HEALTH AND SPORT COMMITTEE

AGENDA

31st Meeting, 2009 (Session 3)

Wednesday 2 December 2009

The Committee will meet at 10.00 am in Committee Room 4.

1. **Decision on taking business in private:** The Committee will decide whether to take item 6 in private.

2. **Subordinate legislation:** The Committee will consider the following negative instruments—

   - The Food Labelling (Declaration of Allergens) (Scotland) Regulations 2009 (SSI 2009/374)
   - The National Assistance (Assessment of Resources) Amendment (No. 2) (Scotland) Regulations 2009 (SSI 2009/381)
   - The Public Health etc. (Scotland) Act 2008 (Sunbed) Regulations 2009 (SSI 2009/388)

3. **Inquiry into the Clinical Portal Programme and the Scottish Centre for Telehealth:** The Committee will take evidence from—

   - Dr Cliff Barthram, Consultant Anaesthetist & Joint Clinical IT Lead, NHS Tayside;
   - Dr Malcolm Gordon, Emergency Medical Consultant, Southern General Hospital and Clinical eHealth Lead, NHS Greater Glasgow and Clyde;
   - Dr Catherine Kelly, Scottish Government eHealth clinical lead and Co-chair Clinical Change Leadership Group, and Dr James Docherty, Consultant Surgeon, Clinical Director eHealth NHS Highland and Co-chair Clinical Change Leadership Group;
   - Alan McDevitt, Joint Deputy Chairman, Scottish General Practitioners Committee, British Medical Association Scotland;
   - Sian Kiely, Knowledge & Research Manager, Royal College of Nursing Scotland;
and then from—

Iain Hunter, General Manager, and James Ferguson, Clinical Lead, Scottish Centre for Telehealth.

4. **PE953:** The Committee will consider a petition by Ms Jean Gall, on behalf of the Scottish Association of Sleep Apnoea, calling on the Scottish Parliament to urge the Scottish Executive to increase awareness, promote the proper diagnosis and treatment and provide sufficient resources, including adequately funded sleep centres, to tackle the health problems associated with obstructive sleep apnoea.

5. **PE1272:** The Committee will consider a petition by Randolph Murray calling on the Scottish Parliament to urge the Scottish Government to ensure that there is adequate provision for out-of-hours GP cover in all remote and rural areas in Scotland.

6. **Inquiry into out-of-hours health care provision in rural areas:** The Committee will consider its approach to the inquiry.

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Clerk to the Health and Sport Committee
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The Scottish Parliament
Edinburgh
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Email: callum.thomson@scottish.parliament.uk
The papers for this meeting are as follows—

**Agenda Item 2**

Note by the clerk  
SSI 2009/374  
SSI 2009/381  
SSI 2009/388

**Agenda Item 3**

SPICe briefing  
NHS Tayside submission  
Clinical Change Leadership Group submission  
BMA Scotland submission  
RCN Scotland submission  
Scottish Centre for Telehealth submission

**Agenda Item 4**

Note by the clerk

**Agenda Item 5**

Note by the clerk

**Agenda Item 6**

Note by the clerk
### Negative Instruments

<table>
<thead>
<tr>
<th>Name</th>
<th>Deadline</th>
<th>Motion to Annul</th>
<th>Purpose</th>
<th>Drawn to attention by the Subordinate Legislation committee (SLC)?</th>
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<tbody>
<tr>
<td><strong>The Food Labelling (Declaration of Allergens) (Scotland) Regulations 2009 (SSI 2009/374)</strong></td>
<td>7 Dec</td>
<td>No</td>
<td>These Regulations further amend the Food Labelling Regulations 1996 (“the principal Regulations”) in so far as they apply in relation to Scotland. The principal Regulations extend to the whole of Great Britain.</td>
<td>The SLC draws this instrument to the attention of the Parliament and the lead committee on the grounds that there has been a delay of almost six months in correcting an incompatibility between Scots criminal law and Community law.</td>
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<td><strong>The National Assistance (Assessment of Resources) Amendment (No. 2) (Scotland) Regulations 2009 (SSI 2009/381)</strong></td>
<td>7 Dec</td>
<td>No</td>
<td>These Regulations amend the National Assistance (Assessment of Resources) Regulations 1992 (“the principal Regulations”). The principal Regulations concern the assessment of a resident’s liability to pay for accommodation provided under the Social Work (Scotland) Act 1968 (“the 1968 Act”). By virtue of section 87(3) of the 1968 Act, accommodation provided under the 1968 Act or section 25 of the Mental Health (Care and Treatment) (Scotland) Act 2003 shall be regarded as accommodation provided under Part III of the National Assistance Act 1948.</td>
<td>The SLC had no comments to make on this instrument</td>
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<tr>
<td><strong>The Public Health etc. (Scotland) Act 2008 (Sunbed) Regulations 2009 (SSI 2009/388)</strong></td>
<td>14 Dec</td>
<td>No</td>
<td>These Regulations make provision under Part 8 of the Public Health Act etc. (Scotland) 2008 (“the Act”) in relation to the regulation of provision of sun beds.</td>
<td>The SLC reports that it raised two questions with the Government on this instrument. Firstly, it sought an explanation as to how the anticipatory exercise of the powers to make the instrument, in sections 95(4)(c) and 96(5)(c) of the Public Health etc. (Scotland)</td>
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<tr>
<td>Agenda Item 2</td>
<td>HS/S3/09/9/1</td>
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<tr>
<td>18th March 2009</td>
<td>ANNEX</td>
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|                                                                 |                                                                 |
| Act 2008 by the Government before those sections are brought into force? |
| The SLC also sought an explanation as to the 3 month delay between the period following notification of the draft Regulations to the European Commission and the period when the Regulations were made. |
| The SLC reports that it was satisfied with the explanation it received from the Scottish government to both these questions. |

Where instruments have been drawn to the Committee’s attention, the relevant extract from the SLC report is given as an annex to this paper.

If members have any queries or points of clarification on the instrument which they wish to have raised with the Scottish Government in advance of the meeting, please could these be passed to the Clerk to the Committee as soon as possible.
HEALTH AND SPORT COMMITTEE

eHealth: Clinical Portal Programme and the Scottish Centre for Telehealth

Introduction

On 2 December and 9 December, the Committee will be taking evidence on two aspects of the eHealth strategy. This briefing aims to provide a brief reminder to Members on the eHealth strategy, the clinical portal programme and the work of the Scottish Centre of Telehealth. Members will receive additional information from witnesses.

Recent policy in this area has focused on building on existing systems, filling in the gaps where necessary and synchronising those systems. This has been viewed by the previous Scottish Executive and current Scottish Government as being both pragmatic and cost effective. It is a different approach to that taken in the NHS in England, which has concentrated on the development of a single IT system for the whole of the NHS.

The last Executive’s policy was outlined in ‘Delivering for Health’\(^1\). It envisaged a single electronic health record where there would be one store of all relevant medical information from a variety of systems which could be accessed by authorised health service staff. The current Scottish Government’s ‘eHealth Strategy: 2008 - 2011’\(^2\) was published in August 2008 and flows from the overall health strategy ‘Better Health Better Care’\(^3\). It continues to envisage the synchronising of separate IT systems. However, it is based on utilising clinical portals that can get access from different databases rather than the creation of a single store.

The eHealth Strategy

The Strategy envisages a “paper-light” NHS, which will lead to the provision of “fast, local and reliable access to patient services through the use of appropriate technologies” (p 5). The benefits are seen as including: improving communication between services; less time wasted searching for information; reducing the need for numerous logins; giving patients access to their own information; more efficient results reporting; and, safer prescribing. Key individual projects include:

- Emergency Care Summary - contains key clinical information for over 5.1 million patients and is used in around 25,000 care occasions per week

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\(^1\) [http://www.scotland.gov.uk/Publications/2005/11/02102635/26356]
\(^2\) [http://www.scotland.gov.uk/Publications/2008/08/27103130/0]
\(^3\) [http://www.scotland.gov.uk/Publications/2007/12/11103453/0]
• secure electronic messaging system - primarily used, at present, for outpatient referrals by GPs at a rate of some 17,000 per month, often made according specialty or condition-specific protocols
• PACS services (digital X-rays) - has reached the point of 21 sites live and over two million images stored. Benefits include fewer unnecessary X-rays being taken due to lost films.
• ePharmacy - prescriptions sent electronically from GP to community pharmacist then onwards for payment is now live with around a million prescriptions a month being transmitted.

It is a nationally coordinated strategy, but allows for localised projects given that no single delivery model suits every situation or area.

**Clinical Portal Programme**

As outlined above, the aim of the previous Scottish Executive strategy was to allow clinicians to access such individual programmes but through a single database, what popularly became known as the single patient record. However, a number of potential difficulties were identified with this approach. Instead, the current strategy seeks to create clinical portals - "electronic windows" that allow clinicians with and other health professionals appropriate authorisation to see a range of information, even if the information is actually held in many different places.

The Scottish Government\(^4\) has previously advised that NHS Tayside and NHS Greater Glasgow and Clyde have implemented clinical portal technology already in some areas. The overall aim of the Scottish Government is to ensure that clinicians throughout Scotland can access a clinical portal, which will hold a minimum amount of information, irrespective of which clinical portal is used. Such matters are being taken forward by the Clinical Change Leadership Group (CCLG), which represents the eHealth views of all clinicians across Scotland. It is comprised of a senior clinical representative from each area Health Board and many of the Special Health Boards. The CCLG will prioritise information based on the importance in supporting delivery of clinical care, recommending what information should be included at different stages of implementation of the clinical portal.

The needs of clinicians are of primary importance. However, another major objective of the Scottish Government is to look at the ways eHealth can be used to empower patients. A number of condition specific portals are already in operation eg Renal Patient View and NHS Scotland Diabetes Patient Information Portal. Such portals provide a range of information and data, including test results, medication records, clinical records and relevant letters. However, the Scottish Government is aware that many patients are most interested in using technology to improve access to services. NHS Ayrshire and Arran is currently piloting a portal which as well as providing information and advice to patients also allows them to request a GP appointment online and provides for electronic prescription requests.

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\(^4\) Personal communication
Overall eHealth budget

Members will recall that the Scottish Government proposes the following spending on eHealth in the Draft Budget 2010-11:

<table>
<thead>
<tr>
<th>Proposed eHealth spending 2010-11</th>
<th>2009-10 Budget £m</th>
<th>2010-11 Draft Budget Cash £m</th>
<th>2010-11 Draft Budget Real £m</th>
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<tbody>
<tr>
<td></td>
<td>97.2</td>
<td>134.7</td>
<td>132.7</td>
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However, as discussed by the Committee in its report to the Finance Committee, there are also funds for specific telehealth programmes included in the Capital budget line. However, the Committee expressed its concern that this funding is disaggregated, so it is not possible to see how spending on telehealth is changing.

As discussed in the section on the Scottish Centre for Telehealth, below, significant spending on telehealth comes through NHS Board’s own budgets. The Scottish Government’s eHealth strategy (p 24) estimated that a combination of capital and revenue across national and local NHS Board funding streams amounted to £225m in 2006-07.

Further discussion of finances is included in the following section.

Scottish Centre for Telehealth

The Scottish Centre for Telehealth (SCT) was established following the publication ‘Delivering for health’ in November 2005. This strategy (p 33) discussed that the aim of the Centre would be to provide practical help to NHS Boards as they sought to realise the potential of telehealth development projects. It outlined its core functions as:

- providing a centre of expertise to define and disseminate best practice and develop inter-operable standards, protocols and processes to support telehealth solutions
- providing practical and informed support to telehealth projects in their development phase and to NHS Boards implementing National Telehealth Reference Solutions
- co-ordinating the evaluation of projects capable of evolving into National Telehealth Reference Solutions and support the process of awarding funds to projects
- evaluating the impact of telehealth solutions on service redesign

It was also envisaged that the SCT would harness the skills and expertise of key groups across Scotland from medicine, operational management, and telehealth technology and impact evaluation. It was decided that NHS Grampian would provide the hub for the SCT, given its local experience in the field of telemedicine.

The role of SCT was reiterated by the current Scottish Government in ‘Better Health, Better Care’⁵. The current strategy (p 63) noted how telehealth, when deployed effectively, can improve the patient’s experience of care by reducing the need for travel to major cities and hospitals to receive care and treatment.

