HEALTH AND SPORT COMMITTEE

AGENDA

22nd Meeting, 2010 (Session 3)

Wednesday 23 June 2010

The Committee will meet at 10.00 am in Committee Room 6.

1. **Decision on taking business in private:** The Committee will decide whether to take item 7 in private.

2. **Subordinate legislation:** The Committee will take evidence on the draft National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010 (SSI/2010/draft) from—

   Nicola Sturgeon MSP, Cabinet Secretary for Health and Wellbeing, John Brunton, Manager, Cross-border Healthcare in Europe team, John Davidson, Team Leader, Cross-border Healthcare in Europe team, and Edythe Murie, Scottish Government Legal Directorate, Scottish Government.

3. **Subordinate legislation:** Nicola Sturgeon MSP to move S3M-06477— That the Health and Sport Committee recommends that the National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010 be approved.

4. **Inquiry into the Clinical Portal Programme and the Scottish Centre for Telehealth:** The Committee will consider a response from the Scottish Government to its report.

5. **Inquiry into out-of-hours healthcare provision in rural areas:** The Committee will consider a response from the Scottish Government to its report.

6. **Improving services for those with mental health problems and sensory impairment:** The Committee will consider correspondence from the Minister for Public Health and Sport on improving services for those with mental health problems and sensory impairment.
7. **Draft Budget Scrutiny 2011-12**: The Committee will consider a draft remit and person-specification, as well as a list of candidates, for the post of budget adviser.

8. **Scrutiny of revenue allocations to NHS boards (in private)**: The Committee will consider a revised draft report.

9. **Work programme (in private)**: The Committee will consider its work programme.

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Edinburgh  
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The papers for this meeting are as follows—

**Item 2**

Note by the clerk

SSI.2010.draft

**Item 4**

Note by the clerk

Response from the Scottish Government

Response from Tunstall (UK) Ltd

**Item 5**

Note by the clerk

Response from the Scottish Government

**Item 6**

Letter from the Minister for Public Health and Sport

**Item 7**

Paper to follow

**Item 8**

PRIVATE PAPER

**Item 9**

PRIVATE PAPER

Letter from the Cabinet Secretary for Health and Wellbeing

Letter from the Convener of the Europe and External Relations Committee
## Affirmative Instruments

<table>
<thead>
<tr>
<th>Name</th>
<th>Deadline</th>
<th>Motion to Approve</th>
<th>Purpose</th>
<th>Drawn to attention by SLC?</th>
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<tr>
<td>The National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010 (SSI 2010/draft)</td>
<td>28 June</td>
<td>Yes</td>
<td>These Regulations give effect to the judgement of the European Court of Justice in Case C-372/04 The Queen, (on the application of Yvonne Watts) v Bedford Primary Care Trust and Secretary of State for Health which held that the obligation under article 49 of the EC Treaty (now article 56 of the Treaty on the Functioning of the European Union which provides for the freedom to provide and receive services in another member state of the European Union) to reimburse the cost of hospital treatment provided in another member state also applies to a tax funded national health service, such as in Scotland, which provides treatment free of charge. These Regulations also cover non-hospital treatment.</td>
<td>The Committee that it is satisfied with the Government's response to the questions it raised (see annex).</td>
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</table>

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.
The National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010 (SSI 2010/draft) (Health and Sport Committee)

1. This instrument gives effect to the judgement of the ECJ in The Queen (on the application of Yvonne Watts) V Bedford Primary Care Trust and Secretary of State for Health. That case held that the obligation under article 49 of the EC Treaty (now article 56 TFEU) which provides for freedom to provide and receive services across the EU applies to require member states to reimburse citizens for charges incurred in respect of treatment available on the NHS which they have obtained in another member state.

2. The regulations amend the NHS (Scotland) Act 1978 to enable payments to be made and for Health Boards to enter into agreements about the provision of services for which it is responsible in another member state.

3. Correspondence between the Committee and the Scottish Government is reproduced at in the annex.

4. Questions were issued to obtain clarification from the Scottish Government to inform the Committee’s examination of the instrument.

5. The Committee accepts the explanation as to why the power in section 74A is extended to cover travelling expenses in relation to treatment received in Switzerland, although there is no specific amendment in relation to treatment costs received there.

6. It was assumed that there was no intention that Health Boards should be able to exercise their functions outside Scotland but the Committee wished to obtain confirmation of that. The Scottish Government confirmed its intention was as the Committee surmised.

7. The answer to the third point confirmed that the reference to the relevant EU regulation in the Explanatory Note is incorrect. As this is an affirmative instrument, it is possible for the Scottish Government to correct this when it is finally made. The Committee recommends that this is done to avoid any possible confusion.

8. The Committee also noted that this instrument is made under section 2(2) of the European Communities Act 1972 which offers a choice between negative and affirmative procedure. The Scottish Government elected to use affirmative procedure. The Committee considers that this is the most appropriate procedure, given that the instrument makes significant amendments to primary legislation.

9. The Committee reports that it is satisfied with the Government’s response to questions 1 and 2 and notes that there is an error in the reference to the relevant EU Regulation in the Explanatory Note could be corrected when the instrument is made.
CORRESPONDENCE BETWEEN THE SUBORDINATE LEGISLATION COMMITTEE AND THE SCOTTISH GOVERNMENT

The National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010 (SSI 2010/draft)

On 27 May 2010 the Scottish Government was asked:

1. To explain why the duty to reimburse the cost of services imposed by new section 75B only extends to services provided in an EEA state other than the UK and does not extend to Switzerland, when the power to regulate the repayment of charges and payment of travelling expenses covers services provided in another EEA state and Switzerland, and Regulation 883/2004 is of relevance to EEA states and Switzerland.

2. To confirm that the functions conferred on the Health Board by new section 2CA to secure the provision of services outside Scotland are only intended to be exercisable in Scotland - since if any functions were to be exercisable beyond Scotland the extent provision specify that and that the regulations only extend beyond Scotland as a matter of Scots law.

3. To explain the reference to services received under Regulation 1408/71 in the Explanatory Note given that the regulations refer to Regulation 883/2004.

The Scottish Government responded:

1. Article 56 of the Treaty on the Function of the European Union, which gives rise to the obligations set out in the Watts case, does not apply to Switzerland which is not a member of the European Union or the European Economic Area. The duty to reimburse the cost of services imposed by the new section 75B has therefore not been extended to Switzerland.

Switzerland is however linked to the EU by a series of bilateral agreements and in particular participates in the scheme under Article 22 of Regulation (EEC) 1408/71, replaced since 1 May 2010 by Articles 20(2) and 27(3) of Regulation (EC) 883/2004, which co-ordinates the social security systems of Member States. The duty to make payments under these regulations is separate from any obligation under Article 56. The inclusion of Switzerland in the amendment to section 75A is necessary to refer to obligations under these regulations.

2. The Scottish Government confirms that the functions conferred on a Health Board by the new section 2CA, to secure the provision of services outside Scotland, are only intended to be exercisable in Scotland.

3. The Scottish Government explains that, as of 1 May 2010, Regulation 1408/71 was replaced by Regulation 883/2004 and regrets that this was not made clear in the Explanatory Note.
DRAFT SCOTTISH STATUTORY INSTRUMENTS

2010 No.

NATIONAL HEALTH SERVICE

The National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010

Made - - - - 2010
Coming into force - - 2010

The Scottish Ministers make the following Regulations in exercise of the powers conferred by section 2(2) of the European Communities Act 1972(a) and all other powers enabling them to do so.

Citation, commencement and extent

1.—(1) These Regulations may be cited as the National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010 and come into force on the day after the day which they are made.

(2) These Regulations extend to Scotland only.

Amendment of the National Health Service (Scotland) Act 1978

2. The National Health Service (Scotland) Act 1978(b) is amended in accordance with regulations 3 to 5.

Reimbursement of the cost of treatment in another EEA state

3.—(1) Section 2C(7)(c) is repealed.

(2) After section 2C insert—

“2CA. Functions of Health Boards outside Scotland

(1) Where it is the function of a Health Board to provide or to secure the provision of a service, the Health Board may secure the provision of that service outside Scotland.

(a) 1972 c.68. By virtue of the amendment to section 1(2) of the European Communities Act 1972 by section 1 of the European Economic Area Act 1993 (c.51), regulations may be made under section 2(2) of the European Communities Act to implement obligations of the United Kingdom created or arising by or under the EEA Agreement. Section 2(2) was amended by the Scotland Act 1998 (c.46), Schedule 8, paragraph 15(3); the Legislative and Regulatory Reform Act 2006 (c.51), section 27(1) and by the European Union (Amendment) Act 2008 (c.7), Schedule, Part 1. The functions conferred upon Ministers of the Crown under section 2(2), in so far as within devolved competence, were transferred to the Scottish Ministers by virtue of section 53 of the Scotland Act 1998.

(b) 1978 c.29.

c) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2).
(2) For the purposes of securing the provision of any service referred to in subsection (1), a Health Board may make such arrangements for the provision of the service as they think fit (and may in particular make contractual arrangements with any person).

(3) Anything done by a Health Board in pursuance of subsection (1) or (2) is to be regarded as done in exercise of functions of the Scottish Ministers conferred on the Health Board by an order under section 2(1)(a)."

(3) After section 75A(a) insert—

"Reimbursement of the cost of services provided in another EEA state

75B.—(1) A Health Board must reimburse the cost of eligible services incurred by or on behalf of an eligible person on or after 23rd August 2010, but this is subject to the limits applicable under subsections (3) and (4), to subsections (6) and (7) and to any deduction applicable under section 75D.

(2) Eligible services are services provided by an authorised provider in an EEA state other than the UK, which are necessary to treat or diagnose a medical condition of the eligible person and are—

(a) services, not being specified services, that are the same as or equivalent to those that the Health Board in whose area the eligible person resides would make or have made available under this Act in the circumstances of the person’s case;

(b) specified services for which the Health Board in whose area the eligible person resides has given authorisation under section 75C; or

(c) services—

(i) which are neither the same as nor equivalent to services that the Health Board would make available under this Act in the circumstances of the person’s case; and

(ii) for which the Health Board has given authorisation under section 75C.

(3) In respect of services other than dental services, a Health Board may limit the amount payable by way of reimbursement under subsection (1) to the amount that the same or equivalent services would have cost the Health Board in whose area the eligible person resides if those services had been provided under this Act otherwise than in accordance with this section and section 75C.

(4) In respect of dental services a Health Board may limit the amount payable by way of reimbursement under subsection (1) to the amount that would have been payable in respect of the same or equivalent services if those services had been provided under this Act otherwise than in accordance with this section and section 75C.

(5) Where the same or equivalent services referred to in subsection (4) would have required approval from the Dental Practice Board, the Health Board—

(a) may require the eligible person to submit evidence as to the clinical necessity of the dental services; and

(b) may decline to reimburse the costs of any services which were not clinically necessary.

(6) The duty in subsection (1) does not apply where the cost of the eligible services was incurred in connection with an arrangement which was entered into by or on behalf of the eligible person in the course of business and under which the applicant for reimbursement has gained or might be expected to gain any financial benefit.

(7) This section and section 75C do not apply in circumstances where Articles 20 and 27(3) of Regulation (EC) 883/2004 apply.

(a) Section 75A was inserted by the Social Security Act 1988 (c.7), section 14(2).
(8) In this section and sections 75C and 75D—
“authorised provider” in relation to services provided in an EEA state other than the United Kingdom means a person who is lawfully providing services;
“eligible person” means a person who is ordinarily resident in Scotland;
“eligible services” has the meaning given in subsection (2) of this section;
“services” includes any goods, including drugs, medicines and appliances which are used or supplied in connection with the provision of a service, but does not include accommodation other than hospital accommodation; and
“specified services” means those services comprising—
(a) services which would require a stay in hospital accommodation for at least one night;
(b) medical treatment that involves general anaesthesia, epidural anaesthesia or intravenously administered sedation;
(c) dental treatment that involves general anaesthesia or intravenously administered sedation;
(d) services whose provision involves the use of specialised or cost-intensive medical infrastructure or medical equipment.

75C Prior authorisation
(1) An eligible person may apply to the Health Board in whose area that person resides for prior authorisation for the purposes of section 75B.
(2) Prior authorisation must be given if the eligible services are specified services which—
(a) are the same as or equivalent to those that the Health Board in whose area the eligible person resides would make available under this Act in the circumstances of the person’s case; and
(b) are not available to the eligible person from the Health Board without undue delay.
(3) Prior authorisation may be given for any other eligible services falling within section 75B(2)(b) or (c).
(4) “Undue delay” means that the services cannot be provided within a period of time which is acceptable on the basis of medical evidence as to the clinical needs of the eligible person, taking into account that person’s state of health at the time the decision is made and the probable course of the medical condition to which the services relate.
(5) In assessing whether there is undue delay for the purposes of subsection (2), the Health Board must consider—
(a) the eligible person’s medical history;
(b) the extent of any pain, disability, discomfort or other suffering that is attributable to the medical condition to which the services are to relate;
(c) whether any such pain, disability, discomfort or suffering makes it impossible or extremely difficult for the patient to carry out ordinary daily tasks; and
(d) the extent to which the services would be likely to alleviate, or enable the alleviating of, the pain, disability, discomfort or suffering.
(6) Any authorisation under this section must be in writing.

