Inquiry into Clinical Portals and Telehealth

British Medical Association Scotland

Introduction

The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 140,000 doctors representing 70% of all practising doctors in the UK. In Scotland, the BMA represents around 13,400 doctors.

The British Medical Association (BMA) welcomes the opportunity to provide the Health and Sport Committee with written evidence on the progress of the development of the Clinical Portal Technology (CPT) project for patient information in Scotland.

To date, BMA Scotland has had relatively little direct input to the CPT project. However, we did encourage our membership to respond to the CPT clinician survey in June 2009 and we have recently been asked to send a GP representative to the Clinical Portal Programme Board which will be responsible for overseeing the implementation of CPT in NHS Scotland.

The CPT project is an essential component of the NHS Scotland eHealth Programme, with the aim of allowing patients and clinicians to electronically access relevant patient information through central portals. Patient information accessible through clinical portals will be aggregated from other NHS clinical systems. There will be benefits for both Primary and Secondary Care in that CPT will improve the sharing of information between them.

Generally, BMA Scotland is supportive of the CPT project. Our concerns relate to patient confidentiality and how access to the system will be managed. We support access logging and auditing to clinical portals but do not believe this is sufficient to prevent abuse of clinical systems in isolation. If portals were to be accessible from public computers, it is our view that username and password access does not offer sufficient security of data – for example it is fairly common practice for usernames and passwords to be shared between medical staff. While this is problematic currently, the risks of abuse in an environment with clinical portals displaying much more data are considerably greater.

It is essential that CPT uses robust identity and access management. Individuals accessing data through a clinical portal should receive a view relevant to their role in the NHS, only access patient data where they have a legitimate clinical relationship (based on referral, admission or patient attendance) and whose activity can be audited. The role basis of access is still under development due to lessons learned in the complex English Connecting for Health (CfH) model.

BMA strongly believes that identity and access management has a much greater role in limiting inappropriate access than using retrospective audit for deterrence, although audit should continue to be used in the current management of CPT.

There are inconsistencies regarding patient consent for sharing information throughout NHS Scotland. It would be helpful if the Committee could obtain clarity as part of this inquiry process on the consent model to be used for CPT and how it compares to what is used for

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1 Identity and access management is a broad area that deals with identifying individuals in a system (such as a country, a network or an organization) and controlling the access to the resources in that system by placing restrictions on the established identities.
other systems such as the Emergency Care Summary. We would also be interested, as a part of this process, to learn if there will be a system for patients to be able to find out who has accessed their records.

**What do you see as the benefits of the CPT project?**

As highlighted by the CPT clinical survey\(^2\) it is still common for clinicians not to have electronic access to patient health summary information (which includes drug reactions, allergies and current medications). The primary benefit of CPT will be reduced risk to patients as clinicians will have greater access to patient information and therefore be able to make more informed decisions with regard to their clinical care.

Another major benefit of the clinical portal is that it does not seek to create a new centralised database of patient identifiable data. Rather, information is temporarily extracted from existing databases only as required. An effective portal will prevent the need for different parts of the NHS to use the same software. This will allow the continued use of software that is most appropriate for the local environment.

Speed of access to information will be greatly increased in those areas of the NHS that use clinical portals. Of the many benefits of eHealth, an example will be less reliance on paper which will reduce storage requirements.

Potentially, clinical portals could provide more secure access. However, as mentioned above this will require sufficient identity and access management.

**How much progress has been made in developing CPT since 2007?**

The CPT project is complex and there remain many challenges to overcome before clinicians across Scotland can access a clinical portal. Two candidate systems exist in NHS Greater Glasgow and Clyde, and NHS Tayside. There are also other candidates being developed in England and Wales.

We expected more rapid progress in developing CPT. There has been considerable activity regarding the CPT project in 2009, including the outcome of the clinical survey, which we consider to have been an important piece of work to establish a baseline. However, generally we are disappointed that greater progress has not been made in delivering clinical portals in Scotland.

We are disappointed that single sign-on for clinicians has been delayed because of being integrated into the CPT project and hope this will become a reality in the near future.

**What is the minimum amount of information required by clinicians and how can CPT deliver this?**

The information available through clinical portals must be of high clinical value and of moderately low risk of abuse. Essential information will be similar to that contained in the Emergency Care Summary, which includes CHI number, current medications, and adverse reactions and alerts. The best source for this information is the GP record, which is intended to be life-long and comprehensive. Information from the GP record should be supplemented with information from pharmacy prescribing records (both from primary and secondary care) and from secondary care generally.

Information available through clinical portals should not be extended in the absence of sufficient consultation with clinicians and the public.

**What are the potential budgeting implications of the development of CPT?**

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BMA Scotland cannot comment on specifics of CPT funding as we have not been involved in this process. However, the CPT project is the agreed direction of travel for eHealth in Scotland and it should be funded appropriately.

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