⁵ http://www.scotland.gov.uk/Publications/2007/12/11103453/0
The new strategy also discussed how, over a five year period, the SCT would support and guide the development of telehealth for clinical, managerial and educational purposes across Scotland. It also noted how this would involve working across boundaries with industry, local authorities and NHS Boards to develop recognised models for redesigning care. It said the focus would be on supporting long term conditions (with an initial emphasis on Chronic Obstructive Pulmonary Disease (COPD)), paediatrics, and unscheduled care, with an emphasis on care in remote and rural areas. It also stated that the SCT would provide support and advice to NHS Boards and help evaluate the potential benefits of new technologies, with the aim of making Scotland a recognised global leader in telehealth.

Organisation of Scottish Centre of Telehealth

The SCT is headed by an Executive Committee, the role of which is to oversee and deliver SCT services and develop new ideas. The Committee is charged with a number of responsibilities including:

- ensure the development of an appropriate Telehealth Strategy that is supportive of Clinical Care, Health Improvement, Service Re-design and Clinical Governance
- ensure that the Telehealth Strategy meets the requirements of the various Health Boards across Scotland by being supportive of the strategic priorities of the NHS in Scotland
- provide a direct link to work on the national eHealth Strategy, thereby ensuring the integration of Telehealth with other eHealth initiatives
- monitor and review availability of appropriate funding to support the Scottish Centre for Telehealth
- ensure that an appropriate and equitable cost model is applied to services provided by SCT

In carrying out its functions, SCT has a dedicated team with a Clinical Lead (Mr James Ferguson) and a General Manager (Mr Iain Hunter).

Review of SCT

Between October 2008 and February 2009 a review was conducted into the SCT. It’s aim was: to examine the SCT’s current method of working; examine the SCT’s success, or otherwise, in guiding the development and implementation of telehealth applications in Scotland; and making a series of recommendations about the funding of telehealth beyond March 2009.

The Report was published in October 2009 and reflected on a number of wider issues including the policy context of telehealth, the development of the SCT and also outlined the projects it has been involved in. It noted that the area of telehealth and eHealth in general is made more confused by the number of terms used with differing interpretations. However, it found that telehealth, in association with other eHealth applications, could play a significant role in shifting the balance of care. In addition it could allow patients to receive treatment and care closer to home, and health care delivery to underserviced areas. The Report also found evidence that the

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6 http://www.sct.scot.nhs.uk/TheSCTExecutiveGroup.html
accuracy of diagnosis can be just as good using telehealth applications as conventional methods and that telehealth is accepted by both patients and clinicians. However, it also considered that the ‘telehealth landscape’ was complex with a number of organisations, ranging from the SCT itself, NHS Boards, community care partnerships and the Scottish Government, all involved to one extent or another in telehealth related activities.

The Report also considered funding for the SCT. It noted that this comes from the Scottish Government through the eHealth budget line and is administered by NHS Grampian. It also outlined how the SCT is not a funding body, given it is the responsibility of Health Boards to fund and resource telehealth projects. However, it did note that the SCT has held funds on behalf of specific projects eg the paediatric telemedicine project. The Report made reference to the fact that NHS Boards do not receive any “ring-fenced” funding for telehealth applications and instead are expected to consider the use telehealth as an option when looking to re-design, improve or introduce new services. The Report stated that the SCT received £1 million/year in 2006-07 and 2007-08. In 2008-09, the SCT received £1,505,428, with: 43% of its budget spent on salaries; 28% on telehealth initiatives and telehealth support; 21% on overheads and support costs; and around 8% on reviews.

Finally, the Report contained a series of recommendations:

- the SCT’s governance arrangements should be streamlined and improved
- the telecare landscape should be simplified with the SCT joining one of the Special Boards; the best fit would be NHS24
- the telehealth and telecare programmes should be more closely integrated, and the terms (and definitions) used should be simplified
- the SCT should become more strategic, focusing on a few clinical areas initially, for example stroke and paediatrics, moving them from pilot to universal use
- the SCT requires a telehealth strategy that this underpinned by an IT infrastructure plan
- action is required to improve bridging and videoconferencing services
- consideration should be given to the introduction of an element of core funding for national telehealth solutions

The Scottish Government has advised that the key recommendation concerning moving the SCT into NHS 24 has been accepted and is currently underway.

Jude Payne
SPICe Research
26 November 2009

Note: Committee briefing papers are provided by SPICe for the use of Scottish Parliament committees and clerking staff. They provide focused information or respond to specific questions or areas of interest to committees and are not intended to offer comprehensive coverage of a subject area.

7 Personal communication
Background
The Clinical Portal is an electronic summary of an individual's healthcare records and bridge to other systems. The Clinical Portal is one of the key deliverables outlined in the SGHD eHealth Strategy. NHS Tayside is the first Board in Scotland to begin the implementation of this service.

Current Scottish situation
Across the general public in Scotland there exists a commonly held belief that medical records are all held on computer and are readily accessible by the health care professionals endeavouring to deliver them the best of care, in whatever setting they present within the NHS. The reality is starkly different.

Primary care (GP) records are almost completely held on computer systems. The GP system holds the most comprehensive electronic record for Scottish patients, but these systems are visible only to primary care workers within the practice. There are also shared systems that operate between primary care and secondary care such as SCI DC (the national diabetes system)

In the hospital setting there is a complex mixed economy of paper records and a plethora of clinical systems and departmental subsystems all holding different pieces of the patient record. For many systems only a small subset of clinicians working within a specialty may have access to information that would be invaluable to other clinicians delivering care out with the specialty. Each system is a silo containing some elements of the patient record. Usually a system maintains its own access policy, which means that multiple usernames and passwords need to be recalled by clinicians accessing the many systems in order to glean a picture of the patient’s history. Before the Clinical Portal in NHS Tayside the only way for a clinician to know if any of these systems contained information useful in managing the patient before them was to log in and search for the patient. When we have over 60 clinical systems that is not a practical proposition.

So the position is that there is no such thing as THE patient record – a large fragment of the record is held in primary care (mostly on a single GP system), others are on paper, and further parts are contained in other systems either shared or within the hospital. The way these are managed, and the silo nature of the systems mean that no clinician in either primary or secondary care has a complete picture of the whole patient record. An incomplete view of the patient history is not a sound foundation on which to build future medical intervention.

The current situation lets down both patients and clinicians by making the service less effective and introducing errors, delays, and inefficiencies.

What is a Clinical Portal?
The Scottish Government’s eHealth Programme aims to try and improve the safety, effectiveness and efficiency of patient care by enabling appropriate access to information in a joined up and timely fashion. Implementation of a Clinical Portal will allow clinicians to access different pieces of information about an individual patient as though a true single electronic patient record existed. The portal is able to instantly scan the many clinical systems searching for records pertinent to the patient and
assemble the results into a meaningful composite picture that is presented on screen. The portal will allow a clinician with suitable access rights to ‘drill’ into the clinical information presented for a more detailed view, and to move into other systems without having to re-authenticate or reselect the patient (e.g. to request a blood test, or add a clinical note). A sort of ‘Google’ for patient information.

As new systems and services become available the portal provides a single intuitive entry point to these. For example telehealth and telecare systems could be accessed in the context of the patient record through the portal.

This “virtual” electronic patient record will start with key pieces of information that are of value to a wide range of clinicians and will develop incrementally. A survey of clinicians across NHS Scotland carried out by Dr Cathy Kelly this summer identified the following elements as essential to a Clinical Portal:

- Past medical history
- Current problem list
- Current medications
- Allergies and alerts
- Treatment plan
- Events and procedures
- Social history (patient and carer contact details, patient preferences, functional status, social care needs and risk assessment)
- Clinical letters (in particular, Outpatient clinic letters, hospital discharge letters and referral letters)
- Diagnostic test results
- Clinical observations
- Local and national clinical guidelines and access to eBNF
- Some types of clinical notes (clinic notes and hospital admission and pre-assessment notes)

Any Scottish national Clinical Portal deployment is interdependent with the NHS Scotland Identity and Access Management System roll out currently under way. IAMS is a cornerstone in the implementation of the Clinical Portal and will be integral to achieving some of the benefits identified for the Clinical Portal. One of the biggest benefits of a combined IAMS and portal solution is the delivery of a single sign-on for clinical systems. With IAMS the Clinical Portal will be able present information in the context of the role of the healthcare worker operating it to satisfy clinical need, information governance, and patient confidentiality. IAMS has many other benefits that are linked with portal benefits but not strictly down to portal alone. These include: rapid safe user provisioning – so password ‘sharing’ is avoided; self provisioning – so a clinician can reset their own password in the event they ‘forget’ it after the help desk has closed; user de-provisioning so live accounts are not left in systems after employees have left; as well as single sign-on to multiple systems avoiding the need to retain multiple electronic identities.

**Clinical Portal Benefits**

The Clinical Portal is expected to deliver benefits in the broad areas of patient safety, organisational effectiveness, clinical effectiveness, patient focussed care, and cost.

**Safer treatment and reduced risk**

- Reduction of clinical errors due to simple lack of information.
- Visibility of primary care information will reduce the risk of medication errors due to drug interactions, prescription of the wrong drug, or omission of an important medicine. It is reported that up to 15% of hospital admissions are complicated by medication errors (Kerr report). Currently when a patient is admitted to a hospital...
ward there is no access to the GP medication record. A portal view of the GP medication will reduce the incidence of adverse events due to medication errors.

- Often a hospital pharmacist or doctor has to spend time phoning primary care and relatives to piece together the medication record. A portal view of the GP medication will alleviate much of this allowing more time for direct patient care.
- Access to identical information (a common view of the record) will enable more informed discussions between health professionals and services, leading to better decision-making.
- Reduced repeat questions to patients to obtain relevant information, leading to time savings that can be spent on the consultation itself and to improved patient confidence.
- Visibility of primary care information will reduce the risk of adverse drug reactions due to unknown allergies.
- Visibility of alerts (e.g. child protection) and security messages will inform better clinical decisions.

**Better use of clinical time**

- Generation of an in context virtual patient record pulled from different systems will speed up access to complete information and reduce the risk of missing out key elements leading to better decisions, time savings and less frustration.
- Patient information being displayed in a standard way will speed up finding relevant information.
- A standardised portal user interface will improve the intuitiveness of the system leading to a reduction in training requirement for users. A standard portal means the mobile workforce of junior medical staff has transferable skills as they move between organisations within NHS Scotland.
- Community and practice attached staff working remote from the practice are able to access summary records from the GP system when they are working away from the practice site.

**Better information governance**

- Availability of audit reports will enable the monitoring of individual access reducing the potential for inappropriate access and discouraging transgressions.
- Making patient information more visible to more health professionals will increase the chance of identifying erroneous data.
- Better visibility of the record will enable updates to demographics and other details to filter through to contributing systems leading to better data quality in the medical record.

**Reduced cancellations and follow-up appointments**

- Availability of a single electronic patient record that is accessible at the point of care, at all times, by all involved, will reduce time spent chasing information by phone (acute) or answering phone requests (GP practices).
- Availability of a single electronic patient record that is accessible at the point of care, at all times, by all involved, will reduce appointments cancellation due to lack of information.

**Better coordination of care between health services**

- Better visibility of the patient pathway will reduce the number of calls from GPs to hospitals to check on referrals progress.
- Better visibility of the patient pathway will enable better coordination of care where multi-disciplinary teams are involved.
Better visibility of the patient pathway(s) will enable hospitals to see what GPs have done to date, reducing the amount of repeat tests and improving coordination of multiple referrals.

Access to information on patients’ other current treatments, hospitals attended, past results and future appointment dates will enable emergency care services to avoid unnecessary admissions, tests and treatments.

Visibility of the complete pathway will make it easier to track and monitor referrals progress leading to better planned and more timely interventions contributing to bettering 18 weeks referral to treatment time.

In complex cases with multiple pathways, visibility of all discrete pathways will enable better awareness of the full picture, leading to better collaboration between clinicians and services.

Sharing of pathway information will enable identification of bottlenecks and specific issues, which can then be addressed.

Reduced costs of managing paper

- Availability of a single electronic patient record that is accessible at the point of care, at all times, by all involved, will reduce the cost of sending records by taxi, courier, and fax to where they are needed.
- Replacing fragmented and locally bound paper files with a single electronic patient record that is accessible at the point of care, at all times, by all involved, will reduce delays and serious risks due to decisions having to be made without proper information.
- Availability of data from different systems will enable the generation and pre-population of letters, reducing delays in their issue.
- Electronic storage of letters will enable quicker access to this information (lab results and clinic letters being the most valuable in term of content).

