The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 18 March 2014

Session 4

Tuesday 18 March 2014

CONTENTS

HEALTH AND SPORT COMMITTEE
9th Meeting 2014, Session 4

CONVENER

Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Stuart Anderson (University of Edinburgh)
Gillian Barclay (Scottish Government)
Professor George Crooks (NHS 24)
Margaret Duncan (Scottish Government)
Justene Ewing (Digital Health Institute)
Ailsa Garland (Scottish Government)
Francesca Giannini (Scotland Europa)
Alistair Hodgson (Scottish Government)
Professor Frances Mair (University of Glasgow)
Alex Neil (Cabinet Secretary for Health and Wellbeing)
Brian O'Connor (European Connected Health Alliance)
Professor Mark Parsons (University of Edinburgh)
Bill Templeman (Scottish Enterprise)
Eddie Turnbull (Scottish Government)
Dr Margaret Whoriskey (Scottish Government)
Peter Williamson (Scottish Government)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 5

Scottish Parliament

Health and Sport Committee

Tuesday 18 March 2014

[The Deputy Convener *opened the meeting at 09:45*]

Subordinate Legislation

Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2014 [Draft]

The Deputy Convener (Bob Doris): Good morning and welcome to the ninth meeting in 2014 of the Health and Sport Committee. As usual, I ask everyone in the room to switch off mobile phones, BlackBerrys and other wireless devices, as they interfere with the sound system, but I should point out that some members and officials are using tablet devices instead of hard copies of their papers.

Agenda item 1 is consideration of two affirmative instruments, the first of which is the draft Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2014. As is usual with affirmative instruments, we will first have an evidence-taking session with the Cabinet Secretary for Health and Wellbeing and his official. When all our questions have been answered, we will move to a formal debate on the motion.

I welcome the cabinet secretary, Alex Neil, and his official, Gillian Barclay, who is head of unit in the integration and reshaping care division of the Scottish Government, and I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): Thank you very much, convener. I will be brief.

These draft amendment regulations reflect the Scottish Government's commitment to increasing free personal and nursing care payments in line with inflation. If approved, they will benefit vulnerable older people.

Last year, we increased personal and nursing care payments to residents in care homes in line with inflation, and the regulations will further increase weekly personal care payments in line with inflation by £3 to £169 per week and additional nursing care payments by £2 to £77 per week. In line with our partnership arrangements with local government, councils will meet the costs of the inflationary increases, which total around £2.45 million in 2014-15. An additional annual amount of £1.5 million was added to the funding for local authorities in October 2012 to cover the additional costs in the current spending review period up to 2014-15.

The free personal and nursing care policy continues to command strong support, and I hope that the draft regulations will receive the committee's support. I am happy to take members' questions.

The Deputy Convener: Thank you very much, cabinet secretary. Do committee members have any questions for the cabinet secretary or his official?

Rhoda Grant (Highlands and Islands) (Lab): I would like to ask a couple of questions. [*Interruption*.] I am sorry—I am shuffling through my papers. My machine is a bit slow this morning.

With regard to financial implications, the cabinet secretary said that £1.5 million of the additional costs have been budgeted for, but that the cost of the increase is £2.45 million. Who will make up the difference?

Alex Neil: Under the agreement that goes way back to the introduction of free personal care, the local authorities will make up the difference.

Rhoda Grant: So the local authorities will have to find that money.

Alex Neil: Yes.

The Deputy Convener: As there are no more questions, we move to agenda item 2, which is a formal debate on the affirmative Scottish statutory instrument on which we have just taken evidence. I remind committee members that they should not put questions directly to the cabinet secretary during this session, as it is a formal debate, and that the official may not speak at this point in the proceedings.

Motion moved,

That the Health and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2014 [draft] be approved.—[*Alex Neil*.]

Motion agreed to.

Patient Rights (Treatment Time Guarantee) (Scotland) Amendment Regulations 2014 [Draft]

The Deputy Convener: Agenda item 3 is consideration of a second draft affirmative instrument. There has been a rather slick change of Scottish Government personnel—I am very impressed.

For this item, I welcome back the Cabinet Secretary for Health and Wellbeing, who is accompanied by two Scottish Government

officials: Margaret Duncan, head of branch, access support; and Ailsa Garland, principal legal officer. I invite the cabinet secretary to make a brief opening statement.

Alex Neil: The draft Patient Rights (Treatment Time Guarantee) (Scotland) Amendment Regulations 2014 will amend earlier regulations from 2012. The main amendments, which will insert new regulation 4A, make provision for periods of time that will not count towards the waiting time calculation where a patient has specifically requested to have their treatment carried out by a specific consultant or to be treated locally.

That has been done at the request of the chief executives of national health service boards, who have indicated that, for a very few patients, it would be appropriate to meet such a request. We do not expect the numbers of such patients to be high, and those cases should be exceptional as NHS Scotland policy is to have patients booked in with a clinical team rather than with individual consultants. We are conscious of the need to ensure that requests for treatment locally do not impact negatively on boards' planning for service delivery. The amendments make it clear that, as part of the process by which a board will accommodate specific requests for consultants or local treatment, patients will be made aware that their choice will have an impact on the calculation of the waiting time for treatment, and that they must accept that there will possibly be a delay.

We also intend to amend the treatment time guarantee directions to require boards to write to a patient to inform them of the impact of their request on the waiting time calculation, and to include in their patient administration systems details of why it was reasonable and clinically appropriate to meet such a request. That will enable the local audits to review the use of such periods of unavailability and ensure that they are not being applied to deal with local capacity issues.

The draft regulations will make some other amendments to the 2012 regulations. In 2012, we gave a commitment to review the exceptions to the treatment time guarantee, and I am pleased to say that the draft regulations make amendments to remove certain exceptions. The exception for treatment of injuries, deformities or disease of the spine by an injection or surgical intervention will be removed from 1 April 2014, and the exception for designated national specialist services for surgical intervention on spinal scoliosis will be removed from 1 October 2014. That means that more treatments and services will be subject to the treatment time guarantee.

Finally, we have also amended the regulations to clarify the definition of "ophthalmic medical practitioner" to address a comment made by the Subordinate Legislation Committee in March 2012 during the passage of the 2012 regulations.

I am happy to answer questions.

The Deputy Convener: Thank you, cabinet secretary. Do members have any questions?

Dr Richard Simpson (Mid Scotland and Fife) (Lab): First, I welcome the reduction in the number of exceptions for spinal problems. It is appropriate that certain divisions of service delivery are not exempted, because they are, after all, national services.

I also welcome the other change that has been made. The cabinet secretary will remember that Audit Scotland's report, "Management of patients on NHS waiting lists", which looked at the situation in NHS Lothian, also strongly featured NHS Forth Valley. That board had a significant number of patients who were being designated as socially unavailable, but that was happening because patients were choosing to stay with their local consultant rather than travel.

It seems that the amendment tackles that problem, but I question slightly the cabinet secretary's comment that he does not expect a significant number of patients to make such choices. The 12-week treatment time guarantee has yet to be met by the majority of health boards, and they are experiencing increasing difficulties from the pressures that they are under.

That said, offering patients choice seems very appropriate. If I do not want to travel to the Golden Jubilee hospital in Clydebank or to a private hospital outwith my area because I wish to stay with my local consultant, that is a perfectly reasonable choice to make.

The Deputy Convener: Dr Simpson, I remind you that this is an opportunity to ask questions. I am happy for you to continue, but there will be an opportunity to debate the regulations after questions have been asked. I must ask you to come to a question.

Dr Simpson: I am just about to do so.

Will the specifics of our very complex coding system allow a patient to make such a choice and allow a board to offer it, provided that there is no long-term loss? That had previously been the problem with the very simple abeyance system that was being gamed. Will the patient be offered that choice if the board is unable to meet the request for capacity reasons or because of holidays, a consultant being sick or an important member of the team being off?

Alex Neil: We should make a distinction between the provider not being able to meet a particular deadline—for example, because a

consultant is ill—and the situation that we are describing, in which the patient makes a proactive and conscious decision to request that they be treated locally rather than go to, say, the Golden Jubilee. In the latter case, the patient obviously has the right to do that, and we agree that that is absolutely appropriate.

However, it is important that two things are done. First, the choice should be recorded, and we are making it a requirement that, in such situations, the board writes to the patient to explain the impact of the patient's decision to exercise that option. Secondly, the records need to show exactly what has happened.

Looking back at the Auditor General for Scotland's report on what happened in NHS Lothian and NHS Forth Valley, I think that it is clear that the suspicion, particularly in Lothian, was that unavailability—which was called social unavailability at that time; we have now redefined the terms—was being abused by the board. We are deliberately building in systems to try to ensure that there is no abuse by either the patient or the board.

Dr Simpson: Just to be clear, you have said that the patient has to make a proactive choice, but at what point are they required to make that choice?

Alex Neil: Normally, the patient would be offered an appointment for their treatment. For example, a board would write to a patient and offer them an appointment for a cataract operation at the Golden Jubilee on Friday 10 October. The patient would then get in touch with the board and say, "I really don't want to go to the Golden Jubilee; I would much prefer to be treated locally", or they might even want to be treated by a named consultant in the Golden Jubilee.

In that case, the board would withdraw the original offer and make a new offer at the earliest possible opportunity either for the local hospital, if that was the patient's choice, or for treatment by the named consultant at the Golden Jubilee, if that was requested. The board would then write to the patient—I expect that it would advise the patient verbally first of all, but it must also write to the patient in black and white—and make it clear that it was their choice, and that they would have to wait a bit longer for the procedure because they wanted it done locally or, indeed, by a named consultant. As the systems, too, will reflect that, it is hoped that there will be no opportunity for a repeat of the NHS Lothian situation.

The Deputy Convener: Richard Lyle has a supplementary. However, Rhoda Grant caught my eye first.

Richard Lyle (Central Scotland) (SNP): My question is on the same point.

The Deputy Convener: So is Rhoda's.

Rhoda Grant: I am not so delighted with the change. In the area that I cover, it is not always a choice for patients to travel that far from home. People are travelling huge distances to access health services. They are being offered out-of-board appointments, and if they do not take them, their waiting time guarantee is halted.

That is a difficulty, especially for elderly people who might want to bring a carer with them and who might not be able to take the appointment unless the health board pays for that carer. It is also difficult for people who have young families and associated caring responsibilities to be removed from their families for that period of time.

We are talking about huge distances. If we give someone from Wick an appointment at the Golden Jubilee, we are almost asking them to go to a different country, and my concern is that a patient's waiting time guarantee stops when they are offered an out-of-board appointment. What steps will you take to monitor the length of time people are waiting? People are used to being treated in their board area and dealing with the distances that they already travel.

Alex Neil: First, in the Highlands and Islands—and particularly in the islands—much of the treatment, especially more complex operations, is already performed and many appointments already happen out of board. The Western Isles normally orientate towards Glasgow hospitals, and the northern islands towards Aberdeen.

Rhoda Grant: That is correct, but people in the islands are often allowed to take a carer with them and pay reduced fares. That is not the case for Highland patients.

10:00

Alex Neil: This is where the word "reasonable" comes in. Clearly, the offer has to be reasonable. If somebody were unable to travel to another board area because they needed to take a carer with them and, for whatever reason, that could not happen or it was not offered, that would not be reasonable. A reasonable offer has to take into account such extenuating circumstances, within reason.

At the end of the day, we are trying to ensure that the time from referral to treatment is a maximum of 12 weeks, and the whole thrust is to work with patients to ensure that that happens. On occasion, a patient will, for whatever reason, decide that they do not want to go to Edinburgh to have a procedure done within 12 weeks and will rather wait for another two or three weeks to get it done at Raigmore hospital.

As I think I mentioned at my previous appearance before the committee in another context, the analysis shows that 99 per cent of those who are not dealt with within 12 weeks are dealt with within 15 weeks. People will make that choice. At the end of the day, we are a national health service and, right from day 1, we have made it absolutely clear that, when there is pressure in one board area, the treatment time guarantee will apply to the use of facilities elsewhere in the national health service in Scotland. I think that that is a reasonable proposition in return for the 12-week guarantee.

Rhoda Grant: Will you monitor how often that happens? I am concerned that, if the measure is in legislation, those people will not appear in the statistics as having had their 12-week guarantee breached, because their time will have been stopped. I understand that it is good to get people treated quickly, but I have a concern that the provision might be a back-door option to let people wait a long time.

Alex Neil: No. If a patient does not get a reasonable offer for treatment within the 12 weeks anywhere in Scotland, that is a breach. However, if we say to a patient that they can have their cataract operation done at the Golden Jubilee hospital but that it cannot be done within the 12-week period at, say, Raigmore, and the patient refuses that, that is not a breach, because as far as the legislation is concerned we have offered the treatment within the 12-week period.

Rhoda Grant: So you will not be monitoring that.