75D Deduction of NHS charges
(1) A Health Board may deduct from any amount to be reimbursed under section 75B(1), in whole or in part, any NHS charge which would have been payable by the eligible person for the same service or an equivalent service if the service had been made available by the Health Board in whose area the eligible person resides.
(2) Subsection (1) does not apply to the extent that the eligible person would, if the services received had been provided under this Act otherwise than in accordance with sections 75B and 75C, be entitled to any exemption or remission from any NHS charge.

(3) In this section “NHS charge” means any charge payable in accordance with sections 69 to 74 or regulations made under those sections.”.

Payment of travelling expenses

4. In section 75A(1) (remission and repayment of charges and payment of travelling expenses), for paragraph (b) substitute—

“(b) for the payment by the Scottish Ministers, in such cases as may be prescribed, of travelling expenses (including the travelling expenses of a companion) incurred or to be incurred for the purpose of their obtaining—

(i) any services provided under this Act,

(ii) any services in respect of which the costs are reimbursable under section 75B,

(iii) any services authorised to be received in another EEA state or Switzerland under Article 20(2) or (3) or Article 27(3) of Regulation (EC) 883/2004.”.

Interpretation

5. In section 108(1) (interpretation), at the appropriate place, insert the following definition—


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(a) O.J. L 166, 30.4.2004, p.1.
EXPLANATORY NOTE
(This note is not part of the Regulations)

These Regulations give effect to the judgement of the European Court of Justice in Case C-372/04 The Queen, on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health(a) which held that the obligation under article 49 of the EC Treaty (now article 56 of the Treaty on the Functioning of the European Union which provides for the freedom to provide and receive services in another member state of the European Union) to reimburse the cost of hospital treatment provided in another member state also applies to a tax funded national health service, such as in Scotland, which provides treatment free of charge. These Regulations also cover non-hospital treatment.

Regulation 3 provides for the National Health Service (Scotland) Act 1978 to be amended by inserting new sections 2CA and 75B to 75D. The new section 2CA gives Health Boards a power to secure the provision of services outside Scotland. This power is not restricted to primary medical services.

The new section 75B places a duty on Health Boards to reimburse the cost of eligible services (defined in subsection (2)) received by NHS patients in another EEA state and sets out the limitations that may be imposed on the amount of reimbursement. The EEA (European Economic Area) consists of the member states of European Union together with Norway, Iceland and Liechtenstein.

The new section 75C provides for prior authorisation to be obtained in respect of certain eligible services and sets out when authorisation must be given by a Health Board.

The new section 75D provides for the rules on charges, remission from charges and exemptions to apply as if the services had been provided by the Health Board.

Regulation 4 amends the regulation making power in section 75A(1)(b) in respect of travelling expenses to cover services received under section 75B or Regulation (EEC) No. 1408/71.

Regulation 5 adds a consequential amendment to the 1978 Act.

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(a) [2006] ECR 1-4325.
Inquiry into clinical portal and telehealth development in NHS Scotland

Background

1. On 8 March 2010 the Committee published a report entitled “Clinical portal and telehealth development in NHS Scotland” (SP Paper 399). This report set out the conclusions and recommendations of the Committee following the short inquiry it undertook in December 2009 with witnesses from NHS boards and the Scottish Centre for Telehealth.

Responses

2. In accordance with the protocol between the Scottish Parliament and the Scottish Government in relation to the handling of Committee business, the Committee has now received a response to its report from the Scottish Government (Paper HS/S3/10/22/4).

3. Following the publication of its report, the Committee agreed to seek comments from the private sector in relation to the use of telehealth systems by NHS Scotland. As a result, the Committee has also received a submission from Tunstall Healthcare (UK) Ltd (Paper HS/S3/10/22/5).

Committee debate

4. The Committee may wish to seek the agreement of the Conveners’ Group for a Committee debate in the Parliament on the findings and recommendations of the report. In the event that the Committee wishes to seek a parliamentary debate on its report on out-of-hours healthcare provisions in rural areas [Agenda Item 5], permission could be sought from the Conveners’ Group for a debate in the Parliament on the findings and recommendations of both reports.

For decision

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

(i) Note the responses received;

(ii) Seek the agreement of the Conveners’ Group for a Committee debate in the Parliament on the findings and recommendations of the report; or

(iii) propose and agree an alternative approach.

Dougie Wands
Clerk
HEALTH AND SPORT COMMITTEE 3RD REPORT 2010:
CLINICAL PORTAL AND TELEHEALTH DEVELOPMENT IN NHS SCOTLAND

Thank you for giving the Government the opportunity to respond to the recommendations that were made in the above report. The Clinical Portal and Telehealth development in Scotland have the potential to improve the quality of care in NHS Scotland enhancing the efficiency, effectiveness and safety of that care. While appreciating that clinical portal and telehealth development are related the responses are outlined separately for ease of reference.

Clinical Portal Development

The Government welcomes the support of the Committee for the clinical portal developments. The development of a clinical portal was first set out as Government policy in the eHealth Strategy for 2008-20011 which I announced in June 2008. This reflected a rejection of the concept of a single national system containing all patient data in favour of a portal which drew relevant patient information from a variety of different systems at the point the clinician treating them required it. The clinical portal will complement the improvements being brought about by investment in many of the other core systems such as the Patient Management System (PMS) procurement of which was completed recently and the replacement of GP systems. The PMS programme and the replacement of GP systems were, like the clinical portal, significant planks of the eHealth Strategy.
The Strategy also marked significant shifts in the way in which IT developments were to be designed and delivered. This involved a move away from large-scale, technology-focused and centrally-driven "rip and replace" programmes to one focused on healthcare improvement, building on what we have and linking systems.

We expect the development of a post-2011 strategy to further embed this change and note that guidance issued this year in NHS England now also emphasises connecting existing systems and avoiding "rip and replace".

We will continue to learn the lessons from progress with our own strategy and from progress in the South and from around the world.

Investment in information technologies is very important in healthcare as the handling and use of information is so important to the effective and safe delivery of care. IT investment, however, particularly in the public sector, is regularly criticised for over promising and under delivering in large scale centralised transformation programmes. Our approach is to tie the promise and the delivery closer together by taking a local approach to development. One that ties the investment more closely to the changes that clinicians plan to make to the delivery of care.

The delivery of the clinical portal approach over the last two years has reflected closely the change in delivery approach. Boards were helped with modest funds to try out key areas of change through demonstrators. What emerged from this approach was further portal work in NHS Greater Glasgow and Clyde and NHS Tayside. In addition to the cost-effectiveness of the approach, there were much more significant benefits in terms of local engagement and in the design focusing on front line care delivery. It also focused Boards on the deliverability of the change as it reflected not the promise of a central design but something that had been achieved on the ground.

We share the Committee’s desire for more sharing and greater commonality of systems. However, prioritising this outcome can increase cost and delay to projects supporting important improvements in healthcare.

We wish to focus more on the delivery of front line support for clinicians and improved outcomes for patients. Consolidation of the underlying IT systems will occur over a longer period reflecting the prioritisation of front line benefit.

The Government is keen to press ahead quickly with achieving the benefits of the clinical portal. The incremental approach advocated in the eHealth Strategy is part of our design. The current phase of portal work is intended to give us much clearer indications of the benefits of different approaches, how much they will cost and how long they will take. We want this information to be available before we invite Boards to commit to a particular route for delivering portal benefits.

Telehealth Developments

The Government agrees with the Committee about the need to quicken the pace of adoption of telehealth solutions. That is why we commissioned a review of SCT activity and why we decided to merge this work with Scotland's largest telehealth provider; NHS24.
The need to embed the work in the wider eHealth Programme has been recognised through NHS24 membership of both the eHealth Strategy Board and the eHealth Programme Board. The business cases which will arise from the development strategy being prepared by NHS24 will be considered by these groups.

We agree with the Committee that the opportunity for cost savings must form a prominent part of the business cases for investment. We are already seeing increased interest in the potential to use technology to replace business travel and cost. We will look for similar innovation in the delivery of clinical care that will be covered by the telehealth strategy in order to deliver improvements in the efficiency and effectiveness of care and to reduce the costs of providing care.

Responses to the recommendations of the Committee are attached at Annex A.

NICOLA STURGEON
### Clinical Portal Recommendations

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<td>26</td>
<td>The Committee recommends that the Scottish Government includes patient representatives on the CPP Board. This will help provide patient input to the development of clinical portals. Such representation is important because the work of the CPP Board will no doubt be central to any future development of patient portal systems. In our view, the CPP Board should also have permanent representation from nursing, midwifery and other allied health professionals in order to achieve as coordinated a strategic approach as possible at the key development stage.</td>
<td>The Government agrees with the Committee about the range of stakeholders who need to be involved. This is why the membership of the Clinical Portal Programme Board includes the Chief Executive of the Long Term Conditions Alliance to provide patient input to the development of clinical portals. The interests of nursing, midwifery and allied health professionals are represented at Programme Board level by NHS Lothian’s Director of Nursing. The Clinical Portal Programme Board will further strengthen representation in the Nursing Midwifery and Allied Health Professionals and patient representative areas.</td>
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<td>31</td>
<td>The Committee recommends that both the CCLG and the CPP Board work closely with the Scottish academic and research community to design a nationwide portal infrastructure that will deliver both professional and medical benefits for patients and clinicians as well as promote Scotland as a world-leader in eHealth. The aim of this project should be the development of a single portal system across all health boards, rather than a range of differing systems across the NHS. The Committee believes that this must be a central element in the Scottish Government’s forthcoming clinical portal strategy.</td>
<td>The clinical portal programme does not intend to develop a large, single national database of patient information. The development of a single database was ruled out in the eHealth Strategy. It is clearly focused on making defined information available about individual patients to support front-line care. Information about the patient is assembled in a temporary view as required, and not retained in a single database. However, the use of a consistent national integration platform which will underpin the clinical portal will make it easier to join up different IT systems in the future so that information can be more readily available for clinical audit and research as well as other possible uses, such as developing quality outcomes.</td>
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The national integration platform will allow consistent information services and standards to be implemented and reused across NHS
Scotland's full range of integration requirements – fulfilling a wider need than that of clinical portal alone.

The clinical portal is not itself a single product. It is delivered by the joining of a complex series of products and services which work together to provide an outcome for clinicians. CCLG and the eHealth Programme will continue to work with the Scottish academic and research community to ensure that maximum reuse of the technologies employed is achieved.

The Government believes that in this context insisting on a single technical approach to supporting the clinical portal would both add to timetables and to costs. The Clinical Portal Programme will, however, promote sharing of solutions and interoperability. In line with the view of NHS Chief Executives and NHS Chairs and Programme will also seek to limit the number of technical approaches to 3 across Scotland.

| 39,40 | 39. As part of the work of the CPP Board, the Committee recommends that the Scottish Government should establish an eHealth professional standards group. This should include clinicians, the medical professional bodies, the teaching and training sector and patient representatives. The group should be tasked with producing a comprehensive code of conduct and professional standards, for all health professionals in relation to information governance and access to technology such as clinical portals.

40. In particular, the code of conduct must address issues of professional standards, conflicts of interest, patient confidentiality, patient consultation and consent on the use of their information, IT and password security, public accountability and auditing of access to patient information. |

The eHealth Strategy Board has agreed to look more broadly at the whole area of information assurance, which includes information governance, and to consider the governance mechanisms which would both lead and support the changes required as part of this review. It is recognised that Health Boards have a multifaceted role in ensuring that information is handled appropriately, and this extends far beyond the handling of IT and even paper to the privacy afforded over conversations between staff and with patients. Discussions have started with Directors of HR about how to support shifts in behaviours and to develop a continuous improvement programme around information assurance.

The Scottish Government is currently funding a UK-wide initiative to develop a framework of competencies for post graduate medical training in eHealth. A national working group has been established, chaired by the eHealth Directorate Clinical Lead, which is working in collaboration with the Academy of Medical Royal Colleges. The framework will be published by the end of this year, and will then be
available for inclusion in the curriculum for any specialty training.

A key aspect of information assurance – information governance - is being taken forward by the ongoing NHS Scotland-wide Information Governance programme. This extensive programme of work has been underway since December 2008. The programme is diverse and includes:

- review and rationalisation of the wider information governance information and guidance available to all NHS employees.

- commissioning the development of NHS Scotland wide training material, including a core on-line learning module for all NHS employees. This builds on the NHS Scotland Information Governance Educational Competency Framework published in 2008. The Framework was a joint collaboration between NHS Education for Scotland and NHS National Services Scotland.

The Information Governance Framework provides a firm foundation for these developments. At the heart of the Framework is a set of national competencies describing what healthcare staff should know and be able to do in relation to information governance. This approach supports Agenda for Change and the application of the Knowledge and Skills framework.

The NHS Scotland Information Governance Team is already working with NES to ensure that Information Governance is built into existing online learning packages for junior medical and nursing staff.