Better coordination across boards and services

- At present, tests are often re-run by the receiving HB to ensure timely access to results. Sharing patient’s information and laboratory/radiology results between boards will reduce unnecessary repeat tests in cross borders referrals leading to best use of NHS services.
- Access to patient records across health boards boundaries would enable a better management of referrals from one HB to the other.

A stepping stone to engaging patients and developing a patient portal

- Much of the infrastructure of the Clinical Portal is the foundation required in a future patient portal development. By developing the Clinical Portal we open the way to allowing patients access to their record through a patient portal.
- The portal will enable health professionals to share the record with patients (initially at the desk sharing a screen, and eventually through patient portal) leading to increased engagement and health literacy.
- Allowing patients to see their own information will make the care process more transparent and increase patients’ confidence in the NHS.

The Tayside Clinical Portal

Since early 2004 NHS Tayside has been migrating towards a single electronic record shared between primary and secondary care. This strategy, supported by the clinicians, the LMC and the board, is one of systems convergence with better integration between fewer systems. The NHS Tayside approach to delivering the portal was to establish a clinically led collaborative development programme involving a number of key NHS
software application providers, both internal and external. There has been no ‘big bang’ purchase of portal technology and we are achieving our objectives with a step-wise, low cost, low risk approach ensuring we maintain clinical leadership and ownership at every juncture.

In 2005 under the GP contract the Tayside GPs came together to decide on migration to a single GP system - Vision 3. This gave NHS Tayside 95% coverage of the population with a GP system that would interface with the Central Vision patient record and lab system shared between primary and secondary care. InPS who produce both Vision 3 and Central Vision (CV) have worked as part of the development collaborative programme on production of the Clinical Portal User Interface within CV as well as links to other systems to support a common shared record. For Tayside this is the natural home for the portal as part of a larger clinical communications strategy. CV provides test requesting and results reporting for labs and radiology, a document store for clinic letters, referrals, discharges, assessments and reports. By incorporating the portal within CV we can display summary information from other systems through the portal in the context of test results and clinical communications. The portal covers medication, allergies, medical history, recent clinical measurements, baseline lifestyle indicators (smoking, alcohol, exercise) appointments tracking, patient location history, summaries of recent investigations, summaries of 5 long term conditions (respiratory, cardiac, stroke, diabetes and thyroid), out of hours contacts. It also provides links to other systems indicating whether or not a patient record exists for the patient selected for each of these systems. The Tayside portal covers the list of essential elements from the national portal survey.

The Tayside Clinical Portal is unique in NHS Scotland in two respects - it pulls information from the GP system; and is a shared view of the record with community, primary care and hospital access. Any portal solution that does not incorporate GP data links is fundamentally hampered. The GP system is the most comprehensive single electronic record in Scotland and as stated earlier is the largest fragment of the complete record. It is the authoritative source for medication, allergies and alerts, medical history, clinical measurement in the community and baseline lifestyle data. Medicines reconciliation without a view on the GP prescribing data is difficult and error prone.

At present we have 13 general practices live with the portal. The roll-out process started 1 month ago following successful pilot in 2 practices. This process will continue until we have universal coverage, projected by summer 2010. In order to pull in the GP data roll-out to the GPs is an essential step in giving the system utility in secondary care. It is planned that roll out to acute care clinicians will begin in the spring.

Behind the portal lies a comprehensive process of patient engagement, clinical buy-in and semi-automated information governance. There is huge enthusiasm for the Clinical Portal amongst primary and secondary care clinicians in Tayside. The benefits of the portal are immediately obvious to clinicians and patients. The evidence from Tayside indicates that the Clinical Portal is one of those projects whose time has truly come.

Dr Clifford Barthram
Consultant Anaesthetist & Joint eHealth Clinical Lead
NHS Tayside
What is the Clinical Change Leadership Group (CCLG)?

The Clinical Change Leadership Group includes senior clinical representation from all NHS Boards in Scotland. The group is currently chaired by Mr Jim Docherty, Consultant Surgeon and Clinical Director of eHealth NHS Highland, and Dr Catherine Kelly, Consultant Physician NHS Lothian and Scottish Government national eHealth clinical lead for secondary care. The other two national clinical leads (Dr Libby Morris, GP NHS Lothian and eHealth clinical lead for Primary Care) and Ms Heather Strachan (eHealth clinical lead for Nurses, Midwives and Allied Health Professionals) sit on the group in addition to the Programme Executive Team from the Scottish Government eHealth Directorate. CCLG is responsible for working with networks of clinicians across NHS Scotland to raise awareness and understanding of the eHealth Programme’s progress and benefits and acts as the representative channel for clinical professions across Scotland. It provides advice and makes recommendations to the eHealth Programme Board and Strategy Board as appropriate.

What is clinical portal technology?

Information is recorded at each stage in a patient’s journey through the healthcare system. Some of this information is recorded electronically and stored in local or national IT systems. Other types of information are only recorded on paper. Where electronic information is available within NHS Scotland it is largely held in information silos and sharing of this information between different groups of clinicians is usually limited.

From a recent national electronic survey approximately 10% of clinicians working in Scotland do not have access to any form of electronic patient information. With the exception of laboratory results there is limited access to information (Figure 1). There is also marked inequity of access to information between different professional groups (Figure 2). For example 94% of General Practitioners have electronic access to information about a patient’s current medication compared with 12% of all hospital doctors and 23% of hospital pharmacists.

A clinical portal is an electronic window that will allow clinicians to access different pieces of information about an individual patient, which are stored in different systems, as though a true electronic patient record existed. Clinicians who have seen the clinical portal solutions deployed in parts of NHS Greater Glasgow and Clyde and NHS Tayside have expressed a view that similar solutions should be implemented across all Boards in NHS Scotland.
What benefits can be realised by implementation of clinical portal technology?

There are a number of potential benefits which could be realised by implementation of clinical portal technology.

- Availability of information would support clinicians making informed decisions, improve medicines reconciliation and reduce the risk of adverse drug events. Patients will not have to answer the same questions repeatedly and can be reassured that staff have the information they need to manage their care safely.

- Ability to view information from other Health Boards in the future will facilitate service delivery for patients who are treated across Health Board boundaries.

- The single sign on feature of the clinical portal means that authorised clinicians will be able to access information held in a number of systems using a single user name and password. This will remove the need for clinicians to remember multiple usernames and passwords, reduce the risks associated with sharing of passwords and reduce the amount of time spent searching for information.

- Access to information will be regulated using a role based access model of authentication, to ensure that only staff with a right to know clinical information will be granted access. Patients can be reassured that access will be more secure, appropriate and traceable than at present with the paper record.

- The configurability of the clinical portal will eventually allow the development of personalised or specialty specific portals for individual users or groups of clinicians.

- The clinical portal will provide the ability to provide links to clinical guidelines and sources of knowledge management to ensure clinicians are providing evidence based care.

- The portal will provide the ability for data entry onto structured forms which could support the development of handover documents, multidisciplinary clinical notes or recording of clinical observations.

- Information could be used by clinicians to review performance against targets and standards and support quality improvement.
What progress has been made and how are clinicians providing input and direction to the Clinical Portal Programme?

There are a number of things to report around progress and clinical involvement.

Portal Programmes in NHS Greater Glasgow and Clyde and NHS Tayside

NHS Greater Glasgow and Clyde and NHS Tayside have invested in portal technology and are in the process of rolling out their own portals to clinical staff. They have used different solutions to achieve the same end point. Different technologies were used as they started the process with different core systems in use in each of the Health Boards and they have exploited what already existed. The experience and lessons learned by each of these programmes will be used to inform the clinical portal programme.

Discovery project

A consortium of Boards, led by NHS Lothian, is currently undertaking a piece of work to identify the current capabilities, products and services related to portal requirements that are already available to NHS Scotland. This piece of work is expected to be completed by the end of December 2009. CCLG is represented on this group. The clinical portal programme will provide a catalogue of components and services that can be used by Health Boards to support the creation of a clinical portal. It is anticipated that the available catalogue of components will promote convergence and avoid duplication of technical capabilities in favour of shared approaches. Each board is at a different state of readiness to implement clinical portal but the provision of a standard catalogue of components will allow those Boards who are able to press ahead, to do so in a manner that promotes interoperability across NHS Scotland in the future.

Links between CCLG and Scottish Government eHealth Directorate

Cathy Kelly, one of the Scottish Government eHealth clinical leads and current co-chair of CCLG, provides the link between the ongoing national work towards the Clinical Portal Programme and clinicians in the Boards through CCLG. This ensures CCLG are kept up to date with the Programme and are asked to contribute to various working groups and to provide clinical input, where appropriate. This relationship promotes partnership working between Scottish Government and the wider clinical community. It also provides a mechanism for clinicians to feedback any concerns they may have or suggestions to support the Programme.

CCLG are actively contributing towards clinical portal related work such as development of a role based access model for NHS Scotland and discussions about information assurance and governance.

Over the last year CCLG and the Board Directors of eHealth have also developed a more collaborative working approach. This has also supported more
productive dialogue to ensure that clinical priorities and Board eHealth priorities are aligned.

**Clinical Portal Programme Board**

A Clinical Portal Programme Board has recently been established which will provide governance for the Clinical Portal Programme. The first meeting of this group will take place on 24th November 2009. Clinical input will be provided by Cathy Kelly, as Scottish Government clinical lead and Cliff Barthram from NHS Tayside as CCLG representative.

**Patient Management System (PMS) procurement**

Some Boards do not have a patient management system that allows clinical data to be recorded. The procurement of a PMS for NHS Scotland has recently concluded. Implementation of the same modern PMS in the majority of health boards across Scotland over the next few years will improve the amount of clinical information that can be made available and potentially shared through the clinical portal.

**What information do clinicians want?**

NHS Scotland aims to adopt an incremental approach to clinical portal implementation. It is important that the early phases of implementation focus on delivering benefits to the majority of clinicians rather than providing a comprehensive virtual electronic patient record for a few. For this reason we recently undertook an online national survey which asked clinicians to rank the importance of different types of information they wanted Boards to deliver in the early stages. In the first series of questions clinicians were asked to rank the importance of availability of different types of patient information to them for delivering safe and efficient clinical care (e.g. results, clinical letters). The second series of questions asked clinicians to rank the importance of having electronic access to other types of information which could support them in their clinical role (e.g. knowledge support, performance indicators, patient lists). The final section of the survey asked clinicians about their current access to information held electronically.

3244 clinicians completed the survey. Replies were received from all Health Boards and all professional groups, with the majority of replies received from senior clinicians. In general clinicians welcomed the opportunity to provide input to the clinical portal programme and there was support for the use of portal technology to improve the availability of clinical information. One of the key messages was that clinicians wanted the portal to be patient centred, easy to use and focused on providing essential summarised clinical information. They would prefer a simple solution delivered in a timely fashion with phased delivery of benefits than an overcomplicated solution that may not be delivered for a long time and that requires significant resource to achieve.
There was a consistent view across all clinical groups about what type of information should be available through the portal. These were:

- Patient health summary (past medical history, current problem list, current medication, allergies, alerts, treatment plan, social history, events and procedures)
- Clinical letters (in particular referral letters, hospital discharge and outpatient clinic letters)
- Diagnostic test results
- Clinical observations and some types of clinical notes (clinic notes and hospital admission and pre-assessment notes)
- Knowledge support (clinical guidelines and electronic British National Formulary)

(*: items of information thought important enough to be provided in the initial phase of clinical portal)

Clinicians saw implementation of the clinical portal as an opportunity to address concerns about data quality and to try and standardise some types of clinical documentation across NHS Scotland.

Can this information be delivered?

The results of the survey were discussed jointly between the Clinical Change Leadership Group and Board Directors of eHealth to determine how technically feasible it would be to deliver each of these types of information through a clinical portal. It was agreed that all Boards would attempt to deliver the information sets marked with an asterisk (*) above, recognising that each Board would be starting at a different state of readiness and would therefore not all provide the same information at the same time through their versions of the portal. The vast majority of information that clinicians have identified as being crucial to managing patients safely and efficiently is actually held currently in an electronic format but, as explained earlier, is often in individual silos. With the help of portal technology these silos can be joined together so that authorised clinicians can access this information. Information that is not currently held electronically will be far more difficult to share via portal technologies as this will involve changing the way data is recorded and may involve major changes to the way clinicians work.

What are the potential budgeting implications of the development of clinical portal technology?