Alex Neil: We already monitor it. That is why I can tell you that 99 per cent of those who are not treated within 12 weeks are treated within 15 weeks.

Rhoda Grant: Yes, but as that will not be considered a breach, you will not monitor the number of people who feel unable to go away from home and who want a local appointment.

Alex Neil: No. We monitor it all and have statistics for every eventuality. The way in which we collect the statistics means that the data can be cut in many different ways, including that one.

Rhoda Grant: Okay. I feel a raft of parliamentary questions coming on about that.

Alex Neil: Just write and ask me what you want to know. That will save you going through the parliamentary question process.

The Deputy Convener: Although Rhoda Grant has made absolutely reasonable points, I feel that we are morphing into the debate instead of having focused questions.

Richard Lyle has a supplementary.

Richard Lyle: I want to clarify Dr Simpson's comment about the boards deciding all this. I take it that the patient will make the choice and that the regulations will actually give the patient more choice and control. The patient will decide where they want to have their operation and who they want to do it. Furthermore, contrary to what was suggested a few moments ago, everything will still be counted.

Alex Neil: I do not want to go down the road suggested by Mrs Thatcher when she said that she would have an operation when she wanted it, where she wanted it and done by whom she wanted to do it. Frankly, if every patient took that attitude, we probably could not meet a 30-week guarantee, never mind a 12-week guarantee. If a patient makes a reasonable request for reasonable reasons to have a procedure done locally or by a named consultant, we should try to accommodate that. The quid pro quo is that we cannot always do that within 12 weeks. If we can meet the request within 12 weeks, we will of course do so, but the patient loses the 12-week guarantee if they make that decision.

Richard Lyle: But at the end of the day, it is the patient—

Alex Neil: It is the patient's choice.

Richard Lyle: Yes. The amendment makes it the patient's choice, not the board's choice.

Alex Neil: Absolutely. In this case, it is the patient's choice.

Richard Lyle: Thank you.

Dr Simpson: This is not—

The Deputy Convener: Hang on a second, Richard. If you have a focused question for the cabinet secretary, I will take it, but there will be an opportunity to make any points that you wish to make in the debate that is to follow. Is it a question for the cabinet secretary?

Dr Simpson: It is just a question to get further clarification. The policy note that we have received states:

"Before agreeing to requests for specific practitioner or specific location, the Board must take account of the patient's health and wellbeing and whether it is reasonable and clinically appropriate to offer an alternative appointment. This is to ensure that Boards' policy and planning for the delivery of services are not negatively impacted."

The patient does not have an absolute choice; the board still has to decide whether it is appropriate.

The Deputy Convener: Are you asking a question?

Dr Simpson: Is what I have suggested correct, cabinet secretary?

Alex Neil: Yes. The caveat is that there must be no major impact on service provision, because we have to think of all patients, not just the one who makes the request. However, I think that such cases will be few and far between.

Dr Simpson: Thank you. That clarifies the position.

Gil Paterson (Clydebank and Milngavie) (SNP): My question is technical, convener; it is not one for the debate.

What will happen if a person who is made an offer does not accept it because they feel that there will be a better outcome? The board will write to them and say, "Here's the offer and here are the consequences"—in other words, it will state that the time period will be extended to, maybe, 15 weeks. When that letter comes in, must the individual confirm that they accept that condition or is it a done deal given that the health board has written to them, pointing out the consequences?

Alex Neil: It really is a done deal. We are not requiring the patient to write back to confirm anything because, by that point, they will already have indicated their preference to the health board.

Gil Paterson: Right, but when they understand that there will be a time lapse, will they need to confirm that they accept that, or is it a fait accompli?

Alex Neil: Ailsa Garland will give the legal position.

Ailsa Garland (Scottish Government): It is a staged process. If the patient does not accept the original offer, the board has to decide whether the patient's health and wellbeing justifies an alternative. Part of that process is that the patient has to accept that there is going to be a period that will not count towards the waiting time because of the change of either consultant or hospital.

Gil Paterson: That is what I wanted to clarify—I understand it now. Thank you.

The Deputy Convener: As there are no more questions, we move on to the formal debate on the affirmative SSI on which we have just taken evidence.

Motion moved,

That the Health and Sport Committee recommends that the Patient Rights (Treatment Time Guarantee) (Scotland) Amendment Regulations 2014 [draft] be approved.—[*Alex Neil*].

The Deputy Convener: Does any member wish to contribute to the debate? I have to say that I am somewhat surprised that no one wants to do so, given the earlier thirst to put questions to the cabinet secretary. Let me indulge myself by raising two debating points that I think are interesting.

First, the Parliament has just passed the Public Bodies (Joint Working) (Scotland) Bill, which deals with the integration of health and social care. I thought that my colleague Rhoda Grant pursued a really appropriate line of questioning when she asked what a reasonable offer was and mentioned the need to ensure that carers assessments are carried out and that carers support individual patients in travelling to wherever the offer is made. I hope that the integration of health and social care will mean that that will happen more seamlessly and that it is less likely that inappropriate offers will be made. That might be an example of the Government working in a joined-up fashion.

Secondly, there is quite a differential between urban and rural areas. I know that because the Public Audit Committee examined the issue in detail when we looked at the management of waiting lists, waiting times and guarantees. After identifying that waiting times and pressures in the system were, for a variety of reasons, starting to build up at the Western infirmary, NHS Greater Glasgow and Clyde put surgical capacity into the Southern general hospital to mop that up. Many patients decided to vote with their feet and wait for their named consultant and for their surgical procedure to be done at the Western infirmary, despite the fact that the Southern general was just down the road. Geographically, the choice was far more convenient than the choices that patients in rural areas have to make, and it is important to realise that there is a geographical split in patients' expectations of what constitutes a reasonable offer.

The big issue for NHS Greater Glasgow and Clyde was not what was happening, but that 13 different computer systems were not recording properly what was happening. I hope that the situation has been resolved. I just wanted to put that on the record for the cabinet secretary as none of my colleagues wanted to use this opportunity to debate the matter.

Have I sparked any other contributions? I see that no other members wish to comment, so I ask the cabinet secretary whether he wishes to sum up.

Alex Neil: I do not think that it is necessary. I hope that I have articulately explained the situation.

Motion agreed to,

That the Health and Sport Committee recommends that the Patient Rights (Treatment Time Guarantee) (Scotland) Amendment Regulations 2014 [draft] be approved.

The Deputy Convener: I thank the cabinet secretary and his officials for attending.

10:11

Meeting suspended.

10:11

On resuming—

National Health Service (Superannuation Scheme) (Scotland) Amendment Regulations 2014 (SSI 2014/43)

The Deputy Convener: We move to item 5, which is consideration of five negative instruments.

Although no motion to annul SSI 2014/43 has been lodged, the Delegated Powers and Law Reform Committee has drawn the Parliament's attention to it. Details of its comments can be found in the papers for today's meeting.

As members have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

Personal Injuries (NHS Charges) (Amounts) (Scotland) Amendment Regulations 2014 (SSI 2014/57)

The Deputy Convener: No motion to annul SSI 2014/57 has been lodged, and the Delegated Powers and Law Reform Committee has made no comments. As members have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

The Deputy Convener: We are speaking with one voice.

National Health Service (Optical Charges and Payments) (Scotland) Amendment Regulations 2014 (SSI 2014/61)

The Deputy Convener: No motion to annul SSI 2014/61 has been lodged, and the Delegated Powers and Law Reform Committee has made no comments. Are there any comments from members? My briefing tells me that I can move on, assuming that there are no comments, but I have learned with this committee to assume nothing.

As members have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

Carers (Waiving of Charges for Support) (Scotland) Regulations 2014 (SSI 2014/65)

The Deputy Convener: No motion to annul SSI 2014/65 has been lodged, and the Delegated Powers and Law Reform Committee has made no comments. As members have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

Community Care (Joint Working etc) (Scotland) Amendment Regulations 2014 (SSI 2014/66)

The Deputy Convener: No motion to annul SSI 2014/66 has been lodged, and the Delegated Powers and Law Reform Committee has made no comments. As members have no comments, does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

10:15

Meeting suspended.

10:16

On resuming—

e-Health

The Deputy Convener: Before we move to item 6, I intimate that our convener, Duncan McNeil, has given his apologies, and it was remiss of me not to mention that at the start of the meeting. In addition, Nanette Milne MSP had intimated that, due to unforeseen circumstances, she was going to be slightly late for the meeting, and I did not put that on the record either, so I apologise for not doing so. Consider that rectified now.

Item 6 is our long-awaited e-health session. We will take evidence from two panels. Our first panel is from the Scottish Government. I welcome Dr Margaret Whoriskey, director of the joint improvement team; Eddie Turnbull, head of e-health; Peter Williamson, the lead for health and innovation in the quality unit; and Alistair Hodgson, partnership improvement officer in the joint improvement team.

We will move straight to questions, starting with Aileen McLeod.

Aileen McLeod (South Scotland) (SNP): The area of e-health was identified as one of the committee's priorities for its Europe-related work, particularly given the range of European Union policy initiatives and European funding programmes that support digital health technologies and solutions as a way of promoting healthy and active ageing through personalised care. It is also an area that has been identified by the European Commission as a key priority in its Europe 2020 growth agenda, and one that not only accords closely with achieving the Scottish Government's 2020 vision, but in which Scotland is recognised as being at the forefront of European and global research and development.

As the committee's EU reporter, I am keen to explore how the Scottish Government is engaging with EU digital health policy initiatives, what contribution Scotland can make, and is making, in that area, and the potential that exists for further engagement and opportunities to arise from such engagement.

A fortnight ago, we had a helpful debate in the chamber on some of the issues and challenges that we face, not least the need to upscale our current efforts and the financial investment that will be required to assist the development of new capacity, so that we can ensure, for example, that the new local health and social care partnerships that are provided for by the Public Bodies (Joint Working) (Scotland) Bill, which the Parliament passed a few weeks ago, will be able to deliver healthcare on a larger scale in communities across Scotland and that they will improve outcomes for people.

My first question is about the extent to which the witnesses think that there is an opportunity to lever in new sources of European funding, as well as through the various EU-level digital health policy initiatives, and the extent to which that opportunity is being grasped. I am thinking of things such as the e-health action plan. We also have the third European health programme post-2014, and the horizon 2020 research and innovation programme has identified health, demographic change and wellbeing as policy priorities and societal challenges. In addition, there are the European structural and investment funds, as well as the cross-border co-operation funding. I would be interested to know how we are prioritising digital health through the Scottish Government operational programmes.

Dr Margaret Whoriskey (Scottish Government): From my perspective as the director of the joint improvement team, we have been working closely with our colleagues in NHS 24 and the Scottish centre for telehealth and telecare to help to support the opportunities in Europe and to consider, in turn, how we can pull out the learning and share it in both directions.

Building on our success in achieving funding for the united4health and smartcare initiatives with our European partners, we currently cover seven health and social care partnership areas. I think that our success in achieving that funding was predicated on our ability to demonstrate that we were working in partnership and were integrating across health and social care. The funding application needed the buy-in of all our sectors, including our non-statutory sectors. That is very much work in progress, and some of that is being showcased in Europe as we go forward.

We have also been working closely with our Scottish Government colleagues and with colleagues in NHS 24 and our wider partnerships on engaging in the European innovation partnership on active and healthy ageing. We are active in the six associated areas. You will be aware that we received two lots of three stars for our reference site application, which showcased our national telecare programme, which ran from 2006 to 2011, and our work on anticipatory care planning. We were also recognised for our falls prevention work.

Although it does not attract any specific funding, the reference site application positions Scotland well in Europe. We are particularly mindful of the horizon 2020 bids. We are connected with 10 bids, seven of which are focused on NHS 24. The joint improvement team and the Scottish Government are also aware that some partnerships in Scotland

are considering how they can build their capacity to put in bids.

That draws together some of the practical work and tangible evidence around our engagement in Europe and, I suppose, the priorities in the health and social care directorate—my colleagues can speak about wider areas—in relation to ensuring that this agenda works across policy areas. We are seeing evidence of that in terms of the attempts to mainstream the agenda across our policy areas. Importantly—particularly from the perspective of the joint improvement team—there is a focus on building that infrastructure so that we can find opportunities and build capacity and capability.

The Deputy Convener: Would any other witnesses like to add anything to that?

Alistair Hodgson (Scottish Government): On the question of how the agenda relates to overall Scottish Government activity, there is a danger that people just chase the money. There are hundreds and hundreds of potential projects across Europe. Some of them are closely aligned to what the Scottish Government wants to do and some are completely different. We are being careful to ensure that we take a collective approach, so that any bids that we put in are extremely closely aligned with the overall Scottish Government priorities, especially around horizon 2020. We are certainly aware of the issue.

Eddie Turnbull (Scottish Government): Our focus has been very much on the projects that have the potential to make a difference with regard to shifting the balance of care. It has not necessarily been on what you might call the core e-health infrastructure, although we have an interest in that area in relation to standards and integration. It is not that we are blind to what is happening elsewhere in Europe, but the focus has been on areas in which the money can make a real difference.