The NHS Scotland Code of Practice on Protecting Confidentiality was originally published in 2003. We are currently taking the opportunity to review the Code to ensure it remains fit for purpose.
and aligns with the updated professional bodies' guidance on confidentiality. We intend to consult widely on the revised draft over the summer, with a view to final publication in early autumn.

| 41 | Despite the need for such procedures, the Committee believes that patients themselves are the best safeguard against the misuse of patient information. We recommend that the portal development strategy has the clear aim of delivering the technological means whereby a patient can audit and track how and where their medical information is accessed within the health service. Such information does not belong to the clinician or health service but to the patient themselves. Giving the patient the means to be at the centre of the decision making process on the use of their information is, in our view, the surest way to ensure that the culture within the health service recognises not only its duty of care for a patient’s health, but its duty of care for a patient’s rights. |
| 47 | The Committee remains concerned that we appear to be developing multiple portal systems across Scotland. While recognising the requirements of the specific technical variations between health board systems, the development of a uniform national-wide portal system remains the optimum solution. This is especially important when considering issues such as, the need for staff to have a single user identity on which most of the features relating to security and traceability of access will be based. Clinicians are leading work to ensure that there is a similar look and feel to the clinical portals that will be deployed in each Board, irrespective of the technology used. Clinicians recognise the value of knowing how to find clinical information without the need for additional training if they move to work in a different Health Board. The provision of robust identity and access management is recognised as a much wider issue for NHS Scotland, and this will be delivered in clinical portal though the national approach that is being taken to identity management and access control. It is recognised that this alone will not necessarily prevent password sharing. Wider organisational issues at local Board level will need to be addressed – for example the number of PCs, their functionality and speed, and processes including registration and |

As now, patients will have the right to request information in relation to how their health record is used within NHS Scotland.

It is our longer-term aim to support that right by giving patients electronic access to information where possible, perhaps through future development of a patient portal or other digital media.

Clinical portal will make use of modern identity and access management best practice and be subject to audit. Use of electronic records has the potential to provide information about access that has never been available with the paper casenote. Clinical portal will make use of information from a variety of sources, and it is expected that progressively more information will become available as our approach to identity and access management matures.
48. The Committee also has reservations with the IT administration systems that will support the portal system for each board area. In our view, there is a danger that different health board IT departments operating their own portal systems, will add to the time, complexity and coordination of staff being granted access to such system, having user identities established and maintaining passwords etc. If the cultural issues of password sharing amongst staff in the NHS is to be successfully addressed, then the development of a quick, efficient and coordinated IT administrative support system for clinical portal use, will be vital.

49. The Committee recommends that the forthcoming clinical portal strategy should address these issues, in addition to drawing up a specific plan for staff training and development, to keep pace with the evolving nature of such technology.

deregistration of staff in a timely fashion. These issues are being taken forward as part of the wider information assurance work described earlier.

As stated previously, the clinical portal is not itself a single product. It is delivered by the joining of a complex series of products and services which work together. The approach taken by the Clinical Portal Programme Board is to enforce standardisation on those technical products which will provide most strategic benefit when delivered on a national basis, and to allow scope for local flexibility where possible to ensure clinical acceptability – particularly around the clinician-facing elements of portal.

Clinical portal will not add to the complexity of user administration. It is designed to give clinicians access to information from other health boards when they need to do so. When a clinician moves to a different health board, there is a range of corporate systems that need to be updated in Boards. Access is generally based on role within that health board and not solely on identity, so it is unlikely that seamless access to different health board systems will be achievable through a centralised administration function.

A nationally agreed approach to identity and access management is currently under development. The aim is to provide opportunities to standardise and better automate the management of user identities for all health boards. It is also intended to support the implementation of roles based access controls.

As described in the response to paragraph 39 above, a national programme of training for staff is being commissioned as part of the Information Governance programme. Staff need to be aware of the increased responsibility that improved access to information confers. The refreshed NHS Scotland Code of Practice on Protecting Confidentiality will be published in early autumn. Clinical Portal itself will operate like any other mainstream web site, and will
53. In our view an open source design and procurement strategy will strengthen the technical ability of the NHS on key issues relating to security and information assurance. As the most recent Microsoft/NHS Scotland contract can to and end in mid 2009, the time is now right for the Government to reassess its future eHealth strategy and decide how much of it should involve strong relationships with one specific supplier or another.

54. In light of this, the Committee recommends that a move to open source be seriously considered and investigated for health service IT procurement. This could reduce both the technical and economic risks of being overdependent on any particular brand or type of technology and would support the views expressed by Scottish Government officials, that such a policy approach could enhance the negotiating position of the NHS with IT suppliers, so as to ensure the best deal for the health service.

60. The Committee recommends that the Scottish Government and health boards clearly establish the costs for portal development. We give notice that we intend to return to this issue as part of our consideration of the Scottish Government’s draft budget for 2011-12.

Consideration is being given to our future product strategy in a number of areas including those covered by the previous Microsoft Enterprise Agreement. This consideration will include open source alternatives. Funding was provided in 2009-10 to start work on future strategy and further funding will be provided to plan and test alternatives in 2010-11. Our current view is that a number of Microsoft products are likely to remain important to NHS Scotland into the medium term and that upgrading of operating systems with newer Microsoft versions in areas like desktop operating systems is highly likely. We do, however, wish to ensure that where possible NHS Scotland maximises the flexibility of its commercial relationships and its choice of suppliers. Open source software may have an increasing role to play in meeting these objectives.

The eHealth Directorate is working towards an architecture vision that allows components or services provided by different suppliers to be ‘plugged into’ an overarching technical framework. This helps to reduce our dependence on individual suppliers.

The Clinical Portal programme is following a sequential discovery, design and deployment approach with each of the 3 regional consortia. The consortium of South and East Boards has now moved into the design phase, which includes obtaining robust costs for clinical portal development and ongoing ownership. This consortium is taking forward a prototyping exercise that seeks to drive out issues around cost and complexity and inform affordability considerations.
<table>
<thead>
<tr>
<th>Para</th>
<th>Committee Report Recommendations</th>
<th>Proposed Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>71</td>
<td>71. The Committee recommends that the Scottish Government must, as a starting point, set a target of making Scotland the first country to establish national-scale telehealth services. This must be achieved within the timeframe of the forthcoming telehealth strategy which, in our view, should be three to four years at most. A key element of the strategy should be the development of national assessment criteria, to allow for the effective analysis and delivery of telehealth solutions in the health service.</td>
<td>Subsequent to the Committee gathering evidence, the Scottish Centre for Telehealth has successfully transferred into NHS 24. This represents a clear strategic fit for both organisations, with NHS 24 currently involved in the provision of a number of national telehealth solutions using a range of technologies including telephone and web based services. &quot;Delivering and Moving Forward&quot;, the NHS 24 Strategic Framework, sets out the organisation's development plans and will be fully supported by the SCT move. As part of the transition process NHS 24 and SCT, with the support of Scottish Government are developing a strategy for SCT, setting out a number of key deliverables, specifically the provision of 4 national service offerings in the areas of paediatrics, stroke, mental health and long term condition management. The timetables for developments would be considered on the basis of the business cases which would follow agreement on future telehealth strategy.</td>
</tr>
</tbody>
</table>
| 86.  | 86. The forthcoming telehealth strategy must identify opportunities for cost savings from telehealth delivery across all NHS spending, so as to ensure the maximum value for money is achieved. | The Business cases supporting this work will be required to outline how value for money will be achieved and indicate what savings and efficiencies can be made. Criteria will be developed to assess new requests from Boards to deliver telehealth solutions, working in collaboration with colleagues in the SGHD Improvement and Support Team (IST), and others including universities, to ensure a sound basis for future deployment of telehealth in support of service re-design. The criteria will include, but not be limited to:  
- Value for money  
- Cost reduction and efficiency savings  
- Strategic fit  
- Improving Access (e.g. supports the remote and rural issues) |
87. The approach adopted by Government to encourage health boards in the use of telehealth systems, to date, has been largely unsuccessful. While many boards have undertaken effective pilot projects, there has been no real incentive to ensure telehealth development overcomes the cultural resistance which has prevented its widespread use. To address this, the Committee recommends the Scottish Government establish a specific HEAT target for all health boards, to mainstream the use of telehealth, in the delivery of patient care. This target should set clear deadlines for health boards in the use of telehealth systems. It should also set out the rewards a health board will receive for meeting its targets and the penalties for its failure to do so.

90. One of the key advantages of telehealth and clinical portal development is the potential to deliver high-quality healthcare to patients in, or close to, their own homes. This is especially relevant for those living in rural and remote areas across Scotland. Portal and telehealth developments provide the opportunity to greatly strengthen the support for public services, in rural and remote communities across Scotland. In the Committee's opinion, every opportunity must be taken by the Scottish Government to find new

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The first priority is to establish the business case for individual service changes. Whether incentives or targets would be desirable would be considered in the business case approval process.

In order to ensure the successful adoption of using technology to support service delivery, an ongoing programme of stakeholder engagement is necessary. NHS 24 and the SCT will therefore:

- contribute to appropriate events and activities covering a broad range of key stakeholder audiences, including Government, Chief Executives and Senior Management across the statutory and voluntary sectors, patients/service users and carers;
- establish a "Champions Network" to promote the use of technology in the provision of health and social care services, working closely with the Telecare Programme, which has a well established stakeholder group;
- review the role, remit and membership of the original SCT Reference Group and create a new group to offer guidance on current and future SCT activity.

The Government agrees that technology offers opportunities to support healthcare in rural and remote communities and to promote linkages between the various agencies delivering care. There are a range of investments in this area such as the Telecare Programme and the development of Electronic Single Share Assessment. The government will continue to invest in these technologies and encourage these linkages.
ways to support small and remote communities, via new technologies. The development of systems such as clinical portals and telehealth services, should be seen in the wider context of their possible advantages to the interdependent nature of remote community life.

91. Therefore, the Committee recommends that the Scottish Government takes this opportunity to seek to include the development of a wider eCare community element in its development strategy for technology such as clinical portal and telehealth. The Government’s eHealth strategy should be planned in coordination with the development strategies of other key services, such as the police, fire and emergency response (coastguard, mountain rescue, etc) and social services. This would strengthen the holistic approach which should underpin all Government planning, both devolved and reserved, to support community life especially in remote and rural areas. The development strategy for the clinical portal systems and telehealth, should seek to examine developments in other parts of the public sector and, where feasible, develop a joined-up planning and delivery model between the NHS and these services for the wider benefit of these communities.

94. The Committee give notice that it plans to use the opportunity of its scrutiny of the Scottish Government’s 2011-12 budget proposals, to assess the level of progress in the development and roll out of telehealth systems by NHS 24. Part of this scrutiny will be to assess whether the necessary financial and staff resources are being put in place by NHS24 and individual health boards so as to ensure this happens. We recommend that the Scottish Government gives careful consideration to how it can assist in this matter.

Investment in this area will be supported by business cases. A key component of that will be robust financial and resourcing plans which are monitored and reported on.
The following document has been compiled to give a commercial organisations view and response following the Health and Sport Committee report on the adoption of telehealth across Scotland and the Clinical Portal Project.

1. Tunstall Healthcare is the leading provider of Telemonitoring services
Tunstall Healthcare Group is the world leading provider of telecare and telehealth solutions and is recognised as the market leading force in the development of healthcare technology solutions which play a pivotal role in supporting older people, and those with long-term conditions, to live independently, by effectively managing their health and well-being.

Tunstall operates in over 32 countries worldwide and is the number one provider in 15 countries.

Governments across the world face the same demographic and social changes with 600 million people worldwide over the age of 60, which is set to double by 2025. There is a significant strain on healthcare resources with over 860 million people worldwide with a chronic disease.

Tunstall benefits considerably in this unique marketplace in the following ways:

- Largest installed user base in the world – 2.5 million users out of the 4.1 million globally
- Ability to act as systems integrator for a wide range of healthcare solutions from strategic partners ensuring that only the most appropriate and cost effective models of care in the most appropriate location are offered
- Unique flexibility to ramp up supply as demand increases and a substantial investment in R&D sustains Tunstall’s strong heritage of innovation

With the largest evidence base in the market, Tunstall’s solutions have been proven to reduce the level of hospital admissions, delay the need for residential care, increase the ability to leave hospital after admission, reduce the burden on carers, manage risks to a person’s health and environment, and improve people’s confidence and quality of life.

Tunstall Healthcare has over 70 Telehealth projects in the UK, with home monitoring systems enabling patients to stay at home, prevent avoidable admissions, support early discharge and improve the quality of life of patients.

Tunstall Healthcare is the market leader in Scotland and has a number of projects across a wide range of disease areas. These include NHS Lothian, NHS Fife, NHS Borders, NHS Grampian and NHS Orkney. It should be noted as well that there are 5 other NHS health boards that are imminently partnering with Tunstall Healthcare for telehealth. Disease areas and models vary widely from Health Board to Health Board with the focus predominately on COPD and heart failure. However, there are also some which are looking at cancer, obesity and diabetes.

Tunstall Healthcare is also working in partnership with a private Neurological Charity to compile a telehealth project for its patients.

2. Telehealth in Scotland lacks a mainstream approach
The telehealth market in Scotland has developed over the last 5 years, and it is probably no coincidence that the main traction coincides with the formation of the Scottish Centre for telehealth. The market for telehealth in Scotland is characterised by a wide range of projects implemented in various settings. However, the majority of projects have been pilots and acute focussed. Tunstall Healthcare shares the frustrations that are illustrated in the report and also hears the same frustrations voiced from health professionals within the NHS and some Local Authorities at all
The focus of government and, to a greater or lesser degree, also the Health Boards, has been to shift the balance of care from the acute setting to the community. The feedback Tunstall receives from NHS health professionals is that if this is the case why are the majority of telehealth projects based in an acute setting?

There certainly is a place for telehealth within an acute setting, for example stroke services, where time is critical and having key health professionals in a different location to the patient is often the norm. However, considering government strategy, and therefore NHS Health Board targets, this type of telehealth will not make a significant impact on the majority of the population, but rather will skim the surface and further cement the view held by some clinicians’ that telehealth is to be used for remote geographies, is a substitute for “proper” acute care and comes at high cost with little return.