The results of the Discovery project will inform the investment priorities for the Clinical Portal Programme. CCLG is aware that with significant financial challenges ahead there needs to be clear justification to buy new products and
that it is important that we utilise existing products in NHS Scotland to maximum benefit.

How is the debate on the development of such projects shaped by the use of wider definitions such as Telehealth, Telecare, e-health etc?

CCLG includes representation from all the territorial and special health boards and also has links with a wide range of national advisory groups and key stakeholder groups. Through this network of clinicians, a wide range of views and experience can be harnessed. Experience from existing projects or new pilots in areas such as Telehealth and Telecare are fed back to the CCLG by the clinical representatives from the Boards involved. CCLG also provides input to the governance of national eHealth programmes, through the Scottish Government eHealth Directorate Portfolio Management Groups, to ensure that future roadmaps for existing national eHealth projects are all strategically aligned and that any dependencies for implementation of clinical portal technology are identified and managed appropriately.

What do CCLG see as challenges to delivering clinical portal?

Clinicians have expressed a desire for clinical portal technology to be implemented quickly. Each Board is at a different state of readiness to implement clinical portal technology. For those Boards who are planning to implement the new PMS solution it is likely that this will be the priority for their eHealth department over the next couple of years. This may mean that some Boards will be in a position to press ahead with implementing a clinical portal quickly while clinicians in other Boards may perceive very little progress until the PMS solution is implemented. This may lead to lack of engagement from clinicians in these Boards.

At the present time clinicians are enthusiastic about the clinical portal programme. Given the proposed incremental implementation of a clinical portal clinicians are unlikely to have everything they would like at the initial stages, therefore it will be important to manage clinical expectations. This needs to be balanced with the recognition that failure to deliver the information that has been agreed as a priority will cause disillusionment and scepticism, which will be hard to address in the future.

The most challenging information set to deliver is likely to be the patient health summary. Most of this information is currently held almost exclusively in primary care and there has traditionally been some reluctance to share this information more widely because of concerns about existing data quality and lack of a consistent approach to ensuring information assurance. The current programme to procure new GP IT solutions for NHS Scotland, along with development of a role based access model for Scotland, guidance regarding audit of IT systems and development of training packages to inform clinicians about information governance principles, offer an opportunity to address some of these concerns. There is a recognition within the secondary care community that wider access to information about medication and allergies, currently available in the Emergency
Care Summary (ECS), would provide significant benefit towards supporting the patient safety agenda. CCLG is actively working with members of the ECS Programme Board to highlight the benefits of wider access to the ECS within secondary and community care.

Mr James Docherty
Consultant Surgeon and Clinical Director of eHealth NHS Highland
Co-chair CCLG

Dr Catherine Kelly
Consultant Physician NHS Lothian and Clinical eHealth Lead Scottish Government
Co-chair CCLG
Figure 1. Electronic access to clinical information for all professional groups

Figure 2. GP and other doctors’ access to patient health summary and clinical letters
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 inquire process on the consent model to be used for CPT and how it compares to what is used for 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?**

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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RCN Scotland evidence on the NHS clinical portal technology project
Health and Sport Committee Inquiry

Outline of paper
This paper sets out RCN Scotland’s views on why clinical portal technology is important to nursing, before considering the specific questions asked by the Health and Sport Committee on the progress of the clinical portal technology project in NHS Scotland. The views of members of the RCN Information in Nursing Forum and feedback from Nursing, Midwifery and Allied Health Professions (NMAHP) eHealth networks have informed our answers to these questions. The paper ends with a summary of our position.

Overview of clinical portal technology
The Scottish Government eHealth strategy for 2008 to 2011 has a commitment to give NHS Scotland clinicians access to a clinical portal. Clinical portals offer the opportunity to use technology to improve access to patient information and therefore offer benefits to delivering patient care.

Described as an ‘electronic window’, a clinical portal is not a single product. A clinical portal is a set of capabilities and services which will help to deliver what to users will seem like a single system. Technology enables information from existing electronic systems to be viewed by the end user, with the benefits of single sign on, robust user identification and access control.

Nurses are the largest group of healthcare professionals in the NHS, and because of their particular role in co-ordinating as well as delivering care to patients, nurses are already major generators of patient information and will be major end-users of clinical portals. It is vital that NMAHPs are fully involved in the development of clinical portals, as they have the appropriate knowledge and skills to obtain, hold, share, use and store sensitive information about patients.

Benefits of clinical portal technology
Clinical portal technology has the potential to benefit patients and clinicians. Patients, nurses, allied health professionals and other staff are already experiencing the benefits of this technology within the sites in NHS Greater Glasgow and Clyde and NHS Tayside where clinical portals are being established.

Benefits for patients include:
• improving patient safety by reducing clinical risk;
• improving links between primary, community and secondary care;
• improving availability of results which may reduce unnecessary duplicate tests;
• providing summarised essential clinical information reducing the number of times a patient has to repeat their own story and history;
• supporting more efficient patient care;
• providing patient centred information;
• reducing delays in processes such as referral vetting; and
• reducing adverse drug events due to availability of medication information.
Benefits for clinicians, and therefore benefits which impact on patient care, include:

- reducing time spent searching for and retrieving clinical information;
- sharing information between different groups of clinical staff;
- providing electronic access to patient information;
- assisting with informed clinical decisions;
- providing summarised essential clinical information on one screen;
- providing easy-to-use access to different information on the same screen;
- widening access to electronic information across clinical staff groups;
- providing a single sign on for authorised users - which will be a considerable improvement from the current requirement to have multiple log-ons and passwords for different systems;
- less reliance on paper based records and processes;
- more secure and appropriate access that is traceable; and
- opportunities to address data quality, clinical information standards and to standardise documents – issues of data accuracy, compatibility and updating must be addressed.

Progress made in developing clinical portal technology since 2007

While there are many potential benefits of clinical portal technology, a realistic and achievable programme is essential. Clinicians can become disillusioned when systems do not deliver. The recent Scottish Government clinical portal survey highlighted that clinicians are looking for a workable system rather than a sophisticated system that is not available to all. There must be recognition that there are limitations to current systems, and that not all boards have appropriate electronic systems in place to link by a clinical portal. Clinical portal technology is also one part of the eHealth programme with other complimentary systems being taken forward on patient data and supporting clinical communication.

In addition to the work in NHS Tayside and NHS Greater Glasgow and Clyde, there is ongoing work in other health boards and across NHS Scotland to prepare for the implementation of clinical portal technology. We understand that the current ‘discovery’ project involving a consortium of health boards led by NHS Lothian is due to report in January 2010. As this project aims to identify current capabilities, products and services within NHS Scotland, the outcomes will have implications for all health boards and will be the next key stage towards identifying funding and procurement direction for the clinical portal project. This discovery phase is intended to inform the main programme, and we look forward to hearing more about assessment of current technology and services available to NHS Scotland, and plans to build a pilot solution.

RCN Scotland would welcome an outline from the Scottish Government eHealth programme of which health boards are planning to implement clinical portal technology during 2010/11.

What is apparent from our members is the need to communicate feedback about the pilot initiatives and share regular updates widely with front line staff. There also needs to be recognition that portal work is likely to be implemented on an incremental basis, for example in NHS Tayside where use of the portal is being expanded by including additional GP practices. Progress on such projects can also be delayed as more time is taken to standardise information, and projects can become much bigger exercises than originally anticipated. It will be important for the national programme to drive progress forward, so that clinicians are not frustrated by a lack of progress in delivering this further. Clinical portal training is essential.

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1 Scottish Government NHS Scotland eHealth Programme Clinical portal survey August 2009
In Scotland, substantial steps forward continue to be been made in the understanding of the benefits of portal technology and also development of systems to support it. For example, within new ambulatory care hospitals in NHS Greater Glasgow and Clyde much work has been done and NMAHPS are using the portal. While information available is limited patient consultations are being undertaken using the electronic note rather than paper records. The clinical portal does deliver and is valued by NMAHPS who have access to pilot portals.

**Information required by clinicians**

A clinical portal connects existing electronic systems and delivers information via the single sign-on to integrated systems. Access is made available to a personalised portal with clinicians only able to view patient information for which they have permission to access. The *Information Access Programme* and *Role Based Access* are essential parts of clinical portal development for NHS Scotland.

The Scottish Government conducted a survey of clinicians across NHS Scotland this year, with the results published in August 2009. RCN Scotland encouraged nurses to complete the survey as an opportunity to inform the Scottish Government clinical portal programme and over 700 nurses completed the survey.

The survey of clinicians has demonstrated a consistent view of information to be made available. Nurses’ views corresponded with this core information set defined across clinical groups, with the additional inclusion of access to single shared assessment. In order of priority for nurses were:

- allergies;
- current medication list;
- alerts;
- current problem list;
- past medical history;
- treatment or care plan;
- local clinical guidelines;
- nursing notes;
- national clinical guidelines;
- biochemistry;
- resources sources, e.g. British National Formulary;
- haematology;
- inpatient final discharge letters;
- microbiology/virology;
- admission assessments;
- clinical measurements;
- events and procedures;
- inpatient discharge letters;
- single shared assessment; and
- clinic notes.

There is a need to recognise that the minimum information needed will vary from specialty to specialty, will vary by clinical staff group, and from patient to patient. This has been reflected in the ordering of information groups by clinical groups in the clinician survey. Portal technology allows staff to view fields that they need to appropriately care for patients.

Each clinical group recorded a requirement for their own notes. The inclusion of a nursing problem list (i.e. not just medical diagnosis) is an important aspect of a complete and accurate healthcare record.
Keeping initial implementation simple and using the commonly used electronic systems first means that more immediate benefits can be realised and boards can then build on that success.

**Potential budgeting implications of the development of clinical portal technology**

With each health board tasked to prepare a business case to support local delivery plans for the development of clinical portals, we do have concerns that the current financial climate could lead to boards focusing on short term benefits, rather than looking at the long term benefits that clinical portals could deliver. Lack of funding in some health boards could results in wider inequalities. If all boards cannot develop portals, clinicians will not have similar access to the right information to support the development of patient care.

Health boards will have different reasons for progressing clinical portal technology, and different starting points. For example, NHS Tayside has based its developments on primary care including GP systems in combination with secondary care, while NHS Greater Glasgow and Clyde has focused on acute secondary care with the clinical portal project based in two new hospital environments drawing together existing acute systems. Some boards may develop a clinical portal to reduce clinical risk and improve patient safety, while others may focus on opportunities to increase electronic communications between clinicians and reduce the focus on paper based systems.

It is likely that health boards will progress at different timescales, given financial pressures, local capability, and scope of existing electronic systems. The benefits of clinical portal technology however suggest that there needs to be a clearly defined national way forward, and the NHS Scotland eHealth programme has a key role in supporting boards to deliver clinical portal technology to ensure patients and clinicians in each board area can realise the benefits. Investment in health boards to help realise the benefits of clinical portal technology is needed.

The aim of the national programme of providing health boards with a catalogue of services and products to enable the creation of locally appropriate portals will require investment in new products. The outcomes of the ‘discovery’ project in early 2010 are intended to ensure investment is correctly focused on procuring products and services that will contribute to those to be made available by the national eHealth programme to health boards. We can see that this approach should ensure budget spend is focused, and enable customised access from a standardised approach.

Health boards will need to invest in local capability to ensure staffing to lead and develop the portal system, and will need to invest in change management and training to support implementation and staff skills to work with the clinical portal. There will also be requirements for investment in computer hardware to ensure accessibility for clinicians across the board area. Delivery of clinical portals in each health board will depend on health board readiness to take on and deliver clinical portal technology.

The Scottish Government draft eHealth budget for 2010-11 has increased from the 2009-10 actual budget of £97.2million to a 2010-11 draft budget in real terms of £132.7 million. However the eHealth budget has decreased by 3.8% from the original comprehensive spending review prediction for the 2010-11 draft budget. Given the recognition by the Scottish Government of the pivotal place of clinical portal technology within the eHealth strategy, RCN Scotland is keen to establish from the Government which eHealth programme projects are being deferred or planned over a longer timescale to accommodate this budget change, and whether any adjustments have been made to the clinical portal proposals to reflect the reduced budget available.
eHealth has the potential to dramatically improve patient care, and therefore save money in other areas of the NHS. It is essential that this budget is maintained. Investment in eHealth and in clinical portal technology is a case of ‘spend to save’. Financial investment in health board capability to deliver clinical portals plus the investment and support from the national eHealth programme is money well spent as the benefits outlined earlier suggest. We understand there is significant commitment from the eHealth programme that clinical portal development is a key focus throughout the timescale of the current eHealth strategy.