Aileen McLeod: One of the projects concerns the international consortium bid that is being driven forward by the University of Edinburgh and involves the need to establish a European Institute of Innovation and Technology knowledge and innovation community in the area of healthy living and active ageing, which is known as the LifeKIC bid.

There was a previous bid for a KIC by the University of Edinburgh in 2009, I think, in the area of the future information and communication society. Unfortunately, the bid narrowly failed, although the Government supported it. What work is being done to support the LifeKIC in the Scottish Government? What benefits could it bring, especially through the digital health institute? How could the Government help to support efforts to obtain European funding through a LifeKIC bid?

Alistair Hodgson: We are working very closely with colleagues in the life sciences division, who are leading in business and innovation. We are aware of the previous bid, which was not successful despite the fact that it was recognised in Europe as being probably the strongest bid. That was attributed to the level of buy-in from the member state, as in the United Kingdom support for the bid. In order to get that support, we have therefore been very careful this time to position the bid not as something that has just been led by Scotland, but as something that has been led by Scotland in partnership with the rest of the UK.

We now meet on a monthly basis. We have a small steering group within the Scottish Government, which is chaired by Professor Mark Parsons and Stuart Anderson from the University of Edinburgh. We are being very careful to build up that support, both within the Scottish Government and, crucially, within the UK Government. That will be where the situation will be make or break.

As for how that turns into something successful for the next year, we are in the very early stages of the initial engagement. Up until now, the focus has been on building collaboration and partnership across Europe and getting the co-location nodes, as they are called, aligned with the University of Edinburgh aspect. Over the next year or so, the focus will be on engagement within the Scottish Government and the UK Government.

The Deputy Convener: I have a supplementary on that. Let me see whether I can take any politics out of this, as that is not my reason for asking the question. You mentioned that there was not buy-in from the UK Government, particularly in relation to the health KIC bid, which could have been the strongest bid on the table but did not quite have support. This is possibly a matter for ministers rather than yourselves, but can you give us any details on how the Scottish Government and the UK Government work constructively on such things to ensure that any bid that comes forward from here dovetails with what the UK Government is doing?

Alistair Hodgson: I cannot remember what the previous KIC bid was in. It was not in health specifically, if I remember rightly. As regards why it did not work, it was certainly before my time. Mark Parsons and Stuart Anderson, who will be speaking later on, will probably have a better idea about that.

The Deputy Convener: I am sure that we will ask them about it.

Dr Simpson: I am glad that we are leading on the B3 action group, which is on integrated health

and social care. That fits with the general programme, and we are clearly well engaged in some of the other European issues.

I know that some of you may be involved in trying to produce the response that the cabinet secretary said that he would make to my speech in the 2020 vision debate the other week, which was mostly highly consensual and very positive. I am concerned that, as we go forward as a leader in the area of telehealth and telecare, we should ensure that what we have already is functioning to an adequate level.

My question is on resilience, which is just one of the eight or nine areas of concern that I raised, on which we will get a detailed answer from the cabinet secretary. We chose, quite correctly, to adopt a much more fragmented approach than the one that was taken in England, where a huge amount of money was wasted on the big-bang approach of trying to solve everything in one system. That has largely failed—there are some gains, but not many.

Because we have a fragmented system, with 14 different boards that are all able to produce their own systems within a set framework, we have ended up with problems that are clinically important. I wonder how we are going to solve those. The main thing, however, is whether we have in place systems that are resilient. As we move to a paperless or a paper-light system, clinicians cannot afford to be without material of clinical importance for any time at all.

The breakdown that occurred in Glasgow could have been extremely serious. I do not think that it was—it delayed a few things—but there is evidence from a freedom of information request that I made that there have been breakdowns in other boards. The classification is not even there in some boards. Highland reported 56,000 breakdowns. It was obviously reporting every telephone conversation with its information technology department, which was ridiculous. What is being done about integrating our systems?

I have one final comment. The deputy convener mentioned the 13 computer systems in Glasgow. I know that Glasgow is making good progress on that, but it is not just the within-board systems that need to be integrated; the across-board systems need to be integrated, too.

10:30

Eddie Turnbull: You raised two points. First, I will first deal with the question on resilience and the ability of the systems to be there 24/7, 365 days a year. Your second question was about integration of services. I see those issues as related but different.

On the question about resilience, the root cause of the issue in Glasgow is still unknown. The manufacturer of the Active Directory software has that failure on file and is monitoring for a similar failure worldwide so that it can gather more evidence. It is frustrating that we do not know the root cause of that incident. However, we agree that, as we move forward and work towards having a paper-light—if not a totally electronic—health service, we need to consider the resilience of our systems and how we deliver those systems. That is a key plank of our strategy as we move forward.

As a result of the incident in Glasgow, the cabinet secretary initiated an independent review of the boards, which was undertaken by NCC Group, a recognised expert in that area. I believe that that report is now in the Scottish Parliament information centre, so members can look at it. The report gave us confidence that the boards were well placed when it came to dealing with that particular type of failure. The boards are different sizes, so they adopted different methods of doing that, but nonetheless they were well aware of the possibility of catastrophic failure.

There was a second level in the report, which was about general information and communication technology resilience and the impact on services generally should IT be unavailable. The report found that the boards were very cognisant of that and, again, that they had in place processes that were commensurate with their size. Clearly, what is in place in Glasgow is quite different from what is in place in the Western Isles, but due heed is paid to risk and planning around the resilience of IT.

However, the report found that we could do more to join up IT resilience with overall business continuity, and it makes recommendations on how we should take that forward. The committee will find the report interesting, because it shows a strong awareness of what things will be like in future. We are planning along those lines.

That links in with the question about integration, because we are promoting more regional working and shared services across boards. For example, in the forthcoming financial year, Orkney and Shetland will implement the TrakCare patient management system. However, they will not implement it in their own sites; they will use the shared service from Grampian. That will build in an element of resilience and integration. It is very much work in progress—we appreciate that we need to up the pace—but it is in our plans going forward. I think that that addresses the question about resilience.

On integration, I concede that we could be more integrated. That is a key plank of our current

strategy for 2011 to 2017, and it will continue to be so as we refresh our strategy in the future.

Over the past few years, we have made great progress in using portal technology to make information available. In one board, the information is actually held by another board. In setting out a road map for integration and the need for interoperability, the cabinet secretary gave the commitment that, by 2020, every citizen in Scotland would have access to a personalised health record. For that to happen, our systems need to be more integrated underneath the surface, and we must build services in which information is presented in a similar way to what happens in the private industry.

We are not taking the one-database-holds-all approach that Richard Simpson alluded to. We are identifying the key points for integration that will enable a clinician to get a single view of a patient who may have passed through a number of boards in their care pathway. Ultimately, the patient must get the view that is appropriate for their condition. For example, a patient who suffers from multiple conditions may require access to a diabetes system and another specialty system, but they will still have the need to access the core information to which everyone in Scotland will have access. We are building towards that and it is very much part of our plans. Nevertheless, I suggest that we have achieved quite a lot up to this point.

The Deputy Convener: Dr Simpson, do you want to come back on that?

Dr Simpson: I wonder whether the other witnesses would like to comment.

Dr Whoriskey: The issue of resilience is also about how we address some of the more general infrastructure challenges, including our workforce. Work is being progressed to develop an approach to technology-enabled learning, and a board has been established to link that strategically with our workforce developments.

On the telecare front, we are working closely with our colleagues in the Telecare Services Association on the standards that are required. We have also recently undertaken dialogue and joint working with the fire service about connecting up information and alarms and ensuring that we have reassurance that the systems exist and that standards are being met. There is an ambition to move from analogue to a digital platform—Professor Crooks can probably expand on that. We are working closely with colleagues in Sweden on that to identify the opportunities that it could bring. We are trying to build the infrastructure around our system.

Linked to that are the citizen-facing platforms. The living it up programme that is being delivered by the delivering assisted living lifestyles at scale—DALLAS—programme, which is funded by the Technology Strategy Board, the Scottish Government and our enterprise colleagues, is exploring capacity building around our infrastructure and the use of mobile technology. Videoconferencing has also been quite a success story, certainly in health, and we are looking at how we can expand that across other areas such as criminal justice and local government.

The particular situation in Glasgow regarding resilience in information technology has been mentioned, but there is a broader resilience that goes beyond the technology and covers the wider spectrum of telehealth and telecare. We need to focus on that and build the infrastructure at the same time as we keep our eye on opportunities for innovation—we have to do both.

The Deputy Convener: Thank you, Dr Whoriskey. Does any of the other witnesses want to add to that?

Peter Williamson (Scottish Government): I re-emphasise what Dr Whoriskey has said. There is a crucial question around the resilience of health systems, but resilience in service user-facing technologies will also be challenging because they could well interact with health and other systems. Our view is that, in the longer term, the opportunity to put the user much more at the centre, connecting to services rather than being connected with them, is the way forward. However, that will open up significant challenges for the resilience of systems and, indeed, the infrastructure of systems.

Dr Simpson: I do not doubt the challenges that are facing us. Partly as a consequence of how we built things up, there are significant challenges to integrating things, and I am not being particularly critical. However, basic things such as being able to access laboratory results at the centre of a managed care network if you happen to have them done in an area outwith the managed care network—far less if they are done within it but in a different board—are fairly important.

I should make a declaration, as I did at the beginning of my speech the other week, that I have two family members who are intensely involved in this particular area, so I have a direct family interest.

The Deputy Convener: Thank you for that declaration, Dr Simpson.

Nanette Milne (North East Scotland) (Con): The papers that we have been given mention the whole system demonstrator project that was commissioned by the UK Department of Health on the impact of telehealth and telecare. I know that the findings of that study are currently being looked at. There seems to be one very positive

finding that telehealth is associated with lower mortality and emergency admission rates. However, one or two negatives have been flagged up that concern me slightly.

One negative was that for patients with long-term conditions, telehealth did not seem to be a cost-effective addition to standard support and treatment. I was hoping that it would be. Telehealth, as implemented in the whole system demonstrator, did not seem to lead to significant reductions in the use of health and social care services over the 12 months that were looked at.

The final negative that stood out was that telehealth, as implemented in the evaluation, did not seem to improve quality of life or psychological outcomes for patients over the 12 months that were looked at. Those are all things that I was hoping would improve with telehealth and telecare. I know that it is early days, but I am interested in your comments on that and on what could be done here to try to ensure that telehealth does achieve those outcomes.

Alistair Hodgson: We are very aware of the whole system demonstrator. For those who are not aware of it, it was the world's largest randomised control trial into telehealth and telecare. The headline findings were quite remarkable and quite startling. The reduction in mortality rates that you referred to was 45 per cent. There was also a 15 per cent reduction in accident and emergency visits, a 20 per cent reduction in emergency admissions, a 14 per cent reduction in elective admissions and a 14 per cent reduction in bed days. The headline findings were very encouraging from a technology perspective.

On cost effectiveness, one issue that we found with the whole system demonstrator was that those involved did not necessarily redesign the whole service around telehealthcare—indeed, those involved with the whole system demonstrator were very aware of that issue. There was a control group and there was a group that had telehealthcare. The members of that group was still getting traditional services—they were getting telehealthcare in addition. The extra cost was because the service was not redesigned around the use of the technology. The whole system demonstrator was very much used as an additive to services, which is why the costs were greater. We have always been very clear in Scotland that we do not want telehealth to be an additional service—we very much want it to be part of the overall package of care that is delivered to those who will benefit from it most, as and when it is appropriate.

On the challenge of reducing the use of services, we found from our work that just because someone has chronic obstructive pulmonary disease, for example, that does not mean that telehealth is suitable for them. It is not suitable for every single person who happens to have a common illness, for example. It is only suitable for those who meet very specific parameters, which is why we are very clear that telehealth needs to be locally led. We cannot just say to people across the country, "This is what you have and therefore this is the standard approach that we will take with you." The approach has to be tailored to each individual and built around that individual, which is where personalised healthcare comes into it, as well as access.

I cannot really comment on the psychological outcomes, because that aspect is not in the papers that I have in front of me. Certainly, we are aware of the challenges around the whole system demonstrator. However, every single area that was involved in the whole system demonstrator has now mainstreamed telehealthcare, so those areas clearly saw the benefits of it and have transformed their services locally. For me, that is the biggest message to come out of the study—that those involved in it saw the benefits as being great enough to implement it locally.

10:45

The Deputy Convener: Does anyone else want to comment?

Peter Williamson: May I reinforce a number of points? Telehealthcare is not of itself a solution; only when it is integrated and meshed with other service changes will it make a difference to people, whether that is about their psychological condition or whether they need to go into hospital.