- Telehealth can do so much more for health boards and government strategy
- Consider patients with long-term conditions, which are the greatest drain on resource for the NHS, then telehealth really comes into its own
- If NHS Health Boards and the Scottish Government could see the potential in telehealth to reduce admissions and manage “beds” better, then telehealth would get the attention and resource it deserves
- From the evidence that is available (there is a commonly held view that there is little evidence when actually the number of studies is high including several large scale programmes, see appendix) there is an average reduction of admissions by 30-40% across all long-term conditions

This simple intervention could help revolutionise the NHS and help improve the quality of care provided to patients in Scotland.

Based on this information it would be reasonable to ask why there has been few transitions from pilots to mainstream deployment in Scotland. One of the main barriers has been that pilots invariably try to “force” a technological solution into an existing care pathway. This can be successful but only to a degree. In order to move to mainstream deployment, there is a requirement for a wholesale service redesign of care in the home and community, where the technology becomes a “bit player” in a wider change to working practices. An additional benefit of this wholesale service redesign is that the technology can be used to ensure that the new pathways are adhered to by all health professionals and that they do not slip back into previous working practices. This approach has worked well in England where more and more Tunstall customers are bypassing the pilot stage and moving to mainstream deployment based on service redesign.

Tunstall has recently been awarded a substantial contract in Northern England to supply Telehealth at scale to over 2,000 patients as part of a redesign of the ‘adult care in home’ service.

Even though a compelling case is often made for telehealth and that there is no longer the need for small scale pilots, the position health boards often take is that they need Scottish evidence. As Scottish specific evidence is invariably not available, the Health Board then opts for a pilot to determine whether telehealth works within their local health economy. This is the typical modus operandi for Health Boards and is real barrier to mainstream deployment. At best it is a naïve view, at worst it stifles health economy development.

Telehealth is seen as new by many senior managers in the NHS and it comes as a surprise to learn that Tunstall equipment has been functioning for decades. The change in culture is a great barrier to overcome and is why so many Health Boards fall into the trap of trying to put telehealth into existing operations. These projects of course fail as a consequence of their design.
Health boards often delegate telehealth project responsibility to long-term conditions managers who are often excellent at project management but this is often at the exclusion of executive “buy-in” to a project. When the business case is devised to enable large scale deployment because senior executives have not been engaged in the development of the project the business case invariably fails, leaving NHS staff very disillusioned about the lack of commitment to change.

Pilots often fail because it is easy to let them fail due to the relatively small sums of money involved, where telehealth customers commit significant resources to projects there is more of a desire to make the projects a success.

Tunstall are of the view that the Scottish Government should adopt a national telehealth mainstream strategy for the home monitoring of patients with long-term conditions to prevent admissions and reduce length of stay. The Scottish Government should introduce this via HEAT targets and pump prime the project through central funding but linked to a return on investment business case.

From discussions with NSS National Procurement, a national procurement exercise, similar to the England model should be adopted where a category for telehealth should be incorporated into the National contract. This would speed up the process for procurement and streamline the effort involved in procuring solutions.

It is well documented that the limitations of broadband are often cited as a real barrier to telehealth, Tunstall agree with this view and feel that the advantages of broadband based products are outweighed by the disadvantages such as speed of deployment and overly complex video conference offerings.

3. NHS 24 and Scottish Centre for Telehealth

Tunstall does not understand the full remit of the proposed joining of Scottish Centre for Telehealth and NHS 24 or the underlying commercial imperative, but that said if the output was a national strategy for telehealth it would be welcomed. In addition, if NHS 24 were to offer technical triage (reading retest and incoming data validation, and missed reading follow-up, for example, provided by non-clinically trained staff) and clinical triage (clinical interventions and decisions provided by clinically-qualified staff) then Tunstall would see merit in this offering.
4. Appendix

Tunstall’s own UK telehealth implementations (see Table 1) have demonstrated significant reductions in hospital admissions, patient A&E visits and patient bed days of care. Furthermore, each project showed patient compliance/satisfaction levels >90%.

Table 1. Tunstall Telehealth Programmes and their Outcomes (UK)

<table>
<thead>
<tr>
<th>Customer</th>
<th>Condition</th>
<th>Patients monitored</th>
<th>Hospital admissions</th>
<th>A&amp;E visits</th>
<th>Bed days of care</th>
<th>Patient compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Blackpool</td>
<td>Heart Failure and COPD</td>
<td>13</td>
<td>75% reduction</td>
<td>-</td>
<td>-</td>
<td>100%</td>
</tr>
<tr>
<td>NHS Leeds</td>
<td>COPD</td>
<td>43</td>
<td>10% reduction</td>
<td>8% reduction</td>
<td>16% reduction</td>
<td>98%</td>
</tr>
<tr>
<td>NHS Sheffield</td>
<td>COPD</td>
<td>30</td>
<td>50% reduction</td>
<td>-</td>
<td>-</td>
<td>97%</td>
</tr>
<tr>
<td>Orchard Medical Centre</td>
<td>Heart Failure</td>
<td>18</td>
<td>46% reduction</td>
<td>67% reduction</td>
<td>-</td>
<td>94%</td>
</tr>
<tr>
<td>Hull &amp; East Riding</td>
<td>Heart Failure</td>
<td>50</td>
<td>50% reduction</td>
<td>-</td>
<td>70% reduction</td>
<td>-</td>
</tr>
</tbody>
</table>

In addition to the evidence from Tunstall’s own remote telemonitoring deployments, there is significant evidence from other trials and clinical studies that support the conclusions of UK projects. Tables 2 and 3 describe the outcomes from two of the largest home telehealth implementations, both of which were conducted in the US.

Table 2. Strategic Health Programmes Telehealth Evaluation (US)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Patients monitored</th>
<th>Hospitalisation rate</th>
<th>A&amp;E visit rate</th>
<th>ADL improvement</th>
<th>iADL improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>6,654</td>
<td>39% reduction</td>
<td>49% reduction</td>
<td>7% improvement</td>
<td>19% improvement</td>
</tr>
<tr>
<td>COPD</td>
<td>707</td>
<td>51% reduction</td>
<td>66% reduction</td>
<td>12% improvement</td>
<td>27% improvement</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3,513</td>
<td>75% reduction</td>
<td>83% reduction</td>
<td>10% improvement</td>
<td>19% improvement</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>3,390</td>
<td>29% reduction</td>
<td>34% reduction</td>
<td>8% improvement</td>
<td>16% improvement</td>
</tr>
</tbody>
</table>

Table 3. Veterans Health Administration Telehealth Evaluation (US)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Patients monitored</th>
<th>Hospital admissions</th>
<th>Bed days of care</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>4,089</td>
<td>26% reduction</td>
<td>25% reduction overall</td>
<td>86% satisfied overall</td>
</tr>
<tr>
<td>COPD</td>
<td>1,963</td>
<td>21% reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>8,954</td>
<td>20% reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>7,447</td>
<td>30% reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>337</td>
<td>56% reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>653</td>
<td>41% reduction</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The combined data from these studies indicate that telehealth dramatically reduces hospital admissions, A&E visits and patient bed days of care. In addition, significant enhancement/stabilisation to patient (independent) activities of daily living was recorded. Patients also reported high levels of satisfaction with telehealth. The wider scientific literature, including randomised controlled trials and observational studies, also supports the conclusions of Tunstall’s
deployments. Table 4 summarises a systematic review of the international clinical literature on telehealth.

Table 4. Review of Wider Clinical Literature (International)

<table>
<thead>
<tr>
<th>Study</th>
<th>Condition</th>
<th>Patients monitored</th>
<th>Hospital admissions</th>
<th>A&amp;E visits</th>
<th>Bed days of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnett et al. 2006</td>
<td>Diabetes</td>
<td>391</td>
<td>9%</td>
<td>-</td>
<td>25%</td>
</tr>
<tr>
<td>Chumbler et al. 2005</td>
<td>Diabetes</td>
<td>445</td>
<td>49%</td>
<td>11%</td>
<td>51%</td>
</tr>
<tr>
<td>Dang et al. 2007</td>
<td>Diabetes</td>
<td>41</td>
<td>19%</td>
<td>-</td>
<td>60%</td>
</tr>
<tr>
<td>Benatar et al. 2003</td>
<td>Heart Failure</td>
<td>108</td>
<td>45%</td>
<td>-</td>
<td>53%</td>
</tr>
<tr>
<td>Bondmass et al. 1999</td>
<td>Heart Failure</td>
<td>48</td>
<td>70%</td>
<td>-</td>
<td>73%</td>
</tr>
<tr>
<td>Capomolla et al. 2004</td>
<td>Heart Failure</td>
<td>55</td>
<td>72%</td>
<td>89%</td>
<td>-</td>
</tr>
<tr>
<td>Cleland et al. 2005</td>
<td>Heart Failure</td>
<td>163</td>
<td>-12%</td>
<td>-16%</td>
<td>26%</td>
</tr>
<tr>
<td>Cordisco et al. 1999</td>
<td>Heart Failure</td>
<td>30</td>
<td>39%</td>
<td>86%</td>
<td>-</td>
</tr>
<tr>
<td>Giordano et al. 2008</td>
<td>Heart Failure</td>
<td>226</td>
<td>35%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Goldberg et al. 2003</td>
<td>Heart Failure</td>
<td>127</td>
<td>27%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Jerant et al. 2001/2003</td>
<td>Heart Failure</td>
<td>13</td>
<td>67%</td>
<td>86%</td>
<td>-</td>
</tr>
<tr>
<td>McManus 2004</td>
<td>Heart Failure</td>
<td>19</td>
<td>67%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mehra et al. 2000</td>
<td>Heart Failure</td>
<td>53</td>
<td>40%</td>
<td>82%</td>
<td>39%</td>
</tr>
<tr>
<td>Myers et al. 2006</td>
<td>Heart Failure</td>
<td>64</td>
<td>33%</td>
<td>0%</td>
<td>-</td>
</tr>
<tr>
<td>Roth et al. 2004</td>
<td>COPD</td>
<td>95</td>
<td>-</td>
<td>-</td>
<td>57%</td>
</tr>
<tr>
<td>Schofield et al. 2005</td>
<td>COPD</td>
<td>73</td>
<td>-</td>
<td>-</td>
<td>81%</td>
</tr>
<tr>
<td>Schwarz 2008</td>
<td>COPD</td>
<td>44</td>
<td>3%</td>
<td>11%</td>
<td>-</td>
</tr>
<tr>
<td>Seibert et al. 2008</td>
<td>COPD</td>
<td>13</td>
<td>-</td>
<td>50%</td>
<td>-</td>
</tr>
<tr>
<td>Vaccaro et al. 2001</td>
<td>COPD</td>
<td>52</td>
<td>50%</td>
<td>73%</td>
<td>-</td>
</tr>
<tr>
<td>Woodend et al. 2008</td>
<td>COPD</td>
<td>62</td>
<td>6%</td>
<td>-</td>
<td>28%</td>
</tr>
<tr>
<td>Pare 2006</td>
<td>COPD</td>
<td>19</td>
<td>83%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>de Toledo et al. 2006</td>
<td>COPD</td>
<td>67</td>
<td>32%</td>
<td>33%</td>
<td>-</td>
</tr>
<tr>
<td>Trappenburg et al. 2008</td>
<td>COPD</td>
<td>59</td>
<td>13%</td>
<td>-</td>
<td>12%</td>
</tr>
<tr>
<td>Vontetsianos et al. 2005</td>
<td>COPD</td>
<td>18</td>
<td>84%</td>
<td>-</td>
<td>79%</td>
</tr>
</tbody>
</table>

The collective evidence above suggests around 30-40% reduction in annual emergency admissions (and associated ambulance call outs and A&E visits) can be realised through telehealth for Heart Failure, COPD and Diabetes. Furthermore, additional efficiencies can be realised in primary care as Telehealth helps reduce unnecessary travel and home visits by nurses and GPs, and also outpatient appointments. This can then enable increased case management potential and more effective prioritisation of care.

1 Strategic Healthcare Programs (2004) Independent Analysis of Monitored/Non-Monitored Patients
2 Darkins et al. (2008) Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions. Telemedicine and e-Health 14, 1118-1126
3 Tran et al. (2008) Home Telehealth for chronic disease management [Technology report number 113] Canadian Agency for Drugs and Technologies in Health
Background

1. On 23 April 2010 the Committee published a report entitled “Out-of-hours healthcare provision in rural areas” (SP Paper 421). This report set out the conclusions and recommendations of the Committee following the inquiry it undertook in early 2010 on out-of-hours healthcare provision in remote and rural areas.

Response

2. In accordance with the protocol between the Scottish Parliament and the Scottish Government in relation to the handling of Committee business, the Committee has now received a response to its report from the Scottish Government (Paper HS/S3/10/22/7).

Committee debate

3. The Committee may wish to seek the agreement of the Conveners’ Group for a Committee debate in the Parliament on the findings and recommendations of the report. In the event that the Committee agrees to seek a parliamentary debate on its report on clinical portal and telehealth development in NHS Scotland [Agenda Item 4], permission could be sought from the Conveners’ Group for a debate in the Parliament on the findings and recommendations of both reports.

For decision

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

   (i) Note the response received;

   (ii) Seek the agreement of the Conveners’ Group for a Committee debate in the Parliament on the findings and recommendations of the report; or

   (iii) propose and agree an alternative approach.

Dougie Wands
Clerk
Thank you for the opportunity to respond to the Health and Sport Committee Report on out-of-hours healthcare provision in rural areas. I was pleased to give oral evidence to members earlier in the year and thank all those who provided written or oral evidence. I think the response to this piece of work shows the level of interest and enthusiasm people continue to have for our NHS. While the Committee report was primarily about provision in rural areas, I believe that many of the issues and conclusions apply across all parts of Scotland.