As clinical portals provide access to existing systems and services, this development avoids the procurement of multiple duplicate systems. Therefore instead of funding being allocated to develop new systems, clinical portal technology enables links to be made between existing systems reusing functionality. This enables NHS Scotland to preserve its investment in existing systems and ensures clinicians keep using familiar tools, while wrapping the disparate systems in a new, easy-to-use interface.

Clinical portals will require cultural change within organisations, for example in respect of staff changing from paper based documentation to electronic systems. Ongoing funding is required for training and support for computer skills and clinical portal developments. Investment is needed in this technology for the future. Without this NHS Scotland could struggle to cope with increased patient need based on demographic change and the resulting prevalence of long term conditions. There is potential for a more cost effective use of staff time, and therefore enhanced productivity.

Clinical portals are essential to patient care, but also in respect of data security, to facilitate controlled and managed access to information. They may help to rationalise use of the plethora of systems currently available as these could be refined to avoid duplication of data entry. The portal provides the ability to use the clinical systems that have been developed with much clinical input over the years, and share their summary content with other clinicians.

How is the debate on the development of such projects shaped by the use of wider definitions such as telehealth, telecare, eHealth, etc
To achieve the desired outcomes for patients in the provision of services, clinicians and providers must work together closely. NMAHPs must be engaged at board level in the development of clinical portals and participate in each board site to ensure locally determined clinical relevance. Within Scotland the NMAHP eHealth leads network has an important role as an effective operational network providing clinical advice and leadership, influencing and communicating about eHealth with clinical colleagues.

We support the principle of role based access control to the clinical portal, with the factors of location, roles and categories of information ensuring secure and appropriate access to patient and clinical information. As clinical professionals, registered nurses, midwives and allied health professionals will have significant role based access, alongside other clinical staff. Professional codes of conduct for NMAHPs, including the Nursing and Midwifery Council Code of Conduct, provides confidence on the professional approach towards patient information.

The recently established Clinical Portal Programme Board will meet for the first time this month. We recommend that the membership of the board includes NMAHP representation to ensure the breadth of clinical views, including nursing, are included in the strategic direction of this project.

The RCN supports the approach of the Scottish Government to eHealth, and the national eHealth programmes in England, Northern Ireland and Wales. There are opportunities for
each UK country to learn from each other’s national programme and clinical portal developments.

The technology which will support clinical portals also enables exploration of complementary ‘patient portals’ which could enable patients to access health information and services securely. Nurses have a key role to play as knowledge workers supporting patients to find and understand relevant health information. A complimentary development to the clinical portal will be patient portal development.

eHealth encompasses telehealth, telecare and developments such as clinical portals. There is potential for confusion about terminology. Straightforward language should be used and appropriate resources allocated for training. All these terms can be seen as part of a patient journey which need information access at each stage. There may be a need for a common minimum dataset which would cover all eHealth projects underpinned by data standards so that they are shareable and have the same meaning to all users. The portal should compliment telehealth and telecare.

The clinical portal facilitates these strategies in the development of patient information being easily accessible and the provision of care being seamless and timely for patients. With information readily accessible to clinicians when required, resulting in improved, cost effective, efficient and effective healthcare services for patients.

**Conclusion**

In summary, RCN Scotland believes that the Scottish Government eHealth programme and the health boards should ensure that:

- nurses, midwives and allied health professionals – who deliver the vast majority of patient care – are fully involved in decisions at board and national levels concerning the development and use of clinical portal technology so that developments are clinically informed, deliver value for money and improve patient care;
- NMAP representatives must be included in the membership of the newly established Clinical Portal Programme Board to ensure all clinical views are included in the strategic direction of this project;
- adequate resources in terms of money and time, including backfill requirements, are allocated to the education and training of nurses, midwives, allied health professionals and other clinical staff to enable appropriate use of clinical portals;
- health boards must ensure that frontline staff have the time and skills necessary to ensure that patients are able to make fully informed decisions about the safeguards and choices related to information sharing; and
- regular feedback is provided to clinical staff on progress towards development and implementation of clinical portal technology.

24 November 2009
Scottish Centre for Telehealth
Submission to Health and Sport Committee
Wednesday 2\textsuperscript{nd} December 2009

Background

1. The Scottish Centre for Teleheath (SCT) was established in 2006 following publication of \textit{Delivering for Health} in November 2005. The stated aim of SCT was to provide practical help to NHS Boards as they sought to realise the potential of telehealth development projects.

2. \textit{Better Health, Better Care} restated the Scottish Government’s support for telehealth and noted how telehealth, when deployed effectively, may improve the patient’s experience of care by reducing the need to travel, or cross, major cities to hospital to receive care and treatment.

3. Over a five year period, SCT was charged with supporting and guiding the development of telehealth for clinical, managerial and educational purposes across Scotland.

4. The SCT was to provide support and advice to NHS Boards and to evaluate the potential benefits of new technologies, with the aim of making Scotland a recognised global leader in telehealth.

5. The potential of telehealth was reiterated in the national eHealth Strategy, published in June 2008. This strategy describes how eHealth has a role in supporting sustainable remote and rural health services. In particular, the strategy states how eHealth will continue to support developments in the areas of telecare and telehealth, through SCT, to expand the effective application of teleconferencing/teleconsultation and image transfer to support remote delivery of services.

6. Representatives of SCT last provided evidence to the Health and Sport Committee in June 2008.

7. In early 2009, the Scottish Government Health Department (SGHD) undertook a review of SCT and, following extensive communication with NHS Boards and others, concluded that there ‘is considerable support for the retention of telehealth expertise and clear evidence that the SCT has had significant successes in various discrete areas’.
Policy Context

1. Changes in demographics, and in particular an ageing population and the growth of people with Long Term Conditions, are driving changes in the demand for, and delivery of, health care services.

2. There is an increasing emphasis on delivering services in the local community and in supporting patients in their own homes.

3. Changing demographics and an ageing workforce also pose specific challenges for NHS Scotland in terms of managing its skilled workforce.

4. Telehealth offers considerable potential to alleviate these challenges. It provides NHS Scotland with the opportunity to develop more responsive, flexible and local services, and to support and develop its workforce through telecommunications.

Definitions

In the review of the Scottish Centre for Telehealth by SGHD, it was identified that terminology was a problem and that work needs to be done to simplify terms used in this area e.g. telehealth, telemedicine, telecare, eHealth, eCare etc. For the purpose of this document, the following definitions are assumed –

*Telemedicine* is the provision of healthcare at a distance using a range of digital technologies, including videoconferencing, with professional clinical involvement.

*Telecare* is the use of a range of technologies to support those in a home or community environment who would otherwise be at increased risk of coming to harm from a range of causes. Professional clinical involvement is not necessarily part of their package.

*Telemedicine* and *Telecare* are the two components of *Telehealth*.

Telehealth Deployment in Scotland

Recognising the need for brevity in this briefing document, the following is only a limited sample of the success stories from across Scotland. More information can be found at [www.sct.scot.nhs.uk](http://www.sct.scot.nhs.uk).

**Scottish Tele-stroke Programme**

- Thrombolysis support services via telemedicine have now commenced in Grampian, Lanarkshire, Fife and Western Isles. Other Boards are committed to follow,

- An award winning tele TIA service in Orkney has been operational for over a year.

- SCT is working in collaboration with the Regional Planning Groups to develop previously evidenced uses of Telehealth to improve region wide access to stroke care, for use at any stage of the stroke patient pathway i.e. thrombolysis support, TIA and stroke rehabilitation.
A tele rehabilitation pilot project is now underway for stroke patients in Grampian.

Paediatric Telemedicine Service
- In January 2009, the Scottish Government published the National Delivery Plan for Children and Young People’s Specialist Services in Scotland. It establishes a national infrastructure for the sustainability of specialist children's services and identifies work that needs to take place at a national and regional level to sustain and develop services.
- A number of the plan’s clinical workstreams highlight the need to strengthen and develop tele-medicine links, particularly to support clinical networking and education.
- Investment has allowed clinical network meetings for renal, gastro-intestinal, mental health, child protection, leukaemia and bone marrow transplant to develop with an increasing number of sites participating.
- To improve the unscheduled care of children in remote and rural areas, investment has been made at Raigmore Hospital in Inverness, Royal Aberdeen Children’s Hospital, Belford Hospital in Fort William and Caithness General Hospital in Wick.
- A pilot project will shortly be started test home-based equipment for children with complex needs and who are receiving palliative care at home.

Tele-dermatology
- In the Western Isles and mainland Highland, it has been shown that a Tele-dermatology service has reduced the need for both patients and the dermatologist to travel and allows for prioritisation of cases. It has reduced waiting times for dermatology opinion for that population.
- Digital images taken by GPs (NHS Tayside), community (NHS Forth Valley) or hospital-based (NHS Lanarkshire) medical photographers are assessed along with conventional referral information to permit prioritization and triage of patients to appropriate clinic or therapy list. The Lanarkshire service has shown that 'store and forward' can reduce waiting times to clinic and to definitive treatment.
- For some time, a dermatology e-mail advice service has been run in NHS Lothian, receiving around 60 enquiries/month. It was principally setup to give advice but about one third of enquiries are for a diagnosis. Audit has revealed high GP and patient satisfaction and its use as an educational tool.

Tele–Cardiology
- Without telehealth, patients of Mid Argyll Community Hospital in Lochgilphead are faced with attending a general medical clinic locally or travel to Glasgow to a sub-specialty clinic. The introduction of tele-cardiology offers an increase to the number of services available locally and a reduction in the number of referrals to Glasgow for outpatient follow-up.
Long Term Conditions Management

- There are many examples of telehealth being used to support patients suffering from long term conditions. Most of these projects are still at the pilot stage. Many of these trials have been funded through the Telecare Programme, with involvement from the Scottish Centre for Telehealth.

- In particular, there are many pilots around the management of patients suffering from COPD. Of particular note is the work being undertaken in Argyll and Bute where there is a small trial using home monitoring to support patients with COPD at home. This pilot won the Improvement and Innovation category at the recent Health Awards dinner.

SGHD Review of SCT

The Review of the Scottish Centre for Telehealth was presented to the SCT Executive Group in August 2009 and released to a wider audience in September 2009. As well as recommending the continuation of a Centre, the review made a series of recommendations to better support the adoption of telehealth and to better support SCT itself. Amongst the recommendations were:

- The repositioning SCT within NHS24, recognising its potential as a service delivery and improvement organisation.
- SCT should become more strategic and initially focus on one or two clinical areas moving them from projects to universal use e.g. building on the existing paediatrics and stroke networks.
- SCT requires to develop a telehealth strategy which is underpinned by an IT infrastructure plan.
- Creation of a ‘telehealth network’ to share knowledge and experience throughout NHS Scotland.
- Closer working with the Joint Improvement Team who run the Telecare Programme.
- In collaboration with NES and other training stakeholders, SCT should develop telehealth education tools.
- Consideration should be given to the introduction of an element of core funding for national telehealth solutions.

Planned Activities

- The Transition of SCT to NHS24 is underway and will be complete by 31st March 2010
- Development of a Telehealth Strategy for Scotland by April 2010
- Development of a supporting Infrastructure Plan by April 2010
- Implementation of National Services e.g. Stroke and Paediatrics – ongoing
- Support of existing Health Board initiatives - ongoing
- Scoping of Developmental Initiatives e.g. Mental Health, COPD, Unscheduled Care – as part of strategy development
- Innovation/Emerging Applications e.g. Rehabilitation, Telecare – as part of strategy development
Agenda Item 3
2 December 2009

- Overarching Activities e.g. Education/Training, Clinical and Technical Standards, Communication, Ethics, coding – ongoing and as part of strategy development

Iain H Hunter
General Manager
Scottish Centre for Telehealth
25th November 2009
Introduction

1. In September 2009 the Public Petitions Committee (PPC) referred petition PE953 to the Health and Sport Committee. This petition relates to the diagnosis and treatment of obstructive sleep apnoea syndrome (OSAS) in Scotland. The content of the petition is set out below.

PE953 – Jean Gall

2. PE953 was first lodged with the Parliament on 27 March 2006 and referred to the Health and Sport Committee on 10 September 2009. The petition reads—

   Petition by Ms Jean Gall, on behalf of the Scottish Association of Sleep Apnoea, calling on the Scottish Parliament to urge the Scottish Executive to increase awareness, promote the proper diagnosis and treatment and provide sufficient resources, including adequately funded sleep centres, to tackle the health problems associated with Obstructive Sleep Apnoea.

