries, including every country in Europe and the Commonwealth. He wanted to locate the archive at Craigcrook castle because, of course, that was the meeting place of Sir Walter Scott, Thomas Carlyle, Lord Henry Cockburn and, above all, Lord Francis Jeffrey, the publisher of the *Edinburgh Review*, which was read so widely internationally at the time.

The legacy of the enlightenment to Edinburgh and to publishing is enormous, and Richard has always wanted to bring back that status to the capital of Scotland. He has worked tirelessly for that. While others played golf and went on holidays, Richard acted as a sentinel for Scotland's arts; he manned the ramparts against the philistines. In a speech to Frank McAveety when he was the Labour Minister for Tourism, Culture and Sport, I called for Ricky's idea of a festival that would compare with the Venice biennale. I remember Frank McAveety having trouble with the word "philistine"—I think he had a pie in his mouth at the time. Richard's idea was for a biennial festival that linked Glasgow and Edinburgh. He saw that such a festival would draw international support and raise our cultural status, thereby attracting many more students to Scotland's educational establishments.

On a more serious note, how can Richard really celebrate his 80 years when the future of the archive is so uncertain? For that reason, I congratulate the Minister for Culture and External Affairs, Fiona Hyslop, on going to Craigcrook and taking her team with her. We now want to know what the result will be. Will she produce any concrete help and funding towards the running of Craigcrook? There is also Richard's real need for at least four archivists to sort out the collection before it goes to the RSA and the National Galleries of Scotland for the exhibition that opens on 26 November. The running costs of the archive are £15,000 a quarter to look after a collection that may be priceless and which Richard is virtually offering to Scotland as a gift.

Just as the church cannot be run on hail Marys, neither can an 80-year-old, unretired Richard continue to pay for everything himself. The archive is a work of genius. It will be appreciated long after all of us are gone. I say to the minister, let us give it a chance. That would be a good present to Ricky, Edinburgh and the people of Scotland.

17:33

The Minister for Culture and External Affairs (Fiona Hyslop): I am very grateful to my colleague Linda Fabiani for bringing the motion to the Parliament. When I wrote to Professor Demarco to congratulate him on reaching the age of 80, I remarked that it was a fitting time to reflect on his achievements as

"cultural advocate, ambassador and mentor at the heart of Scotland's art scene for so many years".

It follows that this special birthday is a most fitting subject for debate. Colleagues have roundly expressed their praise in contributions that have

combined affection, admiration, respect and received inspiration.

I would not suggest that Richard Demarco is a comfortable subject, even having reached an age when people are supposed to slow down a bit. I fancy that no one has tried telling Richard that; such behaviour does not come naturally to him. Typically, he told the *Evening News* journalist who interviewed him recently at Craigcrook castle:

"I'm at the point in life which is most exciting".

Richard's attitude has always been one of looking forward to the next project. He has faced challenges in his life and not a few setbacks, but nothing has dulled his appetite for driving forward his passion for the arts. It has always been a generous passion. He is sometimes referred to as a promoter of the visual arts, an artist and an impresario. I happen to know that the description that he most welcomes is that of educator. When you enter into a conversation with him, pretty quickly it feels as if you are on the receiving end of a lecture—in the most positive sense of the word.

Richard has taught us a lot over the years. He has shown us challenging new art in his various galleries and in performance. For him, art is about humanity—the people who make it and the people who engage with it. Give Richard a room containing two or three people and he will suggest holding a symposium.

This afternoon, we have heard about so many achievements for which Scotland is the richer. I simply highlight the Traverse theatre; Scotland's introduction to the European avant-garde, possibly years earlier than would have been the case without Richard's intervention; his extensive engagement with the Edinburgh festivals; his championing of so many Scottish artists; his growing list of accolades; and his lovely watercolours, which are often the first to sell in any mixed exhibition.

Richard is a citizen of both Scotland and the world. The accolades to which have I referred were bestowed by Poland, France and Italy, accompanying a CBE and a professorship emeritus of European cultural studies from Kingston University in Surrey. His profound appreciation of his fellow men and women has shown itself over many years. A gifted talent spotter, Richard has nurtured the early careers of many young artists who are now distinguished names. The catalogue of those names is impressive. I am merely skimming the surface when I mention Pat Douthwaite, Alistair Park, Ian McKenzie Smith, Kate Whiteford, Will Maclean and Arthur Watson. Thanks to Richard's introductions and exhibitions, artists from Scotland also became known in countries such as Poland, Romania, Hungary and Italy. That dialogue worked in both directions—the Demarco gallery once provided a haven for artists from war-torn Sarajevo.

In Richard, we have a most influential advocate of contemporary art. He sees art in everything, and venues in the most unlikely places—from rubble-strewn cellars graced by the likes of Zofia Kalińska, to a former Edinburgh poorhouse, to Inchcolm Island. To him, nothing is inappropriate, as long as it stretches the mind to consider new possibilities. Richard sees natural associations between art, science and the environment, as did the major figure Joseph Beuys, an abiding influence whom no speech about Richard could omit to mention.

Richard has never sat still long enough to write his memoirs, but there is an excellent record of his life's work, and the world of art that accompanied it, in a substantial and significant archive that was lovingly created and is growing by the day—in fact, every time Richard presses the button on the camera that is his constant companion.

Earlier, I spoke of challenge. I know that the biggest challenge that is preoccupying Ricky is what will happen in the future to his collection and archive. Some of it is already part of the national collection, but anyone who has visited Craigcrook and seen the terrific artworks and memorabilia there—and all those piles of boxes—will appreciate that there is a great deal more.

I am conscious of the fact that there are several options and possible destinations. As Scottish culture minister, naturally I want that destination to be here in Scotland. Accordingly, I have enlisted the services of key culture bodies—the National Library of Scotland, the National Galleries of Scotland, Creative Scotland and Edinburgh College of Art—to work with Richard and us to secure a future for the Demarco collection in this country. I also intend to contribute £15,000 of Government funding towards the archiving of the collection, so that it can be appreciated and understood by posterity as the valuable educational resource that it undoubtedly is.

I have also asked Scotland House, our office in Brussels, to mount an exhibition of items drawn from the collection to demonstrate the significant role that Richard Demarco has played in cementing international friendships and promoting Scotland overseas through the powerful medium of the arts. I am delighted to announce that I have invited Richard to work with us on the events surrounding that exhibition, to acknowledge the fruitful ambassadorial activity that he has undertaken independently for so long. We trust that that will continue—hopefully for many years to come—to celebrate and extend our links with our friends in Europe.

Not many debates in this chamber end with the words “happy birthday”, but we are celebrating a unique individual and that requires a unique response. I believe that it was Henry David Thoreau who commented:

“None are so old as those who have outlived enthusiasm”.

I hope that in this debate all of us recognise Richard Demarco’s contribution. All of us are in awe of his unquenchable energy, enthusiasm and love of life. I invite members to join me in wishing him many happy returns. On behalf of the Parliament, I thank Richard for his long-standing commitment to the arts and to learning—his life’s work, which has enriched this nation’s cultural experience at home and promoted a creative and innovative image of Scotland to the wider world. Happy birthday, Ricky. [*Applause*.]

Meeting closed at 17:39.

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