I am firmly committed to the provision throughout Scotland of out-of-hours services which match up to the ambitions set out in our recently published Healthcare Quality Strategy for Scotland. I therefore welcome the opportunity provided by your inquiry to take stock of the quality of those services. I attach the Scottish Government’s response which I hope the Committee will find useful. This sets out the actions that the Scottish Government and NHS are taking forward to ensure that the out-of-hours care provided across Scotland, and particularly in remote and rural areas, meets the needs of patients and communities. As was clear from the breadth and complexity of the oral and written evidence to the Committee, continuous improvement can only be achieved through a range of measures and approaches.

There a number of particular points I would like to draw to your attention.

I very much agree with the Committee that patients deserve a seamless service. Regardless of how, where and when a patient accesses the NHS, the systems and professionals that provide out-of-hours care must work together in a collaborative way. Indeed, these principles extend far more widely than those areas traditionally associated with the delivery of out-of-hours care. Our direction of travel involves much greater integration between out-of-hours primary care and secondary care, in-hours primary care, social care and other partners.
We must continue to do all we can to support patients to make the choices most appropriate to their needs, but I would be cautious about an assertion that there is a great deal of confusion about accessing out-of-hours care. When their GP Practice is closed, the vast majority of patients are directed to call NHS 24 as the single point of access for primary care support. On average 30,000 people a week do so and patient satisfaction levels with NHS 24 are over 90%. The exception to this will be the small number of patients whose own GP Practice has opted to provide out-of-hours care. I do recognise that patients might not always be sure whether their needs are of a primary care nature, or whether they might need an ambulance. However, that is why NHS 24 and the Scottish Ambulance Service have call transfer systems and protocols for calls and why work has now commenced on the scoping of a common triage tool. I also recognise the importance of clear and focussed information at a local level of the range of healthcare services available to patients in and out of hours. That is why we are supporting Boards to develop local campaigns, drawing from the experience of the 'Know who to turn to' pilot in NHS Grampian.

NHS Boards have responsibility for the delivery of out-of-hours services on the ground and I fully expect them to do so in a way that meets the needs of the communities they support. As the Committee point out, there is no one-size-fits-all solution and I support and endorse innovative solutions. I believe that NHS Boards are equipped and enabled to do so and my officials have asked Chief Executives of territorial boards to reflect on the extent to which out-of-hours services are reviewed and developed in consultation with their different communities. My officials have also met recently with NHS Chief Executives to discuss the Committee’s report and the opportunities that lie ahead in terms of striving to improve out-of-hours services in ways that support greater integration of services and that lead to services being developed that are designed to be more sustainable while at the same time improving quality for patients. It was clear from that discussion that improved integration is likely to be the key mechanism for driving sustainable services in the future.

I hope that this response is helpful and I would be happy to provide any further information that would be of interest to the Committee.

NICOLA STURGEON
Report by the Health and Sport Committee on out-of-hours healthcare provision in rural areas: Scottish Government response

The Scottish Government welcomes this opportunity to respond to the Health and Sport Committee and to re-affirm its commitment to provide high quality health care for patients across Scotland wherever and whenever they need it. This response deals in turn with the three specific issues identified by the Committee in its report.

Introduction

Since the Committee published its report, the Scottish Government has published *The Healthcare Quality Strategy for NHS Scotland*. This sets out clear ambitions for high quality health care throughout Scotland, particularly in terms of safe, clinically effective and person-centred care. In broad terms, we believe that the arrangements currently in place offer the best way of delivering, in today’s circumstances, high quality primary care services, both out-of-hours and in-hours. The changes to the GP contract in 2004 which resulted in the responsibility for out-of-hours provision moving from GPs to NHS Boards were designed partly to ensure adequate levels of GP retention and recruitment and partly to provide patients with better quality care and better access to services. We remain convinced that the needs of patients will be best served not by attempting to turn the clock back to pre-2004 arrangements but by building on the current approach to out-of-hours service provision based on multidisciplinary teams and a whole systems approach.

Nevertheless, we are firmly committed to continuous improvement and welcome the opportunity to set out in the sections below the steps we are taking to ensure that out-of-hours health care meets the ambitions of the Quality Strategy.

1. **Accessibility and Availability**

We welcome the Committee’s recognition of the much improved service being provided by NHS 24. However, we note the Committee’s concern that work needs to be done to rebuild confidence in NHS 24 and to deal with confusion in the public on accessing services.

In that context it might be useful to make a number of points of clarification. NHS 24 deals every year with around 1.5 million people seeking advice or help in accessing primary care services when their GP Practices are closed. While in many such cases NHS 24 offers self-care advice and information, the majority are supported in accessing other services including out-of-hours services, accident and emergency departments, the Scottish Ambulance Service and community pharmacies. The largest proportion of those who contact the service during the out-of-hours period - around 60% - are supported by NHS 24 to access the local out-of-hours primary care services that are delivered by territorial NHS Boards. NHS Boards provide these services for their residents from local primary care out-of-hours centres or, in circumstances where the patient is so unwell that they cannot travel to a centre or there are other factors which may be preventing them from travelling, by arranging for a home visit by a doctor or other member of the local out-of-hours clinical team. For the vast majority of these callers for whom contact with the local out-of-hours service is the NHS 24 disposition, the resultant face to face contact with a clinician will take place within a four hour timeframe of their call to NHS 24. Some, for whom the assessment of clinical need is more urgent, will be seen within 2 hours and some within 1 hour. All patient dispositions ensure that they will be seen within clinically appropriate timescales.
This situation, whereby 6 out of 10 people who phone will be supported by NHS 24 in accessing their local out-of-hours service is very different indeed from the implication in much of the recent media coverage that 9 out of 10 of those who phone NHS 24 during the out-of-hours period will be dealt with by someone over the telephone with no recourse to any face to face contact. We shall continue to take steps to improve the public’s understanding of the arrangements including the vital fact that out-of-hours service are led by GPs, all of whom are fully qualified and on the primary medical services performers list. These organisational structures are the building blocks which will continue to support out of hours services over the years to come.

It is also important to make a clear distinction between out-of-hours primary medical care and emergency services. Services which are appropriate for one are not necessarily appropriate for the other. For example, there are no circumstances where out-of-hours care is provided by Community First Responders. These volunteers are tasked by the Scottish Ambulance Service to support patients in a life threatening condition while the ambulance is en route to them. The demand on emergency ambulance service reported to the committee by the service has increased by 35% since 2004 and the increase during the out-of-hours period is higher at around 41%. We know from the increasing incidence of calls to the emergency ambulance service that are dealt with by see and treat protocols that paramedics and technicians are dealing with more calls now that may be considered to be of a primary care nature. That is a consequence of increasing integration, continued multi-professional team working and the focus on delivering the most appropriate care by whoever is best placed to deliver it. We also know that the emergency ambulance service has seen a significant increase in calls that are alcohol-related with many arising between 22:00hrs and 02:00hrs.

On availability and accessibility, the following steps are being taken:

**The Scottish Government has discussed the Committee’s findings with NHS Board Chief Executives and asked NHS Boards to:**

- Ensure that in their regular reviews of local out-of-hours services they
  - work closely with the Scottish Health Council on best practice in terms of engagement with patients and communities and
  - seek to optimise the opportunities for greater integration of services, recognising in particular the crucial interface between primary and secondary care. This may include, for example, looking to increase the contribution from primary care in the hospital context to provide assessment, treatment and discharge where possible.

- Support the roll-out of new developments such as “virtual wards” and other similar anticipatory care initiatives – both in hours and out-of-hours – which improve the quality of care for patients in the community with chronic and enduring illnesses, reduce the incidence of unscheduled care episodes and avoid unnecessary hospital admissions. A key priority will be to ensure that emerging IT solutions share information in an accurate and timely fashion across all parts of the health system, both in and out-of-hours.

- Develop local social marketing campaigns drawing on the NHS Grampian “Know who to turn to” pilot as a means of increasing the understanding of when and how to use...
unscheduled care services. We have made available to all Boards the Unscheduled Care Marketing Toolkit which contains all of the artwork elements which supported the NHS pilot along with a pump priming resource to support Boards in developing this work. The evaluation to the Grampian pilot was published in December 2009 and may be accessed via the following link: [http://www.shiftingthebalance.scot.nhs.uk/evidence-and-good-practice/case-studies/](http://www.shiftingthebalance.scot.nhs.uk/evidence-and-good-practice/case-studies/)

The **Scottish Government has asked the Scottish Ambulance Service to:**

- Engage with NHS 24, NHS Boards and clinicians from across the system to optimise the use of community paramedics in supporting the continuing development of see and treat initiatives and other alternatives to transfer to hospital, where appropriate. Currently around 10% of emergency responses made by the Scottish Ambulance Service result in paramedics and technicians dealing with patients in their homes using see and treat protocols thereby avoiding the need for an unnecessary journey to and admission to hospital. Expanding the use of the profession to profession communications arrangements whereby paramedics can discuss the patient’s condition with a hospital or primary care doctor will help the service in optimising the benefits of this initiative. Much of the community resilience which this service provides serves to augment the services which are in fact primary care by the nature of the patient contact and are usually provided by GPs – whether in-hours or out-of-hours.

The **Scottish Ambulance Service and NHS Boards will:**

- Work in partnership to implement the key commitment within *The Healthcare Quality Strategy for NHS Scotland* to implement the Strategic Options Framework for emergency and urgent responses across remote and rural healthcare. This will involve the Scottish Ambulance Service and NHS Boards working in partnership to implement a range of different types of response – whether a community response such as first responders or at levels up to and including a full A&E response – designed to fit local needs. Aligned to an agreed set of quality standards, a good start has been made with new models of emergency and urgent response already in place in some areas. But work continues to ensure that the most appropriate model to meet local needs will be developed and implemented across rural healthcare services.

The **Scottish Government has asked the Scottish Ambulance Service and NHS 24 to:**

- Engage with partners and to jointly scope out the development of a common triage tool that will support patient access to unscheduled care. The objective is to create a common tool that would be used by either Scottish Ambulance Service call handlers or NHS 24 call handlers or nurse advisers and which would ensure that patients are better able to access the unscheduled care service appropriate to their clinical needs at first call contact and regardless of whether they called the SAS or NHS 24.

The **Scottish Government is:**

- In partnership with NHS Boards, the Scottish Ambulance Service and NHS 24, continuing to develop and share system-wide information describing patient flows in each NHS Board area across the various service access points that together make up unscheduled care services. This is helping to inform improved local understanding around how patients are using services when they have an unscheduled care
episode. The information helps Boards to establish a baseline of how services are currently being used ahead of such local social marketing campaigns as may be developed within the Board area. It is hoped that the outcome of this work will be to support the reduction in the number of steps taken by patients as they try to access unscheduled care, and provide information / advice for the public on the range of unscheduled care services available both in and out of hours.

- Engaging closely with the evaluation and outcomes of the pilots in England of the ‘111’ number to inform decisions about whether to adopt the number in Scotland.

2. Quality, Clinical Safety and Effectiveness

The existing NHS QIS standards, which were prepared at the time of the introduction of the new GMS contract in 2004, have provided a level of assurance about the robustness of the out of hours processes and systems that Boards have in place. The services in all board areas have been judged to meet those standards. In addition to these, all local NHS Boards have their own performance management measures and reporting arrangements which help provide assurance of the governance and quality of the services they are providing. Six years into the new contract – and in the context of the ambitions set out in the Quality Strategy - the time is right for NHS QIS to look afresh at the existing standards with a view to developing a set of quality standards that would be consistent across Scotland and would enable comparison between different Board areas. We are likely to be looking for a relatively small number of outcome measures and indicators. These will include not only volume throughput (which helps to demonstrate the availability of care and performance of the system) but also the quality of the clinical episodes that comprise that throughput and the quality of the patient experience throughout the pathway of care including the health outcomes patients experience as a result of the care they receive.

On quality, clinical safety and effectiveness, the following steps are being taken:

The Scottish Government has asked NHS QIS to:

- Take forward, in partnership with NHS Boards, work to develop national out-of-hours quality standards with a view to piloting such standards around this time next year.

NHS Boards will:

- Continue to maintain their own local reporting arrangements which have served them well since 2004.

The Scottish Government and NHS Boards will:

- Continue to work in partnership to further develop the emergency care and palliative care summaries and special notes that support the effective communication of patient information. This is vital to maintaining continuity of care, especially for those patients being managed in the community who have chronic and enduring illnesses.
3. **Sustainability and Cost**

We share the Committee’s concern that the services provided should be sustainable. We agree that there needs to be an ongoing debate about how best to ensure in the current economic circumstances the delivery of the high quality services to which we are committed.

On sustainabilility and cost, the following steps are being taken:

**The Scottish Government:**

- Has asked NHS Boards to make full use of the appropriate networking forum to share information describing the models that support out-of-hours services in each local NHS Board, including the NHS Borders model which was commended by the Committee.

- Is working with NHS National Services Scotland, Information Services Division (ISD) to ensure that information covering the cost of out-of-hours services across Scotland, as set out annually in the NHS Costs Book, is up to date and consistent across NHS Boards.

- Is working with NHS Scotland and other key partners on the Health Workforce Programme Board, including the British Medical Association, to review the likely longer term shape of the medical workforce in Scotland. This includes how best to improve the co-ordination and integration of workforce planning and the skills mix for clinical teams. Utilising valuable information collected from the 2009 Primary Care workforce survey, we will ensure the Programme Board’s work takes into account the report of the Health and Sport Committee, including issues highlighted for out of hours training provision in General Practice.