3. On 26 June 2006 the PPC took oral evidence from the petitioner, Jean Gall, after which it sought views on the petition from a variety of stakeholders including the Sleep Apnoea Trust, NHS Scotland, the Lothian Sleep Centre, the Public Health Institute for Scotland and the Scottish Government.

4. In early 2007 the Scottish Government informed the PPC that a working group of the Scottish intercollegiate guidelines network (SIGN), which has responsibility for developing evidence-based clinical practice guidelines for the NHS in Scotland, would conduct a review of the SIGN guidelines on the management of obstructive sleep apnoea/hypopnoea syndrome in adults (known as SIGN guideline 73).

5. Following this correspondence, the PCC sought further details of any new funding to be allocated to NHS boards for the treatment of sleep apnoea/hypopnoea as well as seeking a more specific timetable for the proposed review of SIGN guideline 73. In response, the Scottish Government highlighted the responsibility of NHS boards to fund treatment of sleep apnoea from within their general allocation, while correspondence from SIGN indicated that it would be March 2009 before a review of guideline 73 could be carried out.

6. In September 2008, the PPC agreed to suspend further consideration of the petition until the SIGN working group had commenced its review of the SIGN guideline 73.
7. In May 2009, the PPC further considered the petition and several issues were raised by members including the availability of research from other countries on the effects of OSAS, as well as the potential link between undiagnosed sleep apnoea and road-traffic accidents. The PPC agreed to write to the Scottish Government, seeking responses on these issues, and also to SIGN, asking for an update, following its scoping review, on whether any update of SIGN guideline 73 was required.

8. In July 2009, the Scottish Government responded to the PPC request for information on international research on OSAS and research from other countries on the effects of OSAS, as well as the potential link between undiagnosed sleep apnoea and road traffic accidents, a copy of which is attached at Annex A. The PCC also received correspondence from NHS Quality Improvement Scotland (QIS) stating that SIGN and QIS would review the results of the review of guideline 73 with a view to deciding what action may need to taken on the issue.

9. On 8 September 2009, the PCC considered these responses and agreed to refer the petition to the Health and Sport Committee for consideration.

Recommendation

10. The Committee is invited to consider whether it wishes to—

   (a) write to the Scottish Government, SIGN and NHS QIS to seek an update on the review of SIGN guideline 73; or

   (b) close the petition.

Seán Wixted
Assistant Clerk
LETTER FROM THE SCOTTISH GOVERNMENT TO THE PUBLIC PETITIONS COMMITTEE

CONSIDERATION OF PETITION PE953 (OBSTRUCTIVE SLEEP APNOEA)

24 July 2009

I am replying to your letter of 6 May 2009 to Roy Sturrock in which you asked for a response from the Scottish Government on 2 specific questions: what work is being carried out in other countries on sleep apnoea; and whether any research is being conducted on the link between sleep apnoea and road traffic accidents.

What work is being done in other countries on awareness, diagnosis, treatment, prevention, etc of sleep apnoea?

A Memorandum of Understanding implementing a European Concerted Research Action, designated as COST (European Co-operation in the field of Scientific and Technical Research) Action B26 “Obstructive Sleep Apnoea” was put in place in 2005. COST Action B26, as it is referred to, aims to establish a permanent network among groups contributing to studies on obstructive sleep apnoea syndrome (OSAS) in different European countries, in order to pursue advances in clinical and basic research on OSAS, with a particular focus on its role as a possible cause of increased cardiovascular risk.

Bodies such as the European Sleep and Research Society, an international scientific non-profit organisation which promotes all aspects of sleep research, are also helping to raise awareness of sleep apnoea and facilitate research on it through the Journal of Sleep Research, the promotion of training and education and the dissemination of information.

In the USA, the National Centre for Sleep Disorders Research (NCSDR) encourages research related to sleep disorders; to enhance timely diagnosis and effective treatment for individuals affected by sleep-related disorders, and to implement and evaluate innovative community-based public health education and intervention programs. Sleep-disordered breathing is a major focus of the research being undertaken by NCSDR partners, with particular attention being paid to its potential as a risk factor for cardiopulmonary disease, stroke and weight gain.

In my previous letter of 20 March, I mentioned a paper in the Lancet for 3 January 2009 (Vol 373, 82-93) reporting that current data suggest obstructive sleep apnoea increases the risk of developing cardiovascular disease, and that its treatment has the potential to diminish such risk. A reference to this is included at paragraph 3.36 of our Better Heart Disease and Stroke Care Action Plan, published on 29 June.

Is there any research being conducted on the link between sleep apnoea and road traffic accidents?

Although sleep related incidents are not recorded in UK accident statistics, there is growing concern that driver fatigue plays a role in a significant proportion of road traffic accidents. People with sleep-related disorders need to be properly assessed before a driving licence is issued or extended, but should not be discouraged from
seeking treatment. Driving licence holders must notify the Driver and Vehicle Licensing Agency (DVLA) if they suffer from OSAS. For commercial driving, there is a further requirement for ongoing compliance with treatment, confirmed by consultant or specialist opinion, and for an annual driving licence review.

The UK Medical Research Council (MRC) Clinical Trials Unit, in collaboration with the Respiratory Trials Unit (RTU) at the Churchill Hospital in Oxford, is currently conducting research relating to sleep disorders in recognition that poor quality sleep can lead to severe daytime symptoms which inhibit the ability to work effectively and may lead to accidents, particularly in drivers.

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

In 2007, COST Action B26 hosted a meeting of international experts to discuss the best way to include OSAS within the health disorders representing a serious risk for traffic accidents. It since been able to present its suggestions to the EU High Commission on Transport for the future inclusion of OSAS under Annex III of the European Driving Regulations.

The Chief Scientist Office (CSO) within the Scottish Government Health Directorates has responsibility for encouraging and supporting research into health and health care needs in Scotland, and although it is not currently funding any research on sleep apnoea, it would be pleased to consider research proposals for innovative studies on the subject if these were of a sufficiently high standard. These would be subject to the usual peer and committee review.

I should also mention that, as a result of the reference in my letter of 20 March to sleep apnoea forming part of the work of the Scottish Medical and Scientific Advisory Committee (SMASAC) group on the late effects of polio, the Petitioner contacted the Director of the Department of Sleep Medicine at the Royal Infirmary of Edinburgh. He then got in touch asking for a contact for the SMASAC working group, which he wished to ask for to help in raising public awareness of sleep apnoea. We have provided him with appropriate contact details.

I hope that the information in this letter, the terms of which have been cleared with the Minister for Public Health and Sport, is of assistance to the Committee in its further consideration of the Petition.

Yours sincerely,

WS Scott
Scottish Government
Dear Mr David

Response to Public Petitions Committee Regarding Petition PE953

In 2003 the Scottish Intercollegiate Guidelines Network (SIGN) published SIGN guideline 73 on the Management of obstructive sleep apnoea/hypopnoea syndrome in adults.

SIGN has recently begun a consultation exercise to seek expert advice on the need to update SIGN 73. A scoping search looking for additional evidence has been under taken and a review report has been prepared that looks at how new evidence may alter the guideline. The results of this consultation will be discussed by SIGN Council and NHS QIS in the context of the current programme of work for NHS QIS and the priorities for NHS Scotland.

With best wishes

Yours sincerely

[Signature]

Dr Frances M Elliot
Chief Executive
Introduction

1. In September 2009, the Public Petitions Committee (PPC) referred Petition 1272 to the Health and Sport Committee.

PE1272 – Randolph Murray

2. PE 1272 was first lodged with the Parliament on 7 September 2009. The petition reads—

   Petition by Randolph Murray calling on the Scottish Parliament to urge the Scottish Government to ensure that there is adequate provision for out-of-hours GP cover in all remote and rural areas in Scotland.

3. On 16 September 2009, the Health and Sport Committee agreed to undertake a short inquiry into out-of-hours healthcare provision in rural areas. In the knowledge that the Health and Sport Committee was going to be running this inquiry, the PPC agreed on 21 September 2009 to refer this petition to the Health and Sport Committee, The PPC also agreed to write to the Scottish Government and NHS Tayside for their views on the petition.

4. The following documents are included at Annex A:

   - Background information from the petitioner in respect of healthcare provision in the Kinloch Rannoch area
   - Response form the Scottish Government to the petition
   - Response from NHS Tayside to the petition
   - Further comments from the petitioner in light of the letters from the Scottish Government and NHS Tayside.

5. The Committee is invited to note that, in response to this Committee’s call for evidence on out-of-hours healthcare provision in rural areas, three submissions were received which directly address the situation in Kinloch Rannoch.

6. The Committee will be considering its approach to this inquiry at agenda item 6.

Recommendation

7. The Committee is invited to consider whether it wishes to—
(a) close the petition on the basis that the inquiry into out-of-hours healthcare provision in rural areas will enable the Committee to examine the issues of wider application raised by the petition; or

(b) propose and agree an alternative approach.

Callum Thomson
Clerk to the Committee
Mr Fergus D. Cochrane  
Clerk to the Public Petitions Committee, TG. 01  
The Scottish Parliament  
Edinburgh  
EH99 1SP  

Email: fergus.cochrane@scottish.parliament.uk  

13 September 2009  

Dear Mr Cochrane  

**Consideration of Proposed Public Petition PP760**  

As arranged, I submit an Additional Note background to the Petition for the assistance of the Committee on 21 September.  

I am both faxing this 2 page document to you and emailing it.  

Yours sincerely,  

Randolph Murray
PP760 – Petition to protect and restore GP out of hours services in remote and rural areas:

Additional Note on background to the Petition

1880s – 2006.
Because of its remote situation in North West Perthshire, the Community of Rannoch and Tummel had enjoyed the benefit of a doctor living locally for well over a hundred years, long before the foundation of the NHS in 1948 or even the Highlands and Islands Medical Service in 1913. The practice area extends from Rannoch Station in the West (with a hotel and houses) to Trinafour and Tummel Bridge in the East, and as from the furthest extremity nearly 40 miles over narrow and difficult roads from both Pitlochry and Aberfeldy, and 70 miles from Perth Royal Infirmary. Because of its remoteness, Rannoch had what was termed quasi-island status and its doctors provided a round the clock service which was revered and cherished and saved many lives locally. Its ending in 2006 has been the subject of continuous protest ever since.

2004
The new GMS contract allowed GPs to opt out of providing OOH cover for their patients, except where special conditions applied. In Scotland, 90% of GPs opted out but the remainder did not, most of these being on islands or in remote areas of mainland Scotland. This petition is about these doctors, and about remote rural communities like Rannoch which have lost all-round doctoring and need this service back.

2005
The likely effect of the medical opt-out on rural areas was given serious consideration by David Heaney and Stephanie Hall in a Report ‘Out of hours Care in Remote and Rural Scotland’ in June 2005. This assessed the problems of a one-size-fits-all approach in rural areas like Rannoch which relied on traditional doctoring – i.e. a family doctor who was available on call round the clock. These doctors usually worked with an associate or in cooperatives. (In Rannoch, the doctor worked with an associate). The Heaney and Hall Report anticipated that there would be local resistance to any change in this pattern, stating ‘Managers predicted that a public and political outcry seemed likely….The public will need to be educated about these new roles…’ and ‘In rural areas patients were accustomed to a service with face-to-face consultations with a known GP.’ Many GPs themselves were cited in the Report as being concerned about this and had both moral and practical objections to opting out, some suggesting this would be the death of rural medicine and impossible to reconcile with the NHS principles of equity, universality and continuity of care.

Against the concepts of universal provision and continuity of care (formerly essential building blocks of NHS doctoring) was posed an alternative concept of Community Resilience. This meant, in rural communities, not having a locally based doctor any more, or, at least, not one who would be available
when needed. To prepare the public for this new policy, an action plan, ‘Better Health, Better Care’ was rolled out, stating, unequivocally, that ‘there is no substantial demand for GP services to be available 24/7’, despite clear indications to the contrary in what public consultations had preceded it. A Remote and Rural Steering Group was set up to crack the nut of rural resistance to losing their GP-led out of hours services and to establish a new framework for establishing OOH cover without the frontline involvement of GPs.