You rightly made the point that the approach is at an early stage. One of the challenges is to find more effective ways of using the technology in and around people's healthcare and social care. That position will continue for several years, although I think that we will get better at using technology in that way. The important point is that we try very much to design the approach around individual needs, in a personalised way, rather than just say, "Here's a bit of technology. We'll plug it in and everything will be fine."

Dr Whoriskey: Last year, the *BMJ* published mixed findings around telehealthcare. One of the big messages that emerged was that the effective targeting of telehealthcare is critical, in terms of where the approach sits in the broader care pathway. Telehealthcare has been proven to be beneficial, but if it is applied en masse we get a range of effects.

We are minded to ensure that there is robust evaluation—from the outset we built that into the work that we are doing with our European partners and on the living it up programme. We are also working with our local health and social care

partners, particularly in relation to initiatives that were funded through the change fund, such as the Dalmellington project, to which the cabinet secretary often refers. It is about building in the quantitative evaluation, whereby we measure the difference that a project has made to emergency admissions and clinical interventions, and a more qualitative evaluation—the psychological aspects, such as people's quality of life and how they self-report, which is an important point.

We need to support and encourage local partnerships to do such work, even when they are embarking on small-scale work, so that we build in and share the learning. We are doing that in Scotland and with our partners in Europe and further afield.

Nanette Milne: I found it a little difficult to get my head round our papers, to be honest, because there seem to be so many strands to telecare. There are pockets of activity all over the place; I presume that, ultimately, things will come together and offer an important way forward.

This committee has done an awful lot of work on access to new medicines and appraising medicines' cost effectiveness. In the fullness of time, will we need a formal approach to appraising telehealth and telecare services? I presume that such appraisal is some way down the road, but I suspect that it will be needed.

Peter Williamson: I think that the answer is yes, but again I stress that if we simply evaluate the technology, we will miss a trick. That brings us back to progress on the 2020 vision outcomes for patients—those are the things that matter, rather than saying that a bit of technology has been plugged in so everything must be hunky-dory, as I said. The issue must be considered in the wider context.

Dr Whoriskey: When the committee is scrutinising a range of areas, it might be helpful to consider the role and contribution of digitally supported technology. For example, you could ask questions about that in the context of unscheduled care or delayed discharges—or the discussion that you had earlier about subordinate legislation on waiting times. The trick is to integrate telecare into the way that we do our business—and the way that the committee does its business, so that you can begin to explore the role of technology in the health and care arena.

Our three-year national delivery plan was launched early last year and provides an opportunity to consider key priorities. The committee might be interested at looking at progress against the plan as we begin to draw out some of the evidence and the learning. The process is a bit iterative, but it is about how we include it in our explorations and enquiries.

Rhoda Grant: My question is on how we roll out e-health, which we seem to have been talking about for decades. It still comes down to enthusiasts pushing e-health forward and it does not seem to be totally integrated into how we deliver healthcare. How do we push it one step further, to integrate it properly into the way that we deliver healthcare?

Peter Williamson: The question of roll-out—or spread, as we call it—is important and goes back to the point that we just discussed. If telehealth and telecare are seen as a separate entity, they will come up against or cut across the grain of services. We are very committed to the idea of a bottom-up demand for telehealth, rather than a top-down, technology-driven approach. As people, under the 2020 vision, on shifting the balance of care and improving outcomes, begin to look at redesigning and transforming the service, the question that we need to keep asking is whether technology will help them to deliver those kinds of changes. That will generate momentum from the bottom up, which will make spread happen more rapidly. We will have to do that more and more, to encourage uptake in a positive way—we do not want people to use telehealth just because it exists.

We must also be mindful that technology is not always the answer. Linking with somebody through technology takes them out of having face-to-face contact and, for a lot of people, a social connection remains very important to their health and wellbeing. The more one can offer people opportunities, the better. We need to be clear about where technology will make a difference and where we need to steer away from it a bit.

Dr Whoriskey: Rhoda Grant asks a very important question and I am sure that our colleagues in the next panel will add to the discussion. I would like to draw the committee's attention to three things. First, we are now engaged in some large-scale programmes: we have moved from small projects to united4health, smartcare and living it up, which are on quite a large scale. Secondly, we have a national delivery plan and associated with that we have developed an improvement framework to look at roll-out and improvement capacity and capability. The third element is support for knowledge exchange, which is built into the large-scale programmes—knowledge exchange is not just in those participating areas. A good bit of Scotland is now covered between living it up and the two European programmes. We are working with our local partnerships and wider stakeholders around knowledge exchange. That also links to the knowledge exchange with Europe, which feeds into our good practice. Part of the work that we are doing on integration and supporting implementation is on the improvement around this

agenda, particularly the European-Scottish links, to build that capacity and capability.

Alistair Hodgson: I will add to those three things and say that technology itself is a big driver. If you think about it, five or six years ago nobody had a tablet computer. Now about 27 per cent of the UK population has a tablet computer. It is the same with smartphone coverage, which has gone from a standing start to a situation in which almost everyone who invests in a new phone tends to invest in a smartphone rather than one of the classic wee bricks, although obviously there are differences.

Through the likes of living it up, we are very keen to push the use of those familiar technologies. We are not just saying, "Here's the health service and here's the technology that we're going to give you, and this is how you will use it." We are looking at how we in the health and social care environment can encourage individuals to use their own technology to support themselves. We might provide people with something like a heart monitor that attaches to their own technology and feeds back.

There are issues of access. In some parts of the country, there is less broadband connectivity and less access to the internet. That is why we are also investigating how we use digital televisions, as people have digital televisions—coverage is 98 to 99 per cent in Scotland. We are looking at how we deliver services through the platforms that already exist in people's houses. It is by doing that that we will end up upscaling, because we are not having to invest in individuals; we are just investing in the back-end structure to send the information out. Advances in technology that are, to an extent, consumer driven, are significantly helping us to upscale and make it normal practice.

The Deputy Convener: Just before I let Rhoda Grant back in, I should let other members know that Colin Keir has a supplementary question on driving change, and Richard Lyle will be next. There are no other questions so far, so please catch my eye if you have one.

Rhoda Grant: I thank the witnesses for those answers. Are we doing enough with training? When medics and the like are getting their initial training, is there enough training on digital technologies, e-health, and so on, so that they can hit the ground running with an expectation that digital health will happen?

Eddie Turnbull: We are very conscious of that and are working with NHS Education for Scotland, which is developing a technology strategy for the workforce. We are very cognisant of that.

The deputy convener asked about what the barriers might be to roll-out, and I believe that one of the barriers is around information governance and the fear of sharing data, as reflected in the recent Caldicott re-review. We should be thinking not about the dangers of sharing information but about the benefits that come from it. I just wanted to bring to the committee's attention the point that we are trying to clarify that landscape so that, as there is more widespread use of digital technologies, the barrier is not one of misconception about what information can and cannot be shared.

Patient confidentiality is paramount and that will be built in, but we want to make sure that there is clarity about what individuals and clinicians can feel free to share in a joined-up, digitally enabled environment.

Alistair Hodgson: The technology-enabled workforce has two strands. It is providing access to training so that people can do their own personal training where and when they want to rather than having to go back to base and allocating a specific time to do that training. Sometimes that is just not possible, even if it is desirable. We therefore have to provide modular platform access so that people can access training as and when they want it. That also ties into how people use the technology.

That is for the existing workforce, but we are also cognisant of the fact that the emerging workforce needs to come in fully aware of the situation. The joint improvement team is now part of the undergraduate curriculum in several nursing degrees. We are involved with several social work degrees and are in discussion with some of the universities about medical degrees and how we train up our future doctors.

We should also be aware of the fact that the younger generation is very much digital savvy and is bringing those skills into the workforce anyway, so it is about how we can bring what those young people do in their daily practice into their working lives.

Colin Keir (Edinburgh Western) (SNP): The witnesses were talking earlier about effectiveness and how the overall system has not been designed to take in e-health. Are you coming across any sectors that are less than enthusiastic about the concept of e-health, and is that slowing the process down?

The Deputy Convener: Is there any resistance to the idea?

Colin Keir: Yes. Does anyone out there not like the idea of going over completely to the technology?

Eddie Turnbull: I cannot pick out any particular sector or group, but, as you can imagine, individuals will have their preferences for ways of working. As we introduce technology, we try to

ensure that it is moulded to the way in which individuals work, but equally individuals also have to change their practice to some degree.

As we have rolled out the national TrakCare solution and clinical portal, we have found that the take-up has gone up and up, but it has been variable within boards depending on their own local circumstances. The eventual outcome is that 55,000 clinicians in Scotland now access the clinical portal, although when I first worked in e-health there was reluctance to use it. Once something is in place and people see its benefits, they soon become wedded to it. Following on from Dr Simpson's comments on integration, the challenge that we face is that they now want more.

11:00

Colin Keir: I asked a similar question in another place a few years ago when e-health was first coming out. At that point there appeared to be a degree of resistance. I would like an update on the situation. Is e-health becoming more acceptable? Five years ago, the concept of e-health was maybe not as well known.

Eddie Turnbull: My opinion is that it is now very much embedded in the acute sector and in general practice. We can certainly do more work around the community, but the story is positive.

The Deputy Convener: Mr Lyle has been waiting patiently for a long time. Supplementaries tend to drift into other areas, so I will take questions from members who have not spoken first. The order will be Mr Lyle, Mr Paterson and then Dr Simpson.

Richard Lyle: Thank you, convener.

Medicine and technology have evolved and will continue to evolve. I will show my age by mentioning that I remember a programme that used to be on television—"Tomorrow's World". Many things that were shown on that programme have now come about. I remember seeing a digital TV for the first time when I was in America—the thin ones that then cost £6,000 and can now be bought for only £400.

I turn to a point that Dr Whoriskey made about national videoconferencing, which Peter Williamson also mentioned. The point was made that videoconferencing has been used in the Highlands and Islands in particular. Our briefing paper indicates that more than 60,000 calls are made every quarter and that

"work is underway to expand access outwith the NHS into other parts of the public sector, and into people's homes."

In one case in the Highlands and Islands, a child was seen by a paediatrician using videoconferencing. That saved the child from being transferred hundreds of miles from their home to a hospital. The use of videoconferencing

"allowed the on call paediatrician ... to hear and see the child, which aided a more accurate diagnosis than originally suspected. The child was then treated appropriately in the local hospital and then discharged home, whereas previously a transfer by air ambulance would have been required."

Technology is a wonderful thing; it must improve and it will evolve. It sounds futuristic, but the future is today and tomorrow. Do you believe that videoconferencing is being used more, especially in faraway outlying areas where it is not possible for people to go to a general hospital?

The Deputy Convener: Should we do more videoconferencing?

Dr Whoriskey: Absolutely. In the way that we do our business—not only in our clinical work but in the way we conduct our meetings—we are beginning to rely more on technology, and we are also doing so in our social interactions when we use Skype. The technology is therefore becoming more everyday.

There has been a significant growth in people's confidence in and ability to use videoconferencing. There were some anxieties about the distance between the patient and the professional, but when it is established with proper protocols and with local staff on hand to ensure that the person feels that it is a personalised consultation as opposed to something that is being done impersonally, the feedback from both clinicians and users seems to be very positive.

There are also good examples where videoconferencing has been extended into care homes in more rural and remote areas. For example, a psychiatrist uses videoconferencing to provide advice and assessment to dementia patients in a care home, thereby avoiding a very traumatic transfer of people from the islands or remote areas into the main psychiatric establishment.

As people use videoconferencing more they gain confidence, and patients are becoming more familiar with it, too. All the feedback that I have heard on presentations has been very constructive.

Eddie Turnbull: We are monitoring the use of videoconferencing for clinical engagement and meetings in the health service. The numbers of those using it is increasing rapidly. That increase is based on two things: first, as Margaret Whoriskey said, there is more confidence with regard to the engagement and how that works from the clinician's point of view; and secondly, there is the resilience of the service. Over the past few years, rather than a series of disjointed videoconferencing capabilities across the board,

we have had a single national service. As was alluded to, other sectors in Scotland are looking to build on that service.

Alistair Hodgson mentioned the digital broadband roll-out. That will lead to more VC use. It is a technology that is well understood. Once we have the connectivity, the technology will not be a barrier; rather, the barrier will be the service change around the technology. The technology will be a real boon as we move forward.

The Deputy Convener: Do you want to come back in, Richard Lyle?

Richard Lyle: No, I am fine. I have received the answers that I was looking for. All I say is, "Drive forward".

The Deputy Convener: The future is today.

Gil Paterson: It is not too profound a statement to say that there are usually two barriers to everything. Those barriers are change and cost. NHS 24 proves that we are beyond the change barrier with the public. As has been said, the system that we are developing and the personnel involved are engaging well. However, I wonder about the cost.

An element of what you are suggesting relates to preventative spend—we spend the money on technology now to benefit in the future. I have no wish to lead you in your response, but is there evidence to suggest that the spending is not preventative and that we are instead getting immediate benefit from what we are rolling out? Is there evidence to show where the service is having an impact?