**Conclusions**

The Scottish Government readily accepts that in late 2004 and early 2005 out-of-hours services were under immense strain and that there was a need for significant improvement to be made. We believe that since then NHS 24 and NHS Boards have made significant improvement to the ways in which they provide out-of-hours services. Audit Scotland in 2007 reported that 80% of patients were satisfied with the out-of-hours service they received and understood the role of NHS 24 in supporting access to these services. In 2009 more than 90% of respondents to an NHS 24 patient satisfaction survey indicated that they were satisfied with the service they had received from NHS 24. We believe that these figures, together with the positive assessment secured by every NHS Board against key performance measures, paint a fair picture of the quality of services currently provided across Scotland.

Nevertheless we are committed to continuous improvement and recognise that more steps can be taken to optimise the quality of care which the current structures and arrangements are capable of providing. Some of those steps are set out above.

In taking these steps we have been informed by the Quality Strategy. In developing that strategy we were told by patients that, amongst other things, they wanted:

- Improved collaboration;
- Clear communication;

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[www.scotland.gov.uk](http://www.scotland.gov.uk)
- Clinical excellence; and
- Continuity of care

The actions set out above, building on the quality of the existing services, will allow us to continue to make progress in each of these important areas

Scottish Government
June 2010
Improving services for those with mental health problems and sensory impairment

Background

1. In December 2007 petition PE808, in the name of Lillian Lawson on behalf of the Scottish Council on Deafness, was referred to the Committee by the Public Petitions Committee. The petition called on the Scottish Parliament to “urge the Scottish Executive to develop and establish a specialist inpatient mental health unit for deaf and deafblind people and to provide resources (e.g. training) for mainstream psychiatric services in the community to make them more accessible to deaf and deafblind people in Scotland.”

2. The Committee took oral evidence on this subject from the Minister for Public Health and Sport, Shona Robison MSP, on 11 June 2008. Following that evidence session, the Committee agreed to write to the Scottish Government outlining the main issues arising from the evidence and return to the subject when the Government had considered proposal for specialist in-patient services in Scotland. On that basis, the Committee agreed to close the petition.

Response

3. The Convener wrote to the Minister on 17 June 2008 seeking information on the provision of in-patient services in Scotland. At that point a decision on the provision of such services was expected to be reached by autumn 2008. Subsequently, the clerk has been in correspondence with Government officials during 2009 and early 2010 seeking an update on the timetable for a decision. A response has now been received from the Minister and is attached in the annex to this paper.

For decision

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

   (i) Note the response from the Minister and provide a copy to the petitioner; or

   (ii) propose and agree an alternative approach.

Dougie Wands
Clerk
I am writing to update the Committee on improving services for those with mental health problems and sensory impairment, specifically in relation to the business case for establishing an in-patient service in Scotland.

A key discussion point when I gave evidence to the Committee on this subject in 2008 was our ambition – shared by others, notably The Scottish Council on Deafness as evidenced by their petition (PE808) – to examine the need for and merits of a Scotland-based acute in-patient service (which would replace the current arrangement whereby patients are admitted to the John Denmark Unit in Manchester).

I had previously informed the Committee that The Scottish Government had supported 3 Boards in developing a draft options-based business case for establishing a national in-patient service. When presented with this paper, NHS regional planners were persuaded that the most appropriate approach would be to argue for establishing a national community specialist mental health service - primarily to significantly enhance local services of course, but also to help inform the development of a full business case for establishing an in-patient service.

Consequently I agreed that we would fund the development of national specialist community capacity, with specialists working with the 3 Board regions providing additional support within specialist community services, and helping us in developing care and referral pathways in advance of any future establishment of the national in-patient service. This funding is of course be in addition to the money we continue to provide for admissions to The John Denmark Unit (JDU). A total of £200,000 per year of new money has been allocated by the Scottish Government for this purpose and it is anticipated that this will fund Specialist Consultant Psychiatry, Expert Nurse and other specialist staff time.

Officials worked with key national and regional planners through 2009 to establish the new service which is to be hosted by NHS Lothian with input from NHS Lanarkshire. This service will involve a specialist team with protected time within their normal duties in order to provide...
advice and support to all NHS Boards across Scotland in caring for people with moderate to severe mental health problems who are profoundly deaf or have other sensory impairment.

Primarily a consultation and liaison service, the primary aim will be to ensure timeous access to specialist advice, when needed, by local community mental health teams. Where necessary, patients will receive specialist outreach care from staff skilled in working with people with sensory impairment.

We asked National Services Scotland (NSS) to commission and performance manage this service. This service is of course in addition to the existing specialist in-patient service, provided by the JDU in Manchester, for those patients with severe mental health problems who also have profound sensory impairment and who require in-patient care. We also envisage that referrals to the JDU in-patient service will increasingly be guided by specialist advice from this new service. NSS have now also established a Quality Assurance Panel to monitor the quality of referrals to JDU.

We wrote to NHS Boards at the end of March to inform them of this new national service. The new service is presently at the very early stages of operational planning, and will be launched formally later this year.

I hope this update is helpful.

Best wishes,

Shona.

SHONA ROBISON
Thank you for your letter of 9 June about the European Commission’s long work programme for 2010-14 and various strands of work at a European level, discussed at the Committee’s meeting on 2 June.

Accessing Healthcare in Europe

It may be helpful if I first of all explain something of the means by which European Union citizens can access healthcare throughout the European Economic Area (EEA) as, from the Official Report of the meeting of 2 June, this would appear to be of interest to the Committee.

There are currently two potential routes for patients to receive planned healthcare in another EEA country at the expense of the NHS: the E112 route and the Article 56 Route.

E112

The key difference between the two routes is that the E112 route relates only to state-provided treatment and costs are dealt with directly between Member States, which have discretion to authorise planned treatment in another EEA. However, where treatment cannot be provided by the NHS within a time that is medically acceptable, based upon clinical assessment, authorisation must be given.

Article 56

Under the Article 56 route, patients can seek any health care in another Member State that is the same as, or equivalent to, a service that would have been provided to the patient under the patient’s home healthcare system. The patient has a right to claim reimbursement up to the amount that the same, or equivalent, treatment would cost had the patient obtained that treatment from their home healthcare system - or the actual amount where this is lower. The patient can receive treatment in the state-provided sector or they can access services in the private sector.
The principle of reimbursement assumes that patients will pay the overseas provider at the time of their treatment and then claim reimbursement from their NHS Board. It is possible to limit the amount that may be reimbursed to the cost of the same or equivalent NHS treatment. The patient will also bear the financial risk of any additional costs arising.

Except where legislation requires prior authorisation, a patient may obtain care in another EEA State without authorisation by their NHS Board. By contrast, under the E112 route, all care must be authorised in advance.

**The Cross-border Healthcare Directive**

In July 2008, the European Commission published a draft Directive on the application of patients’ rights in cross-border healthcare. This draft legislation seeks to codify existing ECJ case law on patients’ rights in accessing cross-border healthcare and to clarify its application. The draft Directive aims to set out a legal framework for patients seeking access to healthcare in another EEA Member State under the Article 56 route. The broad outline of the Commission’s proposal is that in cases of patients accessing cross-border care, the ‘home’ state has responsibility for deciding the healthcare it will fund and for setting up a system of cost reimbursement to patients. The patient will then be entitled to a reimbursement of their costs, up to the amount the home state would have paid to treat that person at home.

Following political agreement of the Spanish Compromise Text on 8 June, the Cross-border Healthcare Directive is subject to ongoing negotiations in the European Parliament. The current text appears to be a stable compromise. Importantly, it allows for a workable system of prior authorisation for hospital care and specialist treatment for people wishing to travel to other European Economic Area countries for healthcare.

In the interim we intend to introduce the National Health Service (Reimbursement of the Cost of EEA Treatment) (Scotland) Regulations 2010. As you know, I have been asked to appear before the Committee on Wednesday 23 June to explain the need for the interim Regulations and to move the motion on them.

**Alcohol Labelling**

The record of the Committee’s discussions on 2 June also makes reference to alcohol labelling. Knowing the facts about alcoholic drinks allows consumers to make informed choices about what they drink. Information about alcohol content is important as it informs people of the relative strengths of different products and information on the unit content of particular drinks can help consumers estimate how much they really drink compared to recommended daily and weekly limits. Nutritional information, such as calorie content, can also influence choice of product.

The Scottish Government, along with the UK Government and other Devolved Administrations, believes that consumers should have the same calorie content information on alcohol labels as on labels of other foodstuffs. Alcohol forms 7% of calorie intake on average for UK consumers - this will be higher for regular drinkers of alcohol and much higher for heavy consumers. The Scottish Government will continue to support the UK Government in arguing for this in the European Council. In addition to the work being undertaken at a European level, the Department of Health and the Devolved Administrations published a joint consultation paper on 15 February 2010 on the options for improving the provision of unit information and health guidelines on alcoholic drinks labels.

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www.scotland.gov.uk
The proposal is that alcoholic drinks labels should now include: the drinks unit content; the recommended sensible drinking guidelines; sensible drinking message; website or logo of the Drinkaware Trust, and; advice on alcohol on pregnancy. The consultation ended on 31 May 2010. We will now consider the consultation responses and determine the best way forward.

Commission Work Programme 2010 - 2014

The Commission's Work Programme contains a number of initiatives around health and Sport that are of particular interest to the Scottish Government.

eHealth Plan

In 2004 the EU Commission and all Member States adopted an eHealth Action Plan which aimed to facilitate a more harmonious and complementary European approach to eHealth. In December 2009 the EU Council called upon the Commission to update that eHealth Plan. This has yet to be substantially developed, although discussions are ongoing in the Commission's i2010 group. Scotland is not directly represented on that group - the Department of Health takes the lead at Member State level. However, our eHealth Strategy team is in close contact with DH and is fully consulted, and comments on the proposals as they develop.

Tobacco

Directive 2001/37/EC covers product safety and product labelling and falls within Section C8 of Schedule 5 of the Scotland Act as a reserved matter. Consequently it is necessary for the UK Government to legislate on these matters such as picture health warnings. However, the Scottish Government very much welcomes the move to encourage smokers to give up and reduce the attractiveness of cigarettes to children and young people. Scottish Government Officials are in regular contact with officials in all the devolved administrations in order to keep in touch with matters of common interest.

Sport

The Scottish Government is aware that on 1 December 2009 the Lisbon Treaty entered into force and as a result sport became a new competence aimed at developing the European dimension in sport. Although sport is a devolved responsibility we are working with the UK Government, and the other devolved administrations, to help shape the UK position on sport. We are also working closely with sportscotland, the national agency responsible for the development of sport and physical recreation in Scotland, to ensure that we are fully engaged in this new competence and identify any opportunities that would benefit Scottish sport.

Wider Engagement with Europe

In terms of wider engagement with the EU, the Scottish Government's policy on bilateral relations with Europe is set out in our Action Plan on European Engagement, which is published on the Scottish Government website. The Action Plan contains a six-monthly EU Review and Forward Look (to coincide with the timings of the Commission rotating Presidency) giving stakeholders a clear summary of recent and future EU activity and Scottish Government engagement on areas of interest. The Scottish Government will publish the next edition of its EU Review and Forward Look to accompany the incoming Belgian Presidency of the Council (July 2010).
The Action Plan and Forward Look do not cover each and every area where the Scottish Government engages with the EU, instead they focus on areas where the Scottish Government can add most value at a strategic level. However, this does not mean that activity is not happening across the wider range of policy areas, health being an example. A great deal of work is ongoing across the health portfolio to ensure that we are up to date with the latest EU developments and feeding in to the UK position.

The recent European and External Relations Committee (EERC) debate in the Scottish Parliament focused on the European Commission's Work Programme and the aspects it contains that will have a significant impact on Scotland. The Scottish Government welcomed the Work Programme and supports the priorities within. Fiona Hyslop, the Minister for Culture and External Affairs, took the opportunity to recognise The Scottish Government’s key role in enhancing Scotland’s profile in Europe: not only must we ensure that Scotland fully grasps the opportunities that the EU presents but we should also ensure that Scotland plays a full part in shaping EU policies of the future. We have a track record in leading the field in areas such as marine renewable energy and creating a sustainable fisheries industry.

Fiona Hyslop and her officials have also been working closely with the EERC as part of their Lisbon Treaty Inquiry and related issues of scrutiny, where internal Scottish Government procedures are being revised to give additional support to Scottish Parliament scrutiny of EU proposals, including in relation to subsidiarity.

Since September 2009, a new system has been in place which requires a short report to be sent to relevant committees including the European and External Relations Committee after all ministerial attendance at Councils. Ministers have attended 12 Councils since September 2009. In line with this policy we will of course send you a report of any council which I or my ministerial colleagues attend in future.

I would, of course, be happy to elaborate on any of the health and wellbeing issues that the Committee has a particular interest in.

Best Wishes,

NICOLA STURGEON
Dear Christine

I refer to your Committee’s recent discussion on the European Commission Work Programme on 2 June 2010 and your request for additional information from the Parliament’s European Officer. The European Officer has provided an update on the policy issues that were raised by members of your Committee and I attach his report at the Annexe, which I hope you will find useful.