2008
The Remote and Rural Steering Group duly reported to the Scottish Parliament. It had done its intended work well. Its Report, now entitled ‘Delivery for Remote and Rural Healthcare’, claimed to ‘form the basis of a safe and sustainable service for remote and rural areas that will increase community resilience.’ Community Resilience was defined bluntly as ‘facilitating communities to look after themselves’, and significantly, the Report adds, ‘Strong leadership and management will be required to facilitate the building of Community Resilience’. The burden of medical care in rural communities was now to be shared with others who were not doctors, and notably with First Responders, volunteers who, after five days’ training, were to become the new frontline of Extended Care Community Teams (ECCTs). Single-handed and small GP practices were to be phased out and replaced by these ECCTs, and local surgeries to be re-designated Community Response Hubs. Where now the family doctor? This downgrading of the country GP in both status and availability was to be disguised partially by creating a new specialist-type GP, a GPSI, who would have ‘a special interest in rural medicine’ but would no longer be in the frontline. (The very fact that GPs do not get a mention in this report until page 15 points to the seriousness of this downgrading).

The particularities of Rannoch are referred to in the Petition. But this is not just about Rannoch. It is about all other remote communities in Scotland who have lost their traditional doctoring or who are struggling to keep this, who need doctors not First Responders. The original thrust for replacing doctors in the community arose from a perceived shortage of doctors, which is no longer the case, and from alleged funding difficulties. But in 2008 the Audit Commission found NHS24 to be ‘unsustainable’ – i.e. too expensive. The evidence is that, as Dr. Brian Keighley, the new Scottish Secretary of the BMA has recently claimed, it would be appropriate, particularly in rural Scotland, to return responsibility for OOH cover to locally based GPs and thus to re-establish continuity of care that is economically sustainable and medically right. This Petition asks your committee to take this view and to urge the Scottish Ministers to act accordingly and pursue this policy change. I would draw your Committee’s attention to the under-noted comments placed on the Petition website.

Dr David Player MA, FRCP (Edin)
How tragic, then, that continuity of care has been so compromised by so many doctors withdrawing from providing out-of-hours cover as they responded to the financial incentives crafted into the new contract that
the Westminster government introduced throughout the UK on 1 April 2004. This was a retrograde measure and it should be the task of the Scottish Parliament to rescind it or at least mitigate its worst effects. The campaign that has been mounted by people in the Highland village of Kinloch Rannoch to restore 24/7 cover should be a beacon to us all.

Scotland Patients Association (SPA)
Unless government is aware of how isolated people are within these communities and rectify the situation it would be difficult to recommend that anyone should consider continuing to live in areas which are poorly served by GPs, qualified nurses and paramedics. If such areas only have people substituting for doctors, nurses and paramedics standards will fall and lives will be lost. It is the responsibility of the health board to provide GPs for Out of Hours.

Dr Simon Hurding – Glenelg, Ross-shire
I have lost count of how many out of hours meetings I have attended over the last eight years. All suggested solutions to the problem of remote and rural out of hours health care have been graciously considered. For certain general practices we always come to the same conclusion – that there is no reasonable alternative to the GP covering out of hours. There are GPs still willing to do this work and the level of service is high.

Iain Muir – First Responder and vet – Achiltibuie, Wester Ross
I am a vet and if I were to offer the level of service to my animal patients that opted-out GPs do to their human ones, without an out of hours provision, I would be up before the disciplinary committee of the Royal College of Veterinary Surgeons and could expect to be suspended or struck off.

13 September 2009
Randolph Murray
21 October 2009

Dear Mr Cochrane

PETITION PE 1272

Thank you for your letter of 23 September to Roy Sturrock.

Health boards have a statutory duty to ensure that primary medical services are in place throughout their areas. In most cases this duty is met through individual contracts with GPs. A new national contract for primary medical services came into effect in 2004. In Scotland it is given force by the Primary Medical Services (Scotland) Act 2004, which amended the National Health Service (Scotland) Act 1978, and the NHS (General Medical Services Contracts)(Scotland) Regulations 2004 which came into effect on 1 April 2004.

The changes to out of hours services brought about under the new contract were significant. Under the previous arrangements GPs were responsible for the provision of services for their patients at all times. For the out of hours (OOH) period, defined as night time during the week, the weekends and public or local holidays, it was open to GPs to transfer their responsibility, at their expense, to another qualified practitioner with the approval of the health board. An alternative was for a GP to meet their responsibilities by sharing their duties with other GPs in the locality through a co-operative arrangement. Health Boards had only limited involvement in these arrangements and there were significant variations in the type of service made available to patients.

One of the intentions of the new contract was to address a serious recruitment and retention issue for GPs throughout the UK. Key to the recruitment issue was the requirement for GPs to provide OOH care while faced with an increasing patient workload during the day. General practice was not seen as attractive by medical trainees.
Under the new contract, the regulations provided that a GP could opt out of the responsibility for patient care during the OOH period. In return, the payment they receive from their health board is accordingly reduced. Where they did so the responsibility reverted to the local NHS Board. Most GPs exercised their right to opt out and it was a priority for health boards to ensure the availability of safe OOH service across Scotland. This was achieved by putting into place arrangements which typically incorporate doctors and other clinicians employed on either a salaried or sessional basis and which are supported by NHS 24 and the Scottish Ambulance Service. Since then we have been building on the arrangements to ensure their long term sustainability and improvement. OOH services must meet standards developed by NHS Quality Improvement Scotland to ensure a safe, quality service for all patients. These standards were developed with the support of healthcare professionals and members of the public; they were published as “The Provision of Safe and Effective Primary Medical Services out of hours”. The standards cover 3 key elements of OOH services – accessibility and availability at first point of contact, safe and effective care and audit, monitoring and reporting. All out of hours providers must register with NHS QIS and they have a statutory requirement to meet its standards.

In the case of Kinloch Rannoch the GP did not apply to opt out immediately the new arrangements came into effect. Notice to opt out was, however, submitted in early 2006. NHS Tayside did not oppose the opt out in principal but considered that it should be phased in to allow the development of a team approach along with the local community. The GP asked for the case to go to an independent assessment panel in terms of the Contract Regulations. The panel found, on the basis of experience with other practices in the local area, that there was no reason why the opt out could not safely proceed and it took effect on 1 May 2006.

The GP retired on 31 March 2008. In its advert for the vacancy NHS Tayside said that it would be interested in proposals to provide OOH at practice level. One bid proposed cover for limited periods only and not for “7/24”. The strongest bid overall for the provision of services in normal hours came from the neighbouring Aberfeldy practice proposing amalgamation. That practice had wide experience of primary medical services in a remote and rural area and its bid was accepted. Having opted out of its own provision of OOH it did not propose to provide those services for Kinloch Rannoch.

We are aware that there continues to be concern locally at Kinloch Rannoch about the provision of OOH services. The services put in place by NHS Tayside incorporate NHS 24, an OOH doctor (with a fully equipped car and driver), the Scottish Ambulance Service and other services provided by the board such as local hospital facilities. Since 2006 the Board has engaged with the Kinloch Rannoch community to develop services. This has included the establishment of a group of community first responders. It is important that the position of the first responders is clearly understood. In no way are they intended by NHS Tayside as the replacement of the local GP practice in the delivery of OOH services. They are a supplementary resource of the
Scottish Ambulance Service and their support is not limited to the OOH period.

We are committed to maintaining the high standard of OOH services. There has recently been an interim report from the Care Quality Commission in England following the death of a patient while under the care of an OOH locum doctor from abroad engaged by an independent company with a contract for such services. While the NHS in Scotland does not contract with independent companies in these circumstances we have asked all health boards to consider the matter to ensure that their own services have measures in place to safeguard patients.

Yours sincerely

FRANK STRANG
Deputy Director, Primary Care Division
Annexe C

NHS TAYSIDE SUBMISSION

The individual responsibility of General Practitioners (GPs) to provide out of hours services ended in Scotland in 2004, with the introduction of the New General Medical Services Contract (nGMS). Under the Primary Medical Services (Scotland) Act 2004, NHS Boards have a legal duty to provide primary medical services to their populations through either direct provision or by contract or agreement with a range of providers. Integral to these arrangements was the capability of GP Practices to continue to provide services during the out of hour’s period or to “opt out” of such provision, where Board agreed alternatives could be identified. Where GP practices exercise this right to “opt out”, they give up their personal responsibility for 24 hour provision and the NHS Board assumes legal responsibility to secure the provision of out of hours services consistent with the standards established by NHS Quality Improvement Scotland.

Following consultation, the vast majority of GP practices in Tayside decided to opt out of out of hours and this responsibility passed to the new NHS Tayside Out of Hours Service. The service in Perth and Kinross which was configured following community engagement and consultation incorporates:

- A Primary Care Emergency Centre (PCEC) co-located with A&E at Perth Royal Infirmary.
- Out of Hours GP with driver and vehicle based at PCEC to respond to home visits, and Out of Hours GP with driver and vehicle based at Aberfeldy/Pitlochry Community Hospitals to respond to home visits.
- Rapid Response Unit comprising paramedic single manned vehicle based at Aberfeldy/Pitlochry Community Hospitals to augment the double Crewed Paramedic Ambulance emergency response team based at the Pitlochry Integrated Care Centre.
- Nurse–led, extended hours Minor Injury Illness Units (MIIU), based at Crieff, Pitlochry and Blairgowrie Community Hospitals.
- A District Nurse evening and overnight service based in the localities during the evening and operating from Perth overnight.

In late 2005, the NHS Quality Improvement Scotland (NHS QIS) reviewed the NHS Tayside Out of Hours Service against their standards, and in the March 2006 report assessed the registration status of the service as “Provider is largely compliant with standards”. Following the subsequent assessment and further report in December 2007, the registration was amended to level 4 (the highest rating) - “Provider has achieved full compliance with the standards”. This provides external review and clear evidence that the NHS Tayside Out of Hours Service is safe, effective and quality assured in accordance with the national standards.

The Kinloch Rannoch GP Practice, a single handed practice covering a population of just under 600 patients, was initially an exception to these arrangements and continued to provide out of hours services as a level one
provider under locally negotiated General Medical Services (GMS) contract arrangements. Although the Kinloch Rannoch Practice had applied to transfer their responsibilities for out of hours at that time, NHS Tayside agreed with the practice to defer the opt out for an initial period of 12 months. It is worthy of note that from the start of the deferment period in October 2004, patients registered with the practice, had their out of hour calls triaged by NHS24 and passed to the Tayside Hub at Wallacetown in Dundee, which in turn contacted the Kinloch Rannoch duty doctor. In October 2005 the GP practice expressed the opinion that, despite initial concerns about the change to nurse triage via NHS 24, this system had worked well and the number of calls during the out of hour period were described as light.

Following this, the practice exercised their right to permanently opt out and an external assessment panel approved the decision resulting in the practice ceasing to provide out of hours cover from 1 May 2006 and that responsibility for the Kinloch Rannoch and Tummel population passed to the established NHS Tayside Out of Hours Service. Subsequent to this decision NHS Tayside agreed to separately survey patients living in the Kinloch Rannoch area. Two separate surveys have been undertaken both with high overall satisfaction rates from patients who have used the out of hours service.

In 2007, the extant GP, Dr Roger Simmons intimated his retirement and a recruitment process was initiated for the provision of GMS services, and a specification was issued that included the option for prospective applicants to incorporate proposals for out of hours provision and offering guidance around residency being in Kinloch Rannoch or vicinity. Only one of the short-listed applicants offered any proposals for out of hours provision and this was only for limited provision at specified times, but this application was unsuccessful. On the recommendation of the appointment panel, that included community representation, NHS Tayside Board agreed to award the contract to the Aberfeldy Practice and the merged practice became Aberfeldy and Kinloch Rannoch Medical Practice.

Since the decision to allow the Kinloch Rannoch Practice to “opt out” of out of hours provision, the community of Kinloch Rannoch has been supported by the same high quality service as provided across the rest on the Tayside area, through the NHS Tayside Out of Hours Service, augmented through the enhanced service provision as detailed. The service is able to respond effectively to the limited demands for GP out of hours services in the area. During 2008, there were a total of sixteen home visits made to Kinloch Rannoch by the service and there were twenty-eight attendances at MIUUs by people from the Kinloch Rannoch area. There were no attendances at the PCEC in Perth, a total of seven people were given telephone advice by an out of hours GP and the emergency ambulance service responded to twenty eight calls. Despite this, some members of the Kinloch Rannoch community, including the Rannoch and Tummel Community Council continue to voice concerns over the issue of out of hours cover.