The committee is not looking for savings just for the sake of savings; we are trying to achieve the same as the Government—to save money so that more can be spent in and shifted to other elements of the health service.

Dr Whoriskey: Some evidence demonstrates that the service provides alternatives to people in the here and now. For example, the research and evaluations on telecare and its use for people with dementia and other dependency needs have demonstrated a delay or an avoidance of a care home placement or an emergency admission that would have otherwise happened.

We have also seen examples of where, if the role and contribution of telecare in particular can be embedded as part of discharge planning and included as part of the early assessment, that can facilitate earlier hospital discharges because people are less risk averse.

Evidence shows that we are addressing some immediate interventions in which the alternative would have been a hospital or care home admission. The challenge relates to the bigger picture because that is about shifting the balance of care and supporting more people to be independent and well in their own homes for as long as possible.

We are also supporting partnerships' joint strategic commissioning. That work is looking at the next three years, but we are also taking a 10-year horizon and asking how we redesign our services—based on our assessment of need, the resources that we spend and so on—into the services that will achieve the outcomes that we want. The challenge is how to shift the resource from where we spend it now to where we need to spend it in alternative ways.

Peter Williamson: A lot of what we have seen in e-health and telehealth has involved substituting one service for an existing service, which has often had benefits, such as patients not having to travel and admissions being avoided. However, the opportunity to connect with people and intervene earlier by using digital connections and monitoring equipment, for example, will allow telehealth to move strongly into preventive care. As the technology rolls out, there will be greater opportunities to offer ways for clinical staff and others to monitor patients earlier in the process and—we hope—therefore prevent more often the onset of crisis and breakdown.

Eddie Turnbull: I echo that. We have made great strides to find extra capacity in the service by introducing IT. The committee has probably heard about the use of digital pens in a number of board areas. That started in the Western Isles, where a community worker was given an electronic device that allowed them to record information at the point of care rather than have to return continually to their base to enter data. That saved time and eventually gave that individual more time to spend with the people whom they delivered care to.

I agree that our focus has generally been on looking for efficiency in the service to give us increased capacity and the ability to reinvest. A key plank of our e-health delivery plans, which every board has, is efficiency. We monitor the money that is reinvested in improvement. However, I concur with my colleagues that e-health is about more than efficiency and is now about holistic service change.

Gil Paterson: That tends to back up what the cabinet secretary told us, which is that some of the telehealth pilots had an almost immediate benefit.

Mr Williamson drifted into the subject of my next question. What is the potential for the future? Will telehealth address problems such as having a fixed budget or a health service budget that goes into hyperinflation in comparison with other areas? Can we look forward to telehealth finding people early—as Mr Williamson said—and allowing early

treatment so that less is spent on individuals in the long run and resources can be redeployed?

Peter Williamson: The answer is absolutely yes, but we will discover in time how far that will go. Without doubt, the potential exists not just to monitor people earlier and stave off crises but to allow people to connect more readily with services. That is the other side of the coin, which we need.

As we said, 98 per cent of the population have a digital device in their home, which can be used effectively to connect them with services in a variety of ways and can make it easier for people to access advice and so on. A lot of potential exists, but we are not clear—I do not think that anybody is—about how far it will go.

Alistair Hodgson: I return to the point that I made about the consumer drive. I know that the committee will hear later from the digital health institute, among others. Institute representatives who went to the mobile world congress in Barcelona a few weeks ago said that every mobile manufacturer in the world is looking at how it can embed healthcare in its devices.

The latest iPhones and Samsung devices can monitor someone's heart. They are high-end devices, but stuff in those devices always filters down to low-end devices eventually. What we have now in the really expensive equipment will in five, 10 or 15 years' time be in every person's pocket. Consumers will expect to be able to monitor their own health and wellbeing and will expect the health system to respond accordingly.

We are having to enable that change within the system now, so that when such devices become bog standard, as will happen, we will be fit and able to respond to the demand at local level.

11:15

The Deputy Convener: Before I bring in Dr Simpson, Mr Lyle has a supplementary question. Mr Lyle, it would have to be specifically on the immediate benefits of the use of e-health care. Otherwise, I will take you after Dr Simpson.

Richard Lyle: I will wait until Dr Simpson has finished.

The Deputy Convener: Right. You will have the last question then, Mr Lyle.

Dr Simpson: One political issue at present is the proposed care.data system in England, which is being criticised by many clinicians, who need to have confidence in the system—Mr Turnbull referred to the growing confidence in Scotland in such systems. As well as that, there is a degree of public concern. Indeed, there is a campaign, and care.data has been stopped for six months.

I know that with SPIRE—the Scottish primary care information resource—we have a different system, but are the witnesses confident that we can continue to carry the public with us as well as the clinicians? What are we doing to publicise the fact that our system is not the same as the one that is being criticised?

Eddie Turnbull: Yes, I am confident on that. We have approached the issue in a completely different way from the approach down south—and I think that our approach has been the right one. We have involved patients and clinicians in the construct of SPIRE, and we have designed it in a way that absolutely guarantees the confidentiality of the information.

The Scottish way, if I can put it like that, is to think things through carefully, and it is based on engagement and an incremental approach. I am confident that we will reach a point at which the SPIRE system provides great benefits through the use of the information, which will be held confidentially.

We are working through the communications approach on that—it is work in progress.

Alistair Hodgson: I have a related point that is not so much about the sharing of information for research, which is a feature of care.data, but the sharing of information generally for the benefit of the individual.

There was a lack of engagement on care.data, but we have taken the completely opposite approach with our living it up programme. At the moment, that programme involves only five health boards and their local authority partners, but community engagement has been absolutely at the forefront of it. To date, we have spoken to more than 8,000 members of the public through things such as pop-up stands in shopping centres or going to local community centres. We are going out and doing the engagement.

The feedback from that is that people very much expect their information to be accessible in whatever form in health and social care services. They also expect to have a communication channel with the professionals. Apart from anything else, that engagement exercise has shown us the value of engagement, and we can feed that back into almost anything that we do. When we engage with people and have a proper discussion first, rather than impose something that they do not necessarily understand, generally speaking the response is overwhelmingly positive.

Dr Simpson: I wanted to give our witnesses the opportunity to put that on the record, because we have a different approach here and we are engaging the public, which is important.

As the witnesses will know, however, I still have concerns about the tracking of access to records, which I see as a potential problem. For example, we had the Fife episode involving someone accessing Gordon Brown's records. We have only a retrospective system, and we do not yet have an audit trail that individual patients can access to check who is accessing their data. Lothian is the only area that has an effective system of retrospective checking in place, and it had 260 breaches last year.

I wonder whether we are on top of the situation. We do not want to ruin what is a good system in Scotland because of breaches or because patients feel that people are accessing their data when they should not be doing so.

Eddie Turnbull: As Dr Simpson knows, we are rolling out a programme of retrospective audit with regard to who has access to which particular records. Each board has the target of having an e-health delivery plan in place by 2015, and we are monitoring the situation quite closely.

We have not decided on a policy on individuals accessing their records, or a method by which we would address that issue, so I concede that we will have to think about that.

The Deputy Convener: I give the final question of the session to Richard Lyle.

Richard Lyle: It is just a comment really. With regard to Mr Hodgson's point, we can now do things that we did not think were possible 30 years ago. For example, we can walk in to Boots and buy a monitor to check our blood pressure. On Mr Turnbull's point, out-of-hours doctor services are now supplied with laptops so that a doctor can walk into someone's house and check their records rather than walk in with just a piece of paper.

Eddie Turnbull: The out-of-hours service has access—as others do—to digital information, including the emergency care summary and the key information summary, so that doctors can access information on medications.

The Deputy Convener: I will break my own rule and ask a very brief supplementary question on Richard Lyle's point.

Mr Turnbull, you mentioned out-of-hours doctors and access to the emergency care summary information—I apologise if I am getting the terminology wrong. If an older person presents in hospital via A and E and is admitted to a ward, should we expect that ward to have the social care plans that are in place for that person and a variety of other details, such as whether they require home helps, care assistance, a morning or tuck-in service, or meals on wheels? A care needs assessment is one of the core things that nursing staff have to do in that situation.

Eddie Turnbull: There is very limited integration at the level that you describe, and we need to work on that. We are currently focusing on the interfaces between services. We are well aware of the issues around delayed discharges, so there is a particular focus on that area. We are some way from having a fully-visible-to-all set of information that is relevant to care and health combined, but we are working towards that.

The Deputy Convener: But the opportunities are there.

Eddie Turnbull: The opportunities are there.

The Deputy Convener: I have now sparked off a final question—not just a final question but the final, final question—from Richard Lyle.

Richard Lyle: The answer—

The Deputy Convener: No—we want questions, not answers.

Richard Lyle: Would it be good if we all carried a card that contained our medical history? We could just beep it to bring that up.

Dr Simpson: A smart card.

Richard Lyle: Yes—a smart card that would just beep. Someone could go into a national food chain—I will not mention any in particular—and beep their card, and that would bring up their history. That is something for the future, perhaps.

Eddie Turnbull: There are examples of such a system in Europe—we have mentioned Europe today. That is not something that we can enable at present or for which we have an immediate plan in the next year or so, but we are certainly looking in that direction.

Richard Lyle: I am not advocating such a system—I know that a previous UK Government was talking about that sort of thing, and it would have cost billions of pounds—but it is the future.

The Deputy Convener: Indeed—it is just the future at present. I was hoping to give Mr Turnbull the last word, but my colleague Richard Lyle got it. I thank all four witnesses for their interesting contributions, on which we will follow up in due course.

11:24

Meeting suspended.

11:29

On resuming—

The Deputy Convener: Welcome, everyone, and thank you all for coming along. We will continue under item 6 with our second evidence session of the morning, which is in round-table format. Traditionally, we go round the table so that everyone can introduce themselves, rather than having the convener read out people's names.

I am the deputy convener of the Health and Sport Committee.

Francesca Giannini (Scotland Europa): I am from Scotland Europa.

Rhoda Grant: I am an MSP for Highlands and Islands.

Professor George Crooks (NHS 24): I am a medical director in NHS 24 and I head the Scottish centre for telehealth and telecare.

Aileen McLeod: I am an MSP for South Scotland.

Justene Ewing (Digital Health Institute): I am chief executive of the digital health institute.

Nanette Milne: I am an MSP for North East Scotland.

Professor Mark Parsons (University of Edinburgh): I am associate dean for e-research at the University of Edinburgh.

Richard Lyle: I am an MSP for Central Scotland.

Brian O'Connor (European Connected Health Alliance): I am from the European connected health alliance.

Gil Paterson: I am the MSP for Clydebank and Milngavie.

Bill Templeman (Scottish Enterprise): I am the strategic leader for digital health in Scottish Enterprise.

Colin Keir: I am the MSP for Edinburgh Western.

Professor Stuart Anderson (University of Edinburgh): I am from the school of informatics at the University of Edinburgh.

Dr Simpson: I am an MSP for Mid Scotland and Fife.

Professor Frances Mair (University of Glasgow): I am head of general practice and primary care in the institute of health and wellbeing at the University of Glasgow.

The Deputy Convener: Thank you, everyone—you are most welcome. Before we go to the first question, I point out that, given the numbers, it will be quite challenging to get everyone in, so I will give priority to the non-MSPs. I make a plea to MSPs—myself included—to make their questions focused where they can, in order to give the witnesses as much time as possible to get their comments on the record.

We will open with a question from Aileen McLeod.

Aileen McLeod: Given our time constraints, I will try to roll some of my questions into one.

As I said in the previous session, there is in the EU a clear recognition of the digital health sector's potential as a key driver for delivering significant benefits to those who rely on health and social care and for providing new avenues for economic growth and job creation. What scope exists for the further development of Scotland's role as a leader in digital health and care in Europe? Where does the new digital health institute fit within that?

I am particularly interested in hearing a bit more about Scotland's participation in the European innovation partnership on active and healthy ageing, and the opportunity within that for the exchange and learning of best practice. I would also like to hear about how we plan to use the new European structural and investment funding programmes and the cross-border co-operation programme, as well as the horizon 2020 programme, to help us to scale up initiatives and build research and innovation capacity through smart specialisation strategies in the area of digital health.

With regard to the LifeKIC—knowledge and innovation community—bid, what more could we be doing as a committee and as a Parliament to help to support that at a Scottish, UK and European level? Perhaps Professor Parsons can update us on where the bid is just now and what the timescales are, and tell us about the benefits that it may bring not just in Scotland but across the EU.

The Deputy Convener: Given that Professor Parsons has been named, he can start.

Professor Parsons: The European Institute of Innovation and Technology was established in 2008, largely as a European response to the success of the Massachusetts Institute of Technology in the US. In standard European fashion, the institute is not in a single place, as it delivers its benefits to Europe through knowledge innovation communities.