I would also like to take this opportunity to provide you with some additional information on the operation of the European and External Relations Committee (EERC) and on how we see our role in the wider context of the Parliament’s scrutiny of EU issues. As you will appreciate, the role of the European Officer is integral to the work of my Committee and of the Parliament as a whole in furthering our engagement on EU issues. Therefore, I am concerned about some of the remarks made during the discussions as they relate to the scrutiny of EU issues and, specifically, the European Officer. I trust that this letter and its supporting material address those comments.

Judging by your Committee’s discussions, however, we are clearly in agreement that EU issues are significant to Scotland and that we, collectively as a Parliament, need to work harder to ensure that the EERC and subject committees engage on such issues more effectively. On this basis, I hope that we can use your discussions in Committee as a platform on which to promote greater engagement and understanding of EU issues in the subject committees and across the Parliament as a whole.

The Cross Border Health Directive could offer such an opportunity for our two committees to engage on EU issues. In the context of the Brussels Bulletin, the EERC discussed the Directive on 15 June and agreed to consider possibilities for facilitating
further input on the issue. We will keep your Committee informed of any further discussions that we have on the matter and would welcome the involvement of your Committee members.

The EERC consultation on the Commission Work Programme (CWP)
The aim of the EERC consultation is to both raise awareness of European issues, and specifically to forewarn committees of proposals emerging from Brussels at the earliest opportunity. The current CWP covers the entire mandate of the Commission (up to 2014), providing very early warning indeed. It is at this early stage that we have the greatest opportunity to exert influence both on the Scottish Government and the European institutions.

To accompany the CWP consultation, we requested an analysis of the programme and a report from the European Officer, to help guide the committees in their consideration of the issues. Since the ambition of the consultation is to allow us to ‘get in early’ to the issues in the current CWP, the report does not cover proposals already in the system and currently under review by the European Officer.

I can confirm that ongoing issues, such as the Cross Border Health Directive, remain part of the European Officer’s work programme. The European Officer will continue to report on these issues via the Brussels Bulletin until they have completed their legislative journey.

It is hoped that the outcome of the EERC CWP consultation will reflect broad committee agreement on the list of Scottish Parliament priorities. These priorities will form the work programme of the European Officer.

Updates from the European Officer
To date developments in Brussels and updates on legislative proposals have been provided by the European Officer in a digestible form via the Brussels Bulletin. Each edition of the Brussels Bulletin is considered formally by the EERC at each committee meeting (approximately every two weeks when Parliament is sitting). Following this, the Bulletin is forwarded on to the subject committees for information. Where a committee would wish further information on any European matter, it is anticipated that they will commission an appropriate report from the European Officer. Committees can also request a more informal briefing or update.

Certain committees with an active interest in European matters have requested a more detailed update. For example the Rural Affairs and Environment Committee has asked the European Officer to produce a quarterly summary report on relevant EU issues and intends to invite him to address a private session of the committee on a biannual basis, whilst the Justice Committee has requested that the European Officer appears in formal session to discuss the CWP.

The Brussels Bulletin
Since September 2009, the European Officer has provided updates (see Appendix) of relevance to the Health and Sport Committee on seven separate occasions via the Brussels Bulletin, each of which has been formally transmitted to your committee. The updates range from shorter notes covering issues such as organ transplants or revision...

I read your concerns about the Cross Border Health (CBH) Directive, and note that a short update was included in the January 2010 Bulletin covering the views of the Health Commissioner where he stated that CBH is one of his top priorities and that he is in discussions with the Spanish Presidency regarding it. I also draw your attention to the European Officer's update at the Annexe.

I note your concerns regarding the 'missed' consultation on EU sports policy. Forewarning of this consultation was given on 15 December 2009, and details given when the consultation opened in April 2010, both of which were drawn to your committee’s attention via the Brussels Bulletin. In addition, I wrote to you on 22 April, formally drawing the consultation to the attention of your committee. I also understand from the European Officer that during his meeting with your clerks on 30 April, he suggested forwarding on your report on sport to the Commission in response to the consultation.

Therefore, I hope that you will recognise that the European Officer has provided intelligence and updates on issues relevant to your committee’s remit.

Presidency priorities
It is true that each incoming Presidency of the Council prioritises issues that it would wish to progress during its term. Indeed the member states adopted a ‘troika’ formation to allow collaboration between the upcoming three holders of the Presidency and to provide for greater continuity. (The current troika includes Spain, Belgium and Hungary). However the Presidency priorities are primarily drawn from the work programme of the Commission (which is itself born of an extended collaboration between the Council, Parliament and Commission). As Ross Finnie pointed out, own-initiative Presidency priorities rarely make rapid progress.

In order to ensure that the Scottish Parliament is fully aware of the priorities of each Presidency, EERC members visited the Czech and Swedish governments prior to taking up their Presidency roles and conducted a series of meetings with ministers and officials to explore the emerging priorities. The reports of those visits were forwarded to the subject committees.

Since 2010, the EERC has focused its engagement with the Presidency of the EU on inviting the Ambassador of that member state to address the Committee in formal session. To date, the Spanish Ambassador to the UK attended the EERC meeting on 27 January 2010 and details of that meeting were circulated in advance to all MSPs inviting them to attend. Where particular issues of note arise in these sessions, this information is then forwarded on to the subject committees. You may be interested to know that the Belgian Ambassador to the UK will address the EERC on 21 September, and I would strongly encourage your members to attend.

Further, in advance of each Presidency, the European Officer has, via the Brussels Bulletin, provided early intelligence of the likely presidency priorities. Such updates were produced on the presidencies of Sweden (16 June, 29 September), Spain (15
December) and Belgium (15 June). In addition, SPICe produced two separate briefings on the Czech and Swedish Presidencies of the EU, both of which are publicly available.

**Actions of the Scottish Government**

The Scottish Government’s EU priorities are currently set out in its Action Plan on EU Engagement, and the accompanying Forward Look which covers the period to June 2010. The Forward Look was updated to include the Government’s EU priorities for January-June 2010 and a further update is expected in July 2010 to coincide with the start of the Belgian Presidency of the EU.

As per an agreement brokered by the EERC, each Minister who attends a European Council submits a formal report to the relevant subject committee. So far Ministers have attended the following Councils: Agriculture & Fisheries, the Education, Youth & Culture, Justice & Home Affairs, Transport, Telecommunications & Energy, and Environment.

I understand that the European Officer is available to meet with you, your committee and your clerks at any time to discuss how best to ensure that your committee has at its disposal all the information needed to do its European business.

I hope that this information is of value for your discussions of 23 June.

Yours sincerely

IRENE OLDFATHER MSP
CONVENER
## EU updates provided by the European Officer on health and sport policy areas and on the Presidency of the EU

<table>
<thead>
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<th>Issue</th>
<th>Description</th>
<th>Brussels Bulletin edition</th>
<th>Date of referral by EERC to Health &amp; Sport Committee</th>
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<tr>
<td>Swedish Presidency</td>
<td>Details key priorities of the Swedish Presidency of the European Council. No health issue is prioritised.</td>
<td>32</td>
<td>29 Sept 2009</td>
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<tr>
<td>College of Commissioners</td>
<td>Outlines likely changes to Commissioners and their portfolios, including Health Commissioner Vassiliou</td>
<td>33</td>
<td>3 Nov 2009</td>
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<td>Working Time Directive</td>
<td>Warning of the Commission’s intention to try again to secure support for revision</td>
<td>34</td>
<td>17 Nov 2009</td>
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<tr>
<td>Commissioners-designate</td>
<td>Details of the proposed Commissioners, including Health Commissioner-designate John Dalli</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spanish Presidency priorities</td>
<td>Details of the priorities for the upcoming Spanish Presidency. No health issue is prioritised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EU role in health post Lisbon Treaty</td>
<td>Details change in health policy following adoption of the Lisbon Treaty, in particular the concept of ‘wellbeing’ (based on Article 3 of the Treaty of European Union &amp; Articles 9 &amp; 168 of the Treaty on the Functioning of the European Union) and the reality of a ‘shared competence’</td>
<td>35</td>
<td>15 Dec 2009</td>
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<tr>
<td>EU role in sport post Lisbon Treaty</td>
<td>Details of the implication of Article 165 of the Lisbon Treaty, and likely consultation to follow</td>
<td></td>
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</tbody>
</table>
| Health Commissioner John Dalli hearing | Details priorities of Commissioner-designate:  
• Patient rights and the ‘Pharma’ package  
• Cross Border Health (and his discussions with Spanish health minister)  
• Lifestyle health issues (where no further legislation is expected)  
• Cloning Directive, expected by end 2010 | 36 | 26 Jan 2010 |
| The new Presidency Troika | Details of the joint EU presidency programme (Spain, Belgium & Hungary) including discussion of social agenda | 37 | 9 Feb 2010 |
| Maternity leave directive | Details Commission’s proposed revision of the Maternity Cover and Parliamentary discussion | 39 | 16 Mar 2010 |
| Commission work programme | Details of Commission proposals for the 2010 & beyond; reference to supporting paper by European Officer detailing proposals of interest to Scottish Parliament. 4 health & sport issues raised | 41 | 20 Apr 2010 |
| Sports policy | Details of on-line consultation on the determination of EU sports policy | | |
| Sports policy follow-up | Details Commission’s intention to develop a framework for sports policy | 42 | 4 May 2010 |
| Clinical trials | Details Commission’s intention to overhaul Clinical Trials Directive | | |
| Sports policy | Details first meeting of new Sports Council, and the Commission’s intention to publish a communication in the autumn | 43 | 1 Jun 2010 |
| Organ transplantation | Details Parliament’s endorsement of standards for organ transplant and the Commission’s 2009 – 2015 action plan on organ donation | | |
Report from the Scottish Parliament European Officer on issues raised during the Health & Sport Committee meeting, 2 June 2010

The members sought further update on four substantive issues:

- The Cross Border Health Directive
- The Food Information for Consumers Regulation (which covers alcohol labelling)
- EU Sports Policy
- E-Health

Executive Summary

Cross Border Health Directive
The Spanish Government, despite its earlier implacable opposition to the proposal, in its capacity as President of the European Council, brokered a deal at the 7 June Health (EPSCO) Council, and secured member state agreement on a compromise text, so re-invigorating the legislative process. A second reading can now be expected in the European Parliament, followed by further discussion and possible adoption of the Directive by the end of 2010.

I noted Helen Eadie’s comments regarding the unlikelihood of progress on this directive during the Spanish Presidency. This was a view widely shared in Brussels. It therefore made the Spanish volte face all the more extraordinary and unexpected.

Food Information for Consumers Regulation
The aim of this directive is to make food labels clearer and more relevant to consumers. It combines two existing directives covering labelling and nutrition and recast (but does not amend) the 1987 Directive on Alcohol Strength. However, the only substantive changes envisaged in this regulation relate to ‘alcopops’ and their ingredients. Derogations are provided for wine, spirits and beer, with the Commission indicating that it will review these derogations five years after the regulation is enacted.

EU Sports Policy
With the coming into force of the Lisbon Treaty, the EU gained a formal competence in the area of sport. The Commission has been consulting on how it should develop its competence, and the recent consultation was intended to contribute.

Although the Committee has missed the deadline for this consultation I would strongly recommend forwarding your Pathways into Sport & Physical Activities report. I am sure it would be welcomed.

E-Health
Preparations for the development of a five year e-Health strategy are at the early stage. Much of the work of the Commission has been focused on reviewing the current strategy and learning lessons. I have included a short review of the key issues, and links to a number of the supporting documents, which may help the committee formulate its engagement with this issue.
CROSS BORDER HEALTH DIRECTIVE

Chronology of events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>26 September 2006</td>
<td>Commission launches consultation <strong>Communication</strong> on cross border health care provision, with a deadline of 31 January 2007. Details forwarded on to EERC.</td>
</tr>
<tr>
<td>23 November 2006</td>
<td>Issue referred by EERC to Health and Sport Committee; see <strong>Appendix I</strong>.</td>
</tr>
<tr>
<td>2 July 2008</td>
<td>Commission publishes a <strong>proposal for a directive</strong> on patients’ rights in cross-border healthcare.</td>
</tr>
<tr>
<td>21 September 2008</td>
<td>In-depth analysis of Directive by the Council (EPSCO)</td>
</tr>
<tr>
<td>31 March 2009</td>
<td>European Parliament Health (ENVI) Committee adopts a <strong>report</strong> by John Bowis MEP.</td>
</tr>
<tr>
<td>23 April 2009</td>
<td>European Parliament plenary session adopts the Bowis report on 1st reading, with few amendments.</td>
</tr>
<tr>
<td>1 December 2009</td>
<td>Following the efforts of the French and Czech EU Presidencies, the Swedish Presidency fails to secure a deal on cross-border healthcare, due to a blocking majority which included Spain. Such was the opposition that the Commission was expected to withdraw the proposal.</td>
</tr>
<tr>
<td>14 January 2010</td>
<td>Health Commissioner-designate John Dalli, during his confirmation hearing before the Environment &amp; Health Committee of the European Parliament, states that he will work with the Spanish Presidency in an attempt to secure a compromise on the proposal; referenced in Brussels Bulletin</td>
</tr>
<tr>
<td>7 June 2010</td>
<td>The Spanish Presidency unexpectedly table a compromise <strong>text</strong> at the Health (EPSCO) Council (see below). Following discussion political agreement on the text is reached.</td>
</tr>
</tbody>
</table>

Next steps:
1. The draft directive will have a 2nd reading in the EP, beginning with consideration by the Health (ENVI) Committee (late September/October) and concluding with a plenary vote (late October/November).
2. The draft directive will return to Council where, depending on EP amendments, agreement could be reached and the Directive adopted (6 December 2010).