During 2008, the report of the Remote and Rural Steering Group was published under an NHS Scotland Chief Executive’s Letter (CEL), requiring
NHS Boards and Special Health boards to take account of the recommendations in assessing and planning services for remote and/or rural communities. In August and September 2008, NHS Tayside through the Perth and Kinross Community Health Partnership in whose area the community of Kinloch Rannoch is situated, undertook a series of community engagement events to consider the issue of community resilience around healthcare. The conclusion from the process was that the overriding concern of the community was in relation to response in emergency situations. A number of options to improve emergency response in the area were identified and presented to the community in October 2008.

The NHS Board agreed the recommendation to establish a community first responder scheme, augmenting the pre-existing enhanced out of hours services, to establish a local reference group to secure an improved model of emergency response and to financially support the measures in collaboration with the Scottish Ambulance Service.

During 2009, the reference group has met seven times and has initiated a number of developments, including:

1. Establishment of a Community First Responders Scheme, which is supported by NHS Tayside and run by the Scottish Ambulance Service (SAS), now delivers to the people of Kinloch Rannoch an additional emergency response over and above the current arrangements for out of hours. There are six volunteers who have started the service (commenced in August), which will continue to be developed by the Scottish Ambulance Service, and there have been five responses made by the scheme since its inception.

2. During the in hours period, the Aberfeldy and Kinloch Rannoch Medical Practice now respond to emergencies with advance trained GPs equipped with emergency kit bags and connected via a vehicle location system to ambulance paramedic response.

The position of NHS Tayside can be summarised as follows:

- Ensuring appropriate standards of care either in or out of hours in remote and rural areas such as Kinloch Rannoch remains a priority responsibility of NHS Tayside.
- NHS Tayside’s provision of GP out of hours cover to Kinloch Rannoch is within a framework that meets and exceeds the legal, regulatory and inspectorate requirements and standards and has neither employed out of hours locum GPs from abroad nor employed GPs engaged by independent contracted companies.
- Evidence continues to demonstrate that requests for GP response in the Kinloch Rannoch area in the out of hours period average two per month, and that these requests are routinely met within the required timescales.
• We believe that the issue in Kinloch Rannoch is the community’s concern around providing an emergency response - this is very different from providing GP services out of hours.
• That additional emergency response service based in the heart of the community is now available through the Community First Responders Scheme, and is additional to the current out of hours GP provision which will continue to respond to non-emergency situations.
• The Community First Responder Scheme ensures the patient has rapid access to a specially-trained individual with life-saving skills putting an emergency response which is safe, sustainable and economically supportable, right into the heart of the community until a paramedic reaches them.
• We believe we have given all members of the Kinloch Rannoch community, both those who are involved in the Community Council and the many others who live in the wider community, the opportunity to put their views forward and we have listened.
Ms Alison Wilson  
Assistant Clerk to the Public Petitions Committee  
Scottish Parliament T601  
Edinburgh  
EH99 1SP  

21 November 2009

Dear Ms Wilson

Petition PE 1272 by Randolph Murray

I hereby submit final comments on the responses by the Scottish Government and Tayside Health Board to this Petition about restoration and protection of GP out-of-hours cover in remote and rural areas of Scotland, with particular reference to Kinloch Rannoch.

Firstly with regard to the response from Mr Frank Strang, Deputy Director, Primary Care Division, St Andrew's House, Edinburgh, dated 21 October 2009, on behalf of the Scottish Government, the following points need to be made:

1. Because, for sound geographical reasons, there had been a doctor in Rannoch for over 120 years, the local community has opposed any opt-out. NHS Tayside itself opposed the opt-out at first instance and then also at the panel hearing which the doctor (who had refused mediation) insisted upon. The panel decision was unsound, was conducted in a manner contrary to NHS guidelines and was criticised in the Scottish Parliament. Consequently, when the doctor later decided to retire and the post was newly advertised, this was, under pressure from the community, done on the clear basis of returning responsibility for out-of-hours cover to the new practice. This was to be a ‘core component’, not merely an ‘option’, the new doctors were to live locally, and there was stated to be funding in place for this. The decision by Tayside Health Board to ignore all this and appoint a practice which refused to do any OOH at all shocked the local community because it left them without an effective doctor for two thirds of the time. This issue is not resolved by replacing doctors with ‘Community First Responders’, as Mr Strang recognises, but by bringing back GPs to do OOH in remote areas where NHS24 can’t cope as is the case of Rannoch.

2. It is clear that the Scottish Government has been misled by Tayside Health Board as regards (a) the strength of local feeling on this issue, (b) the cost of restoring out-of-hours cover and (c) the absolute necessity for such continuity of care in remote areas like Rannoch. The true position on these three critical points is as follows:
a. The recent questionnaire for Rannoch residents by the Centre for Rural Health has revealed that 73% of respondents wanted a return to GP OOH cover;
b. There was funding available for OOH cover on the basis of the advertised practice specification, maintaining existing inducements for in-house OOH cover and offering new inducements for its continuation, all as per the specification; and
c. It is impracticable to try to cover the practice area by using NHS24 and a GP (operating for all of Highland Perthshire) based in Pitlochry or Aberfeldy bearing in mind the time required to reach all parts of the practice. A doctor is needed to live locally to do this and to dispense essential drugs from the in-house pharmacy when necessary. To claim that NHS QIS standards are satisfactorily met in Rannoch is an absurdity when it takes a journey equivalent to travelling from Edinburgh to Glasgow and back to get a prescription out of hours, and well over an hour for a Pitlochry or Aberfeldy based GP to reach all parts of the practice area. How can criterion 1(a)4 ‘...access to and delivery of services is not compromised by physical...and other barriers’ be upheld in any meaningful way in relation to Rannoch’s geographical situation? Does there have to be a death before NHS QIS will pay attention to this as the Care Quality Commission had to do in England?

3. As regards the submission of Tayside Health Board by letter from Professor Tony Wells, Chief Executive, dated 22 October 2009, I would submit the following points:

a. NHS QIS rating is not just meaningless in relation to Rannoch but wrong in that it ignores all the cases where NHS24 has been deliberately by-passed, people have had to be attended to by non-doctors or have arranged to drive sick relatives to hospital themselves without any reference to NHS24. Similarly, the Tayside Health Board statistics are seriously flawed and cannot be relied on. There is no local confidence in either the service or the statistics. This lack of confidence is apparently shared by the Public Audit Commission, which found NHS24 to be ‘unsustainable’ but also made special reference to the 2004 contract which, specifically, it concluded was not appropriate to deal with two problems, namely rurality and deprivation.
b. It is not accurate to suggest that anything other than a return to traditional doctoring was acceptable to the Rannoch Community. This issue was repeatedly evaded in Tayside Health Board Community Updates which, perversely, ignored criticisms of the status quo and punted First Responders as the preferred solution in Rannoch, contrary to all the evidence from public meetings and the Community Council. It has repeatedly pointed out to the Health Board that the community wanted doctors for doctoring and that this was not simply a matter of emergency
cover or ‘resuscitation’ (see Professor Allyson Pollock’s evidence).

Reference is made to the annexe in this letter which contains further detail relating to these and other matters relevant to your Committee’s enquiries and the documents produced.

Yours faithfully

Randolph Murray

Encl. Annexe referred to (below)
ANNEXE to R Murray’s letter of 21/11/09 to Ms A Wilson re: PE1272

DEPRIVATION AND SOCIAL EXCLUSION IN REMOTE RURAL AREAS

A powerful medical voice has been raised against having a local GP OOH service in Kinloch Rannoch on the grounds that the money would be better spent in a deprived area of Dundee. This viewpoint has been expressed in a letter that Dr Buist, Chair of the General Practice Sub-committee of Tayside Area Medical Committee, recently sent to Mr Watson, Chair of the Health Board. Dr Buist asserts that Kinloch Rannoch suffers no disadvantage in the health care service that it receives and concedes that rurality does have its costs. But he also writes that:

“The most recent life expectancy data available show that the average man living in the KR postcode area will live for 79.3 years, this compares with the Scottish average of 73.9 years (and just 65.1 years in the most deprived part of Dundee). Such a difference in life expectancy within Tayside makes it difficult to justify the cost of providing permanent OOH cover in the community - particularly when such resource could be targeted towards meeting the health needs of the poorest patients in Tayside…”

This makes for disturbing reading, coming as it does from such an influential quarter. It is concerning that urban poverty in Dundee should be set up as a weapon against what Mr Watson and his senior officials have so disregarded and which this community believes is based both upon the principle of equal entitlement and upon the proven inadequacies of the NHS24 service in this remote area.

On broader public health grounds it would be worrying if Dr Buist’s argument gained currency in Tayside or elsewhere in Scotland. He bases his judgement upon the single factor of comparative life expectancy when the Scottish Index of Multiple Deprivation uses no less than 38 indicators across 7 domains: income, employment, health, education, skills and training, housing, geographic access and crime. Furthermore, research in other remote rural areas has established that these kinds of indices are fine for measuring deprivation where there are concentrations of population but are not so useful where people live scattered along secondary roads and miles from major services. For places like this you need to talk directly to people, so as to find out how rural households often face disadvantage in public transport, high costs of food and fuel, the lack of affordable housing, jobs and career prospects and access to services. And the existence of large elderly populations, so far from indicating comparative advantage, actually increase the need for the continuity of care that is assured by the traditional model of health care with 24/7 local GP cover.

NHS QUALITY IMPROVEMENT STANDARDS (QIS)

The underlying issue of geographically based inequality, that is so central to understanding the needs of people living in remote rural areas is not covered
by NHS QIS which is “committed to equality and diversity [across] six equality
groups which they embrace are “age, disability, gender, race, religion/belief
and sexual orientation”. Thus is excluded any recognition of inequalities that
arise through geography: specifically, the disadvantages experienced by
remote rural communities.

The point is important since the Cabinet Secretary for Health and Wellbeing,
in a letter to the solicitors acting for Rannoch and Tummel Community Council
on 11 October has argued that NHS Tayside has been validated by NHS QIS
in a report of December 2007. This validation excludes the vital factor of
geography. This point is enlarged upon in other evidence that has been
submitted to the inquiry that is being conducted by the Health and Sports
Committee.

COSTINGS

A key question is how much it would cost to provide a locally-based GP OOH
service, whether in Kinloch Rannoch or in a similar remote rural area.
Despite an objection lodged during their local consultation process the Chief
Executive and Deputy Chief Executive of NHS Tayside persisted in their
course and presented to the members of their Board an extraordinarily high
figure for what they claimed would be the annual cost of a local GP OOH
service in Kinloch Rannoch. In a report to the Board and in a verbal briefing
they claimed that the cost would be £556,876.

Inquiries by this community have shown that the commensurate cost in the
adjacent Highland Health Board area (which had sixteen 24/7 medical
practices as of the summer of 2008) is of the order of £140,000 a year. This is
based upon an hourly OOH rate of £18. The community has also established
that there are doctors willing to provide our OOH service in Kinloch Rannoch
for about the same amount. This annual figure is close to the £150,000 that
has been cited by Dr Buist in his letter to Mr Watson (see above), which he
claims is too high to be justified. The salient points are that (a) Dr Buist is
implicitly recognizing that the £556.876 figure was excessive (b) that
members of the Health Board were given figures completely out of scale with
any realistic costing and (c) the actual cost could be reduced quite drastically
if GPs could be persuaded by their Health Boards to accept a lower hourly
rate than £18. This, indeed, is the case in some places in the Highland Health
Board area where the going rate is £10. As we understand the matter, a lower
rate is paid in at least one of the island groups.

There has so far been no recognition by Tayside Health Board that their
officials asked their Health Board to make an important decision on the basis
of misleading figures. The matter has so far been disregarded by the Scottish
Government.

We do not ourselves have the kind of access to costing figures that will be
available to the Committee. However, we would make two further points.
First, it is highly relevant to the debate about delivering OOH care to inquire
into offsetting savings. The obvious point is that there are considerable financial savings to be made by having a local GP OOH cover in reducing both unplanned hospital admissions and unnecessary ambulance call-outs (not to speak of less pain and distress for patients in emergencies that may not be life-threatening but that should not be allowed to arise in the provision of quality care). Secondly, we suggest that any investigation of costs should also encompass NHS24. This service would appear to be very expensive for what it is, not least because the doctors concerned would appear to receive vastly more than the comparatively modest (although varied) rates that are paid to local GPs who cover OOH within their own practices.