Scotland is leading one of the bids, which is called LifeKIC. It focuses on the theme of active healthy living and ageing, and is a large and complicated bid involving six co-location centres that are spread around Europe. Each of those is expected to set itself up as a centre that acts in addition to the research and development that is

already going on in the region. Universities and companies—in the health sector, in this case—are working together, and the KIC bid will top up the funding by providing around €10 million euros per centre per year for approximately 10 years. It is a big bid for €600 million euros in total.

Aileen McLeod asked specifically what the committee and Parliament should be doing. To date, we have received very good support in Scotland from MSPs, and we have been briefing people in the Scottish Parliament and in the UK Parliament as well—for example, David Willetts is very aware of the bid.

What we need now, as we enter the six-month period before we submit the bid on 10 September, is strong written support from the Scottish Parliament when we ask for it, so that we can say that the bid is important for Scotland—for our universities, for our businesses and for the people of Scotland.

One of the fascinating things about the bid is that it involves a network of European centres. I am sure that Professor Crooks will mention this later: Scotland is taking a lead role in Europe in this area, and it is very important that we are seen to be doing so.

The KIC gives us an opportunity to show leadership, and also to learn from other regions. I was briefly in Bordeaux three or four weeks ago, speaking to the Vice-President of the French region of Aquitaine. One model that the people there are experimenting with is that all the people who work for the post office will become people who go into old people's homes and check that they are taking their tablets in the morning. That is an example of the novel ideas from across Europe that we can all learn from—it is an example of the powerful things that working in big European networks can give us.

The Deputy Convener: It is almost as if the witnesses have arranged this previously—Professor Crooks has just been mentioned, and he is next.

Professor Crooks: It is not that we have rehearsed this in any way.

Just over three years ago, I was tasked by the then chief executive of the NHS in Scotland, Derek Feeley, to engage actively in Europe and to promote what we were doing in Scotland. That was for a number of reasons. As a number of people around the table have noted, we are recognised by the European Commission as being one of the leaders in digital health and care innovation. We need to trade on that, so as to raise the profile of Scotland. That can do two things. First, it can create opportunities for inward investment, bringing global technology companies into Scotland to work in partnership with our public services and our academic community to address the challenges that we have in delivering health and care for our citizens in a sustainable way. Secondly, it can create an advantage for our small and medium-sized enterprises.

For me, as a general practitioner of 23 years, the challenge of regarding health spend as investment—as Brian O'Connor will discuss later—is liberating, from a Scottish point of view. We usually regard health spend as cost, and people tend to seek to cut costs. However, health spend is an investment in our citizens.

Our engagement across Europe is influencing a number of things. Because of our recognised position, we are now influencing the European Commission in its thought processes about future funding opportunities. As was said by Government colleagues earlier, we are unashamedly looking to point the Commission in the direction of the strategy that has already been adopted by the Scottish Government, particularly on the integrated care agenda, which all European countries are now examining. We are certainly in the vanguard as far as that is concerned.

This is about how we transform the situation from one where care is solely delivered to people by the public sector to one where citizens do not simply take responsibility—which is the wellbeing agenda—but feel supported in delivering their own health and care through the appropriate use of technology.

We did a very large public consultation exercise, and the citizens of Scotland told us a number of things, one or two of which surprised me. The citizens of Scotland want to give something back. They want to give something back to their communities, and they want to care for others, but they find it difficult to do so, either because their parents live a distance away or because both partners, being in full-time employment, do not feel that they have the time. Citizens like the sense of community.

People believe that technology can help them in those things. They want to use technology, but they want it to be simpler, and they want to be able to learn how to use it more effectively. Our programmes are unashamedly designed to do just that. Our engagement in Europe allows us to learn from good examples across Europe and to share our learning with others. We do not have the luxury, in terms of time or investment, to design everything bespoke in Scotland. We need to take good examples, tartanise them and move them into our service at scale.

My final point is one that has just been made. For the first time, we have digital health included as one of the key strands in the smart specialisation strategy for Scotland, along with

some of the other things that we are recognised for—food and drink, renewable energy and so on. That is really liberating for us. It is not simply about getting a mention in a document; it is about how we lever that to benefit our citizens. If we can grow Scotland's economy, we will generate wellbeing, and that is often better than shovelling out tablets to our citizens.

The Deputy Convener: Thank you, Professor Crooks.

I call Mr O'Connor, who caught my eye before Professor Crooks name checked him.

Brian O'Connor: George Crooks told me to make sure that I immediately followed him. [*Laughter*.]

I represent an organisation that has members throughout Europe from all sectors, including academia, industry, Government and health, and the external view of Scotland is that it is clear that you have recognised the power of digital health and working together. However—you may not want to hear this, but I will say it anyway—you must not become complacent. You might say, "We're not complacent," but my experience of going round Europe to many countries where we have ecosystems, as we call them, and we regularly meet all the different sectors is that it is easy to get carried away with a little bit of success. You have had success, and you deserve it but, as a critical friend of Scotland, I say that I think that you need to focus much more strongly than you appear to be doing on the economic benefits.

If I may, I will take a moment to tell you about a piece of work that we did last year in Northern Ireland, which is my home country, involving the ministry of the economy, as I call it—it calls itself the Department of Enterprise, Trade and Investment, but I prefer to use the word "economy". Until two years ago, the economy and health ministers, although they were from the same party, did not really see the need to have their departments work together, so we organised and arranged that there would be a formal memorandum of understanding between the two departments.

That was challenged by one of the agencies of the economy ministry, which said, "Why do we need to do that? We know everyone." We said, "Please name the client managers that you have for the health department," and the answer was that there were none. Why were there no client managers for something that spends so much of the Government budget? The answer was, "Because it's another Government department." We learned a lesson from that, and we produced a report last year that I think is instructive.

I realise that you are the Health and Sport Committee, but I suggest to you that there is a big economic opportunity here. In Northern Ireland, £4.5 billion a year is spent on health and social care—it is an integrated service—and that represents 40 per cent of the total public sector spend in Northern Ireland. That is bound to get anyone's attention. Many people said that we should cut the budget. However, our report revealed that that £4.5 billion employs 70,000 people, which is almost 10 per cent of the total workforce in Northern Ireland, and that £3 billion of that money goes straight back into the economy through salaries and payments to doctors, dentists and so on. Some £1.3 billion is spent on buying things—on procurement—and the other £200 million is for capital spend.

As a result of a single declaration, which has now been accepted not just by the two ministries but by the Executive in Northern Ireland, "the annual investment of £4.5 billion" is how it is referred to by everyone from Peter Robinson and Martin McGuinness down. That has created a complete change in the mentality, the culture and the way in which we look at healthcare, and as a result we are beginning to attract jobs, because people throughout Europe and the world realise that we have a joined-up approach involving both health and the economy.

I recommend that the committee, no doubt working with other committees, should at least consider that approach. Sometimes, a statement of something obvious is really important, because it is not always obvious until you know it. One action that the committee could take is to consider whether there should be a formal, overarching MOU—there may be one already—that says, "We are going to work together." It is amazing how it plays internationally when you brand a country as a place that is joined up not only in health and social care but in the economy as well.

11:45

I do not know whether Scotland is very different from all the other countries in Europe, but one thing that is becoming very clear to us as we travel around Europe is that the more successful your health and social care policies are, the bigger your risk of failure is. By that I mean that in Northern Ireland and in other countries the big push is to keep people in their own home and out of hospital, and to get them out as quickly as possible if they are in hospital and stop them being readmitted. At the lower end—that is unfortunately how people look at it—there is a shortage of domiciliary care workers, as we call them in Northern Ireland.

We can be successful in keeping people in their own homes, but if they go back through the revolving door into hospital, believe you me, that would be unacceptable both politically and economically and from a human perspective. I am

leading a workforce skills programme in Northern Ireland at the moment to identify how many additional jobs we need to fill with people who are properly trained in the use of smart technology and in supervisory and managerial skills, because often those people do not have a career path. That is why they leave when a corner store opens, for example. They can get more money for stacking shelves in a supermarket than they can for providing hands-on care for people. I suggest that there might be an economic opportunity through digital health to create jobs and take people off the dole queue, as well as to stop people going back through the revolving door into hospital.

The Deputy Convener: That is quite challenging for the committee. Scotland is in the vanguard on many telecare activities and we are going out there to seek resources at European level, but we cannot be complacent. In addition to the health aspects of telecare, are we really exploiting all the economic opportunities that exist for it as a business venture, Mr O'Connor? Further, are we doing enough to ensure that we train some of our lowest-paid care staff, who will use a lot of the e-health opportunities? I throw those two points into the mix to say, "Look, it's not all rosy. Yes, there are good things going on, but we can't be complacent. We have to move forward."

Justene Ewing: I want to touch on Brian O'Connor's point about the opportunity that presents itself. I will also add a little bit about the basis of how we are working.

The first point is that digital health is now recognised as a clear and emerging market. The latest report on it that I could find stated that the global digital health market will be worth £14 billion by the end of 2017, with a clear indication that Europe will have the lion's share of the market, as the report stated specifically that £4.1 billion will be generated in Europe. I do not wish to make any wild assumptions, but I suggest that a significant opportunity is presented by Scotland having a leadership position in digital health, with perhaps two or three other countries closely aligned.

On Brian O'Connor's point about working together, I am actively working with the digital enterprise and health and care directorates in St Andrew's house and receiving a significant amount of support in relation to the activities that the DHI is undertaking. The DHI is about collaborative working at the front end, which means having a clear and specific understanding of need and opportunity. In that regard, I reference some of the conversations in the earlier evidence session around the potential for digital health in preventative care as well as in monitoring.

The DHI is only six months old but, from our point of view, there is significant support for the digital health agenda in Scotland, and I would like that to be noted. The acceptance of the DHI and the digital health opportunity are very significant.

Bill Templeman: From an economic development standpoint, I think that the digital health sector may be unique in as much as we have the demand side in the NHS and the care sector of people wanting to buy stuff and solutions to problems. We do not have that in many other sectors in Scotland. In addition, the digital health sector has the ability to innovate and has very strong academic capability.

We have three component parts to produce significant economic gain in terms of jobs outwith the NHS. When Justene Ewing, George Crooks and others talk about attracting inward investment, that is built on the reputation that we have built up over the past few years. We now have firm foundations to enable us to attract much more inward investment. There is a buzz when we speak to people at the mobile world congress. Companies come to the Scottish Development International stand and say, "We would really like to come and talk to you about what we could do in Scotland." That is not something that generally happens with the intensity that we are sensing now. That is an important aspect of building the strength of the activity in Scotland and the KIC itself builds on that and enables it to a significant extent.

Francesca Giannini: Aileen McLeod asked about what we are doing in Scotland to make the most of the European funding that is available. The Scottish Government is promoting opportunities for increased support to Scottish organisations. There is now an integrated service, which involves a group of organisations. Scotland Europa is part of that group, so we are working with the enterprise agencies—Scottish Enterprise and Highlands and Islands Enterprise—and the Scottish Further and Higher Education Funding Council to take an integrated approach to enable Scottish organisations to access European funding. The group focuses mainly on horizon 2020, which is currently the programme with the biggest budget, but there is also the issue of promoting wider engagement in Europe, so there are a few initiatives. A series of events on specific areas was held in 2013. Two events focused on health, and e-health was addressed.

Together with Scottish Enterprise, Scotland Europa is promoting sector mapping. We are working with our colleagues from Highlands and Islands Enterprise and Scottish Enterprise to identify opportunities for Scotland to engage in Europe on more meaningful and strategic projects. E-health is an emerging opportunity; it is a work in progress and I hope that it will be part of the

integrated approach to supporting Scottish organisations to access European funding.

Professor Anderson: I will add a little bit to Bill Templeman's comments. It is important to have the public sector involved in the digital health institute, because of regulation and the importance of deciding what not to do. We referred to that issue when we talked about telehealth being understood within the overall package of service. In order to innovate effectively, you need to make a big enough hole to fit an innovation into. We are currently trying to cram telehealth into a very narrow hole within already existing services. Understanding that dynamic and understanding how you regulate and decommission when you commission new elements is crucial. The digital health institute has that perspective, as do NHS 24 and the enterprise agencies.

Professor Mair: I reiterate what Professor Crooks said about people needing to be fully supported. When we hear about telehealth and telecare, we often hear about interventions for people with chronic lung disease, people with heart failure and people with diabetes, but we should note that here in Scotland most people are multimorbid and have multiple chronic conditions. My nightmare scenario is that my patient with heart failure, diabetes and COPD has three separate boxes that do not talk to each other. That scenario is not that far away. Not too long ago, the Wellcome Trust had an innovation challenge. I asked it about putting in a bid for telecare for multimorbid individuals and its representatives said, "Oh, no—you can't do that. We need disease-specific bids." It will be important to involve in the DHI groups such as the Health and Social Care Alliance Scotland and groups that speak for patients who have not only one condition but multiple conditions, because in Scotland almost everybody over the age of 65 is multimorbid and 40 per cent of the whole population is multimorbid.