What’s happening?
Despite the implacable opposition of the Spanish Government to the draft Cross Border Health Directive during the Swedish Presidency (July – December 2009), when Spain itself assumed the Presidency (on 1 January 2010), its role changed from ‘opposer’ to ‘seeker of compromise’. In this capacity, and following lobbying from the new Health Commissioner John Dalli, the Spanish presidency presented a compromise text at the Health (EPSCO) Council on 7 – 8 June 2010.

The compromise text sought to resolve the two outstanding blockages: (i) the definition of the member state of affiliation with regard to pensioners living abroad; and (ii) reimbursement and prior authorisation as regards non-contractual healthcare providers.

**Pensioner health care.** On the issue of reimbursement of healthcare costs of pensioners living within the EU but outside their home state and receiving healthcare in that non-home state, the presidency proposed that as a general rule the home
state should meet the healthcare costs, since that country would be responsible if the pensioners had not moved abroad.

Reimbursement & prior authorisation. The Spanish compromise follows the original Commission line, namely that prior authorisation must be sought for treatment that would involve an overnight stay in hospital or which is 'specialist' in nature. The term ‘specialist’ remains undefined. Costs would only have to be reimbursed up to the limit of costs in the home state.

Next steps
With agreement at the Health (EPSCO) Council, the legislative process begins once again. A second reading in the European Parliament is likely in autumn 2010. The nature of the Spanish compromise is likely to find favour with the Parliament’s Health (ENVI) Committee, given the limited nature of amendments tabled during the first reading.

If the draft proposal secures second reading in the Parliament, it will return to the Health (EPSCO) Council, likely to be 6 December 2010. If the Parliament has made few amendments, or the given amendments find favour in the Council, then adoption is likely.

Thereafter member states will have one year to implement the directive.
## Chronology of events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>23 November 2006</td>
<td>Paper on the Commission Legislative Work Programme, detailing emerging issue of obesity and health, formally transmitted by EERC to Health &amp; Sport Committee; see <a href="#">Appendix II</a></td>
</tr>
<tr>
<td>30 May 2007</td>
<td>Commission publishes <a href="#">White Paper on Obesity</a></td>
</tr>
<tr>
<td>30 January 2008</td>
<td>Commission publishes <a href="#">draft regulation</a> on the provision of food information to consumers</td>
</tr>
<tr>
<td>7 November 2008</td>
<td>Parliament Health (ENVI) committee publishes report by Renate Sommer MEP. However, report withdrawn and 1&lt;sup&gt;st&lt;/sup&gt; reading begins with new legislative term (2009).</td>
</tr>
<tr>
<td>11 November 2009</td>
<td>New <a href="#">draft report</a> presented by Renate Sommer MEP.</td>
</tr>
<tr>
<td>14 December 2009</td>
<td>Council takes note of the EU presidency <a href="#">progress report</a>.</td>
</tr>
<tr>
<td>16 March 2010</td>
<td>Health (ENVI) Committee adopts Sommer <a href="#">report</a>.</td>
</tr>
<tr>
<td>7 – 8 June 2010</td>
<td>Health (EPSCO) Council holds debate on proposal and adopts <a href="#">general approach</a>.</td>
</tr>
<tr>
<td>16 June 2010</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; reading vote in European Parliament</td>
</tr>
</tbody>
</table>

### Next steps

1. In September, the UK Government intends to consult the devolved administrations on the nature and impact of the proposed regulation.
2. The Health (EPSCO) Council will seek political agreement on the draft regulation 6 – 7 December 2010.
3. If there is no 1<sup>st</sup> reading agreement at Council, the matter will return for a 2<sup>nd</sup> reading in the Parliament early in the new year.

## What's happening?

The Food Information for Consumers Regulation aims to combine Directive 2000/13/EC on the labelling, presentation and advertising of foodstuffs and Directive 90/496/EEC on nutrition labelling for foodstuffs into a single instrument. In addition, the proposal simplifies the structure of the horizontal food labelling legislation in Directive 2000/13/EC, by recasting and replacing provisions already in place under this Directive. The regulation will also recast (but not amend) Directive 87/250/EEC on the indication of alcoholic strength by volume in the labelling of alcoholic beverages for sale to the ultimate consumer.

The aim of the directive is to make food labels clearer and more relevant to the needs of EU consumers. The draft Regulation would modernise and improve EU food labelling rules to ensure that consumers have, in a legible and understandable manner, the necessary information to make informed purchasing choices.

Although the regulation would recast Directive 87/250/EEC on alcoholic strength by volume, the only substantive changes in the new regulation affecting alcohol concern ‘mixed alcohols’. The proposal provides that ready-to-drink mixed alcoholic beverages (‘alcopops’) should include an ingredients list and information on nutrient content to ensure consumers are aware of the potential contribution of such beverages to their overall diet.

In the case of other alcoholic drinks, derogations are provided for wine, spirits and beer. The Commission intends to produce a report on the derogated alcohols five years after the entry into force of this Regulation and may propose at that time, if deemed necessary, further action.
At present the Scottish Whisky Association is lobbying the Parliament and Council on two issues that they would like to see included in the Regulation: (i) a stipulation that all whiskies sold in the EU declare their country of origin; and (ii) that there be no national rules on the use of commonly used labelling terms rather only EU-agreed terms.

Next steps
Council discussions are at an early stage. From preliminary engagement between the UK and Scottish Government, it is anticipated that there will be agreement within the UK. Whether there is common agreement amongst the member states will become apparent when political agreement is sought in December 2010. The UK government will be gathering these views early in the autumn.

This is a particularly technical regulation, but its implications for alcohol strength are limited.
EU SPORTS POLICY

Chronology of events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>17 March 2008</td>
<td>EU sports ministers adopt joint declaration on Social Significance and Dialogue in Sport, outlining the direction for a European Programme for Sports.</td>
</tr>
<tr>
<td>12 December 2008</td>
<td>European Council adopted a Declaration on Sport.</td>
</tr>
<tr>
<td>16 March 2009</td>
<td>Commission adopts preparatory action plan on sport</td>
</tr>
<tr>
<td>1 December 2009</td>
<td>The Lisbon Treaty enters into force, giving the EU a competence on sport.</td>
</tr>
<tr>
<td>8 April 2010</td>
<td>Launch of consultation on EU sports policy, with a closing date of 1 June 2010; referenced in Brussels Bulletin.</td>
</tr>
<tr>
<td>20 April 2010</td>
<td>Convener of EERC writes to Convener of Health &amp; Sport Committee drawing attention to the consultation.</td>
</tr>
<tr>
<td>30 April 2010</td>
<td>During meeting with clerk of Health &amp; Sport Committee, European Officer suggests committee submit its report 'Pathways into Sport &amp; Physical Activities to consultation.</td>
</tr>
<tr>
<td>11 May 2010</td>
<td>Commission launches call for proposals under the 2010 Preparatory Action in the field of sport; referenced in Brussels Bulletin.</td>
</tr>
</tbody>
</table>

Next steps

2. Commission draft decision on EU sports programme and budget (November 2010).
3. First limited EU sports programme (2012-2013) expected to come into force (1 January 2012).

What's happening?

With the coming into force of the Lisbon Treaty, the EU gained a formal competence in the area of sport. Article 165 of the Lisbon Treaty provides the European Union with a soft competence on sport, which means that the Commission will develop a specific EU sports programme, supported by a budget. The competence also allows for better promotion of sport in other EU policy areas and programmes, such as health and education. Further, the treaty provision allows the EU to speak with a single voice in international forums.

The recent consultation solicits stakeholder views on the priorities for an EU sport strategy as well as addressing specific issues including governance, volunteering, equal opportunities, doping and the physical and moral integrity of sports people.

Next steps

With the new competence, greater priority will be given to sport. The Education & Culture Committee of the Parliament gains operational competence over the issue. A new Sports Council (of ministers) has been instituted to take the lead on sporting issues at a Council level.
The publication of the Communication in November will set out the Commission’s ambition in this new area.
Chronology of events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>30 April 2004</td>
<td>Commissions first eHealth action plan with the ambition to facilitate a</td>
</tr>
<tr>
<td></td>
<td>more harmonious and complementary European approach to eHealth.</td>
</tr>
<tr>
<td>21 December 2007</td>
<td>Commission published Communication on the ‘Lead Market Initiative for Europe’, with eHealth as one of the first six markets. An action plan is annexed to the Communication.</td>
</tr>
<tr>
<td>January 2009</td>
<td>EU publishes eHealth in Action - Good Practice in European Countries</td>
</tr>
<tr>
<td>9 September 2009</td>
<td>Mid-term report on eHealth Lead Market Initiative</td>
</tr>
<tr>
<td>1 December 2009</td>
<td>EU health ministers publish conclusions on e-Health, calling for action on building ‘an e-Health area for European citizens’.</td>
</tr>
<tr>
<td>15 March 2010</td>
<td>EU health ministers sign declaration on e-Health at the 8th ministerial e-Health conference in Barcelona</td>
</tr>
<tr>
<td>31 May 2010</td>
<td>Commission publishes study evaluating e-Health in EU</td>
</tr>
</tbody>
</table>
| Next steps      | 1. The Commission is likely to publish a guiding communication later in 2010 or early in 2011, as part of the Digital Agenda (see recent speech by Competition Commissioner here that outlines the ambition of the project). This Communication is expected to summarise the actions necessary to roll out the strategy.  
|                 | 2. Both the Council and Parliament can be expected to be fully engaged on the development of a second action plan. Preliminary Council Working Group discussion is expected to commence in the Autumn. |

What’s happening?
The EU is moving towards a European e-Health Area, co-ordinating actions and promoting synergies between related policies and stakeholders, with the aim to develop better solutions, prevent market fragmentation and disseminate best practices.

The specific objectives of the policy are:

- to create an electronic health record architecture by supporting the exchange of information and standardization;
- to set up health information networks between points of care to co-ordinate reactions to health threats;
- to ensure on-line health services such as information on healthy living and illness prevention;
- to develop teleconsultation, ePrescribing, eReferral and eReimbursement capabilities.

The Commission is reviewing its current (2004) action plan, with a mind to adopting a new five-year plan (likely to be launched in 2011 or possibly 2012). Progress in this area is likely to be closely entwined with the Commission’s proposals for a Digital Agenda (which forms part of the Europe 2020 ‘Green Growth & Jobs’
The recent study initiated by the Commission (May 2010) set out a series of policy recommendations for the Commission and other stakeholders to improve the overall quality and efficiency of health services through e-Health. The responsibilities foreseen for the Commission, as set out in the study, include:

- Fostering the sharing of specific best practice, for the design of value-creating and sustainable business models for eHealth systems.
- Defining benchmarking parameters to ensure that individual organisations are able to monitor and compare the way that they develop and implement business models for e-Health.
- Supporting the development of best practice for funding and financing individual e-Health systems, via specific incentives such as tax breaks and/or different reimbursement procedures or co-funding mechanisms.
- Bringing legal clarity to facilitate the identification and authorization of professional health staff accessing and using personal health data. The safe exchange of medical data across national borders must be ensured. The need to protect health data and the personal integrity of the patient as well as the rights of patients to give their consent to the use of their medical data must be respected.
- Working towards the solution of technical issues and the facilitation of market developments via interoperability, common medical terminologies and technical standards as well as pre-procurement activities.

**Next steps**

The Commission is currently evaluating the functioning of the current e-Health Action Plan. Proposals on reform are likely to emerge in the autumn, linked to the launch of the Commission’s Digital Agenda under the stewardship of Neelie Kroes, Commissioner for Competition.

The likely structure of the next e-Health is still in the early stages of development. Of greatest concern at present are: (i) interoperability issues; (ii) cost (in an age of austerity); and (iii) privacy issues. Of these three issues, privacy has already been raised by the Health (ENVI) Committee as an issue of particular concern, not just as its relates to e-Health but also more widely, *e.g.* travel documents, airline manifests, etc.
Appendix I: extract from EERC report December 2006

Title: Community Framework for safe and efficient health services
Nature of proposal: Communication
Expected date of proposal: June 2007

Background
Health systems across the EU are becoming more interconnected, due to a movement of patients and professionals, common public expectations across Europe, and the dissemination of new medical technologies. A Commission High Level Group on health care currently brings together national experts at a practical level. However, there is a lack of clarity over what EU law means for health services. Attempts to clarify this situation within the Services Directive failed (2004). The Commission agreed to develop a framework to establish legal certainty in the area of cross border health care and to reinforce co-operation between Member States. The Commission is currently consulting on this issue (closing date, 31 January 2007).

Details of proposal
The objective of the proposal is to establish a Community framework for health services across the EU that addresses the legal obstacles to cross-border healthcare. Although the consultation is ongoing, possible options already identified include:

- reinforcing co-operation through the existing High Level Group;
- maximising use of financial instruments (such as the structural funds) to develop proper structures;
- developing non-binding standards at EU level (e.g. charter of patients’ rights, guidelines for patients & providers of cross-border healthcare);
- a framework directive on safe and efficient health services providing clarity over the application of Community law to health services;
- a regulation providing a direct framework for health services at Community level (to complement to the existing regulations on the co-ordination of social security schemes).

Impact on Scotland
Following the recent European Court of Justice ruling against the NHS (May 2006), patients facing ‘undue delay’ in their treatment can pay for treatment in another EU state and recoup the costs from the NHS. This followed an earlier judgment (Jul 2001) in which it was decided that health care is subject to the same EU laws as other services, even when funded by the public purse. A framework