The Deputy Convener: You say that new technologies are being used but that individual clinicians are perhaps working in silos rather than joining together. Whose job is it to join up the dots? Is it the digital health—

Dr Simpson: It is the GP's job.

Professor Mair: I was about to say that that is the missing link. We have talked about engagement and barriers. I have been a GP for 25 years, and telehealth and telecare are totally absent from my landscape. I have always worked in more deprived areas. I have worked in Toxteth in Liverpool and I now work in Thornliebank in Glasgow, which is more mixed, but my practice is still in the top 200 most deprived practices in Scotland.

There is an issue about the digital divide; people have smartphones, but it is about how they use them. I always tell people about NHS 24 and the cognitive behavioural therapy telephone service, and it is interesting to see the barriers in that regard. People have mobile phones, but they say, "I can't call an 0800 number from a mobile, because I'll have to pay for it." When I ask people about using the living life to the full website, which is a great online CBT resource, I find that many people have no internet access. There is an issue about supporting people, as George Crooks said, and increasing their capacity to engage with such resources.

We are very aware of inequalities, especially in Glasgow, where there is the disparity in life expectancy between the east side and the leafy west end and suburbs. I have a concern that there is a consumer drive for telehealth. That is right and I do not want to hold it back at all; my concern is that the haves and the more able people are driving the agenda. We must ensure, especially in Scotland, that we do not leave the have nots behind. GPs are central to that. We have done work on barriers and facilitators to implementing telecare for long-term conditions.

An issue is the drivers in general practice. Since 2004, we have had the general medical services contract and the quality and outcomes framework, and GPs have been driven into a tick-box exercise on chronic diseases in individuals. Now, a person who has had heart failure is seen by the practice nurse, but comes separately to be seen for their diabetes and separately to be seen for their COPD. We are trying to make inroads into that. In NHS Greater Glasgow and Clyde there are new smart templates for local enhanced services, so if we start populating one template another is populated. We need to think more about that.

For GPs, telecare and telehealth are a peripheral activity; they are not core business, but are something extra that we have to do. People talk about "professional resistance", as if professionals are difficult, but if professionals were not ready to change they would not work in the NHS. There has been perpetual change since I entered the NHS. We have to think about people's core business, and when we consider policies just now and how GPs get paid and the boxes that they must tick, we can see that telehealth is not there. It is a peripheral activity, and it will be until we make it part of the routine core business.

GP practices now use 100 per cent electronic records, so GPs are not anti-technology—they can see that it helps them to get paid and to work. We use the portals for referrals—I use them for 100 per cent of my referrals. If I see a patient who has a breast lump I can send the referral off the same day and the patient will get an appointment within

two weeks, although I still have to wait months to get the letter back from the hospital, which amazes me. It is not that GPs and people in primary care are anti-technology; it is just that telecare is not integrated in the service. We should remember that 90 per cent of healthcare contacts are with primary care.

The Deputy Convener: I know that Dr Simpson wants to ask a follow-up question, but let me first bring in Professor Crooks.

Professor Crooks: You asked who is joining the dots. Following discussions with the deputy chief medical officer last week, the Scottish centre for telehealth and telecare has an integral role in taking forward the agenda. I am joining up all the dots that are on the table. There is no doubt that that is challenging.

Why was IT adopted across general practice? It was because time and investment were put into the issue and there were incentives for GPs to adopt technology. Something being a good thing to do or benefiting patients does not mean that it will be adopted. We need to take all the levers across the system and bring them together.

We must not take a scattergun approach whereby we say, "We'll do a small bit over there and a bit over here." We need to identify two or three big-ticket items that present challenges to our health and care system just now and for which there is an international evidence base that shows that technology can make a difference, and we need to focus our efforts on those big-ticket items, at scale.

We know that the citizens of Scotland want to make appointments with their GPs online. The vast majority of practices do not make that offer, although the technology is available to do it today, should practices choose to turn it on. Why is that? There are a number of reasons, which are about culture and control. However, if we put in place a strategic plan we can move things forward. That is fundamental.

12:00

The other critical thing is that we need to recognise that technology will not benefit everyone, as someone said earlier, and that some people are excluded, for a number of reasons. That is not a reason for not doing something; it is a reason for making plans robust, so that people are included. We are working hand in glove with the digital directorate in the Scottish Government to look at digital inclusion.

This will be my last point, convener, after which I will be quiet. I go back to what Brian O'Connor said. We are joined up. I chair the digital health and care innovation programme board, which is the oversight group that monitors the whole landscape. Round that table we have Government representatives from enterprise and digital and from health and care, both enterprise organisations, people from the academic community—Professor Anderson is on the group—and representatives from local authorities and health boards, housing and the voluntary sector. All the key parties are around one table, to co-ordinate and drive the agenda forward, because we can only do that in partnership.

Professor Mair: That sounds like a very inclusive group. Are there clinicians on the group, apart from you?

Professor Crooks: Yes. We have clinicians on the group.

SCTT has been asked to interact formally with the GP community, because we have the 2020 vision for primary care and general practice, but technology is not mentioned in the document, which is fascinating. General practice is recognised as being one of our most innovative sectors in Scotland, so it is not that people do not want to engage. We need to sit down and get into dialogue today.

Dr Simpson: I think that Professor Crooks has almost answered the question that I was going to ask. A lot of telehealth and telecare seems to link specialists with individuals, but it is primary care—I should declare an interest, as a fellow of the Royal College of General Practitioners—that holds the reins on integrated care planning for individual patients. That is fundamental, but as we heard from the first panel, if telecare and telehealth is an add-on and is not core business for general practice, we will not succeed, and we will continue to have a silo-type service.

Patients do not want that; they want to be able to go to their clinicians and ask about this, that and the next thing in a system that is integrated. I have just experienced that. When I asked my oncologist about certain things, he could not tell me whether they were side effects of other medication that I was taking, because that was not his field. When I asked the GP, the GP was able to tell me.

Professor Mair's point was fundamental. The big flaw in the system is that we are not making general practice central to telecare and to health and social care integration. If we do not do that, we will not succeed.

The Deputy Convener: I think that that was a comment, rather than a question.

Dr Simpson: As usual. I am sorry.

The Deputy Convener: No, that is fine. We will leave that hanging.

Justene Ewing: One thing that is clear in the DHI is that the engagement of general practitioners is fundamental—regardless of whether we are talking about healthcare or social care. You will not find a project in our portfolio that does not involve front-line engagement. A project that we will announce in the next couple of weeks involves five territorial health boards and five GP practices in each board. The message has been heard loud and clear.

In all the engagements that the DHI has had in the past year and a half of getting ready and the past six months of its being live, it has been clear that digital health, with all the opportunities that it presents, will be successful only if it can be adopted, if it can be scaleable, if it is interoperable and if it is needed—and not necessarily wanted.

There are big challenges to do with finance over the next three to five years and probably far beyond that, and there are opportunities for job creation, company creation and wealth generation.

Gil Paterson: I have a question for Professor Mair. My GP practice—which I have been in for my whole life—is in the Milton scheme in Glasgow, which is probably one of the most challenged areas in Europe. Therefore, I was interested in your view on how we are proceeding, which you think might mean that we will leave behind such challenged areas. Do you think that we should have two models? Do we need to find ways of engaging with such areas?

Professor Mair: I agree with Professor Crooks that we do not want to hold back advances by the people who want to push ahead, but it is extremely important that we put in place mechanisms for bringing with us the people who are in more challenged circumstances. People who have multiple health problems have a treatment burden—many demands are put on them by healthcare systems. People from more disadvantaged backgrounds, especially those who do not have good social support networks—perhaps because of drug, alcohol or other problems—will have less capacity to deal with self-management tasks and to think about monitoring their blood pressure, their sugars or whatever.

We need to ensure that we put in place systems for enabling those people. That might involve using health and social care, lay workers or other mechanisms to bring those people along with the front runners—the consumers who are pulling the systems—so that we do not leave them behind. How we enable those people must form an extremely important part of the planning process. I know that as part of the UK-wide DALLAS—delivering assisted-living lifestyles at scale—programme, which living it up is part of, groups in places including Liverpool are using champions and lay workers to enable people digitally. All sorts of mechanisms are being trialled. As well as being in the vanguard and going for EU funding, which is great—we should do that—we should think about those challenges.

Other EU countries face the same challenges. We are working with partners in Greece, where the austerity measures have put them in a particularly difficult situation. We can share learning on how to deal with the challenges. An important strand of the integrated e-health plan needs to be about how we will enable those who are less able.

Professor Parsons: Part of the work that I have been doing in LifeKIC relates to industry engagement. That has two sides to it. It involves talking to a number of Scotland's small companies, which the DHI deals with. In talking quietly to some larger European companies, what has struck me is that twice the whole sector has been described as the wild west. There are a number of very large companies, all of which believe that they can do it all. That is one of the challenges that we face as we try to apply the new technologies in the real world of real patients and real GPs. Scotland is in the vanguard, but we need to recognise that it is a complex area of technology and that the process cannot be driven by the technology. It needs to be driven by the process change in the health service and the way in which patients access those changes. That is fundamental.

Professor Anderson: I want to pick up on something that Aileen McLeod said at the beginning about the role of the European innovation partnership on active and healthy ageing, which we have not really touched on. It would be interesting to hear George Crooks say a little about that. In my experience, it brings together the whole of the European experience, in which Scotland plays a very big role. A great deal of learning and exchanging of knowledge goes on through that. I think that it is extremely useful in terms of the European context and Scotland's role in it.

Professor Crooks: I lead the integrated care action group of the EIP with my colleague Donna Henderson. It is a collaboration that involves more than 450 individual members from 280 European organisations in 23 countries across Europe. It looks at the totality of integrated care. It does not look simply at the integration of health and social care; it looks at vertical integration within health and at how systems integrate.

When we talk about technology, we always think about monitoring something—a person's blood pressure, their weight or whatever—but technology should also connect people with their communities. That is what we in Scotland are saying.

I return to the issue that Frances Mair was discussing. Lots of people have simple mobile phone technologies, with 2G services. 2G can be used to do a huge amount of stuff; more can be done with 3G. That can help someone with a chaotic lifestyle to access services—not to treat their drug or alcohol problem but to give them back some structure in their life.

We are very good at innovative service redesign in Scotland. We invested a huge amount of time and effort training our middle and senior managers on service redesign. That is where our strength is. The ICT is designed to support service redesign, not to drive it. Sometimes we get carried away by the glamour of technology, but it is not about that—it is about people.

I say this in all my presentations, and it is fundamental. Our strategy is to use ICT to protect the most valuable resource that we have, which is face-to-face contact in health and care. That contact is most valued, and it is most valuable. We can make it more accessible through appropriate use of technology. It is not about replacing a social worker, doctor or physiotherapist with a piece of kit, although some people are concerned that that is what it means. In the Scottish context, it is far from that.

The Deputy Convener: I have a question that concerns two aspects of health technology innovation. There are things that the patient, consumer or resident does not have to see—the clever bits behind the scenes that make things work more efficiently. As for the things that patients do see and connect with, however, who is asking them what they would like to change? There are all these clever boffins thinking about clever ways to innovate. I represent Milton in Glasgow. Who is asking people in housing schemes like Milton how they would like things to change? Perhaps all those good things are happening, but it is important to get on the record whether it is happening. Who is asking patients how they would like technology to enhance their experience?

Professor Crooks: That is happening. Is it happening as efficiently and effectively as it could? No—it never will.

Living it up, which is an ICT-enabled programme, has been mentioned a number of times. Living it up is the largest co-production programme in Scotland—probably in the UK. It currently involves 8,000 of our citizens from deprived and well-off communities co-creating and co-designing the web-based service. That is the model for the future.

For far too long, clinicians have gone into darkened rooms and designed services, and people had to be grateful for what they got. I will hold my hands up: I was probably as guilty as all the other clinicians in this room who did that. That was the way we did things, but it is no longer the way. We cannot afford it. Co-creation and co-production are what this is about. The joint improvement team is working with my team at the Scottish centre for telehealth and telecare to drive the technology.

We are working with design experts at the Glasgow School of Art, which is a key partner in the DHI and is integral to what we are doing. Our academics designed the consultation exercise from day 1; we did not bring them in at the end to evaluate it. Professor Mair has the task, on behalf of the technology strategy board, to evaluate how living it up has worked. We will stand or fall by that evaluation.

The users really appreciate being involved, and they value seeing their input make a difference.

The Deputy Convener: Professor Mair, do not worry—I am not going to put you on the spot in relation to that. Do any other witnesses wish to comment?

Bill Templeman: George Crooks is absolutely right. When we started work on living it up, we were very conscious that we needed to engage fully with the community. Although many companies abroad say that they are doing this kind of thing, they are not quite in the same league, and they are not focusing on design-led activity as we are doing it in Scotland. That is important, because it means that we are getting the right solutions for the right people in the right places. We are still in the foothills, and we have a bit of work to do, but we will get there.

Brian O'Connor: I am very interested in the response to the question. I am learning a lot about Scotland as I visit here more often. As I said earlier, you have a lot of good things going on, but we do not seem even to be utilising the technologies that exist already. Too many people think of technology as something that will come along tomorrow.

Not long ago, one of my grandsons, who was eight years old at the time, was not feeling well. He said to his mum, "But I really want to go to school today, because I've got a project." She told him, "You've got to see a doctor." He handed her his iPad mini and asked whether he could talk to the doctor, and she said that he could not. He asked, "Why not?" When an eight-year-old asks that, you have to find an answer. The answer was that the doctors would not allow him to do that.

12:15

A clinician in France, I think, did not want to bring his patients back in after operations because

they might have a three or four-hour journey each way to see him for 10 or 15 minutes, but his local hospital authority and doctors would not allow him to use Skype, even though all the people concerned were on Skype. If they were not, their children would help them get on Skype.

There are barriers that are man-made—perhaps I should say man-and-woman-made—but there are simple things that people could do that would allow them to consult more widely and to become more part of a citizen's life. We do not use existing technologies, never mind the new ones that we are creating.

The Deputy Convener: That is a specific and clear example. We have all the pre-eminent telehealth experts round the table. Are there examples of that kind of telehealth activity happening in Scotland already? Is it being developed?

Professor Crooks: Yes, there are good examples of that, but they are not deployed at scale across the service. People can travel some distance for orthopaedic procedures at the Golden Jubilee national hospital, and a number of the follow-up appointments happen using videoconferencing links. There are good examples of remote clinics in the north of Scotland, where there is the challenge of rurality, for things such as neurology, epilepsy management, psychological therapies and mental health care.

We have not yet focused on the challenge that the NHS in Scotland has in providing health and care services in prisons and custody suites. Videoconferencing is among the digital technologies that are being considered by a number of health boards to allow prisoners to access services in a confidential way and with dignity. The last thing that prisoners want is to be taken with two guards, sometimes handcuffed, to an out-patient clinic where everybody stares at them as they go along the corridors to the coffee shop, for instance. They would rather be treated with dignity. Using videoconferencing technology can improve the experience for everyone, as well as creating efficiencies in the system.

We have good examples, but they are not at scale.

Justene Ewing: Patient engagement was discussed earlier. We are doing a number of things in that regard, and I will give an example of how that engagement works. There are three different types of activity in the DHI. One involves understanding need or answering questions that have no answers. The development of our concepts may well move into finding digital interventions, whether they are videoconferencing or something that does not yet exist. Users—by which I mean users of social care services and the third sector as well as patients and their families and circles of friends—will be involved every step of the way.

When we are replicating or prototyping things, we have something called the experience lab. We have literally replicated hospital wards, bedrooms and GP surgeries. We have gone through the entire process. We call them actors, but they are actually patients or members of the public who have been through particular circumstances and who can evidence, personally and clearly, the impact that technology has or does not have, depending on what we are speaking about.

Not wishing to replicate or to spend money unnecessarily, we have already tapped into the living it up community and agreed with it that the platform of 8,000 users who are already actively involved in some of its programmes will be actively engaged in DHI activities, too. There is a real strength in the capability that has been built there already.

Patient and user experience is critical. The ability to adopt the new types of services that are coming in is very much dependent on will as well as on skill in doing the work.

Professor Mair: Something else about information exchange that came up in the earlier evidence session was the fact that barriers to information sharing exist because of governance issues. When I was up in Inverness at the centre for rural health, I heard about its transnational EU-funded telemedicine service. One of its projects is an app that enables people with inflammatory bowel disease to input information about their symptoms and send it to a specialist nurse who can then take action if things go wrong. I said that I thought that it is a very biomedical model, because it involves somebody taking down their symptoms, sending the information to the clinicians and never getting any feedback. When I asked why people were not sent messages to say, "That looks good," or graphical displays, I was told that, because of governance controls at NHS Highland, that could not be done, in case it was not a secure pathway to send back information.

GPs could email patients, but most GPs do not want to do that for a variety of reasons, one of which is the risk of confidentiality being breached. If their email is hacked into, that would be an issue for them. The situation is not helped when people phone the Medical and Dental Defence Union of Scotland to talk about telecare and telehealth and are told that we are just waiting for case law to be made. That does not help people's confidence, even though there should not be a greater risk in doing things that way.

We need to look at the governance information-sharing rules, which are there for good reasons of

data security, and talk about how we can break down some of the barriers that prevent innovation, integration and information sharing to provide more person-centred care.

Dr Simpson: I have two points to make. First, Scotland has a system of managed care networks. The King's Fund has said that it does not yet know whether they are entirely beneficial, but I am a great believer in them and think that a co-operative and collaborative approach is vital. Even in the central belt, practitioners often reach out over quite long distances, yet we are not using technology to link in patients, so they still have to travel for two or three hours, there and back, for a 10-minute appointment. Frankly, such appointments could be done easily by Skype. Brian O'Connor made a vital point. We should be asking patients who have gone through the experience what would have made their experience better. For me, it would have been not having to travel for three hours to see someone for 10 minutes, which was a waste of their time and a bigger waste of mine, frankly.

Secondly, I do not understand why we do not use encrypted email. The email system that I use can encrypt emails to other people who use the same system, but it can also now encrypt emails to people who are not using the same server. I can ask someone a question and if they answer it correctly they can get into my email. I do not see why GPs are not doing that and giving people confidence.

I would like our colleagues to comment on those two existing issues. As Brian O'Connor rightly said, we should forget about all the innovative stuff, although it is wonderful and everybody gets excited about it, and ask why we are not using the basic stuff that we have now in a system that gives people confidence.

Professor Crooks: I am happy to answer that. I absolutely agree with everything that you say. In Europe, there are examples of email being used regularly as a way for doctors to interact with patients and the world has not come to an end. In Denmark and Holland, that is usual business activity.

I have spoken to the chief physician in Kaiser Permanente in the United States. When it moved to a digital consultation system, a number of clinicians thought that they were going to be swamped by patients emailing questions, but nothing like that happened, because people used the system responsibly. People are comfortable with using email and with a recognisable level of security that, as you said, is available now.

If Eddie Turnbull was sitting at the table, he would tell you that the bane of our lives is the information security governance regulation, which is a bit of a black art in Scotland, as it is across Europe. People make things up and will say something with such authority that we all believe that it is true, but when we look behind it we see that it does not exist.

It is not written down anywhere that you cannot send an email to a patient in the NHS in Scotland. It is also said that people cannot access video. There are issues about how Skype works and where it gets its server capacity, but there are a number of off-the-shelf and free-to-use videoconferencing technologies that are being used just down the road in Lothian. However, if you were to ask in another health board north of here whether you can use the same thing, its e-health people would say no. That is because of a lack of understanding, rather than there being anything written down.

We need to issue simple Noddy guidance to people, to get rid of those who make up policy on the hoof, either because it suits them or because it makes them sound important.

Did I just say that?

The Deputy Convener: I am certainly going to look forward to reading the *Official Report* of this evidence session. It is getting interesting just as we are drawing to a close.

The committee does not just want to take the temperature on the issue, and I am grateful to Aileen McLeod MSP, who was keen to have this round table today. Whatever we decide to do with our work plan, if we were to return to the issue this time next year and do something similar, what should we look at to see whether there has been real progress?

For example, we could track how much inward investment there has been in the year or monitor how much innovation there has been, or we could find a way of measuring the roll-out of good practice in embedding existing technologies, such as those mentioned by Mr O'Connor. Perhaps more importantly than any of that, we could actually ask patients whether the system has better provided the outcomes that they needed. That is before we get on to the IT stuff and the Noddy's guide to rolling out best practice.

If we return to the issue, how should we carry out that monitoring? Is there a set framework that the committee could look at when one year and then two years have passed, so that we can see where we are? How can we measure and scrutinise that?

Professor Crooks: Could I make a suggestion?

The Deputy Convener: No, but only because Justene Ewing caught my eye first.

Justene Ewing: I was going to mention the work that we have been doing with our enterprise partners, particularly in the innovation centre community, of which I am one member out of what will eventually be eight, along with the Farr institute and a number of other organisations that are looking at the wider picture of digital health, which includes data and genetic revolutions as well as sensors and microchips. A reporting framework is being developed between the enterprise partners and the Scottish funding council to track developments and, particularly in my area, to look at improving cost effectiveness, health performance, patient experience and quality of life, as well as economic measures. The groundwork exists and could be used to give a sense of what is going on in that specific market without recreating that structure or investing a huge amount of effort and money.

The Deputy Convener: Before I bring in other witnesses, I should say that we are running out of time, so this is the opportunity to make final comments before we draw to a close. I know that Professor Anderson and Professor Crooks both want to come in.

Professor Anderson: At the beginning, George Crooks made the important point that we should focus on one or two large-scale initiatives, see what changes are happening there and understand those things. It is possible to confuse innovation with novelty. In order to innovate, we have to bring something that gives value, and that could be a bunch of stuff that has been around for 10, 15 or 20 years, but understanding how to integrate and build an ensemble is what innovation is really about. Looking at that at scale in Scotland is the big thing to do.

12:30

Professor Crooks: We have a national delivery plan for telehealth and telecare, which was formally signed up to by the Scottish Government, the Convention of Scottish Local Authorities and the NHS in Scotland, and it has defined annual targets for the next two years. That is one way of looking at the agenda in Scotland.

I would like to say something that is directed specifically at the committee. Scotland is where it is because we have had national consistency of policy in telecare for the past 12 to 14-plus years. That is because telecare has had cross-party support and consistency of approach. That is fundamentally important in the area. Countries that do not have that and where policy changes every three to five years with a change of party in power are set back a huge amount. Scotland has a great deal to commend it. That consistency of policy in this committee and the Parliament is very much appreciated by those of us who are tasked with taking the agenda forward, because it makes our lives slightly easier.

Professor Parsons: I have two brief comments, one of which is on what Justene Ewing said. Scottish Enterprise is doing a piece of work on the economic and social benefits if we get the LifeKIC funding. The study is looking at the number of companies that would be created and the value generally to the Scottish economy. That would very much feed into the indicators that we were discussing. That work is already happening, and I am very happy for it to happen.

Secondly, by the time that we appear before the committee again, we will know whether the LifeKIC bid has been successful. However, even if it is not successful, there is value in the network that we have created round it. Obviously, I hope that it is successful, but the process that we have been going through with Scotland and the other regions is important.

The Deputy Convener: The last person I see intimating that they wish to speak is Professor Mair.

Professor Mair: It is just a plea that, if we are coming back in a year's time to look at the national delivery plan for telehealth and telecare and how the targets have been met, we should look at the socioeconomic profile of those who have been targeted to see what the mix is. It would be interesting to see whether we have targeted the hard to reach as well as those less so.

Bill Templeman: I have one last point, which is to reiterate that there is great strength, great focus and a great direction of travel, and we have an opportunity to capitalise on that. I know that George Crooks, Justene Ewing, Mark Parsons, Stuart Anderson and Frances Mair are all involved in that. It is important that we take advantage of that now, take that initiative in Europe and drive that for our own benefit—the benefit of our health service, of individuals and of our businesses.

The Deputy Convener: I think that the last word is from Ms Giannini.

Francesca Giannini: To follow up on what Stuart Anderson said about innovation, that is exactly the concept of innovation that we see at European level. Horizon 2020 was mentioned, which is the main funding framework for research and innovation, as opposed to research and development, which was the name of the predecessor programme. Innovation in that context means not just technological innovation but social and economic innovation. The main policy and funding in Europe is looking at innovation from different angles.

There is also integration, which has come up a lot. A way of looking at innovation is in the

integration of technology, policy—in the public and private sectors—and users, so the patients as well. A number of the calls for bids that are out at the moment are for proposals on patient self-management and empowerment of patients in the context of e-health. Everything that has been said here is very much in line with European priorities for the next seven years.

The Deputy Convener: I thank all the witnesses for coming this morning, although I see that it is now the afternoon. I am sure that the committee will wish to return to the issue. I think that I can say on behalf of all members that we very much hope that the LifeKIC application is successful. Thank you once again for your time.

Meeting closed at 12:34.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice to SPICe.

Available in e-format only. Printed Scottish Parliament documentation is published in Edinburgh by APS Group Scotland.

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

For details of documents available to
order in hard copy format, please contact:
APS Scottish Parliament Publications on 0131 629 9941.

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@scottish.parliament.uk

e-format first available
ISBN 978-1-78457-016-3

Revised e-format available
ISBN 978-1-78457-033-0

Printed in Scotland by APS Group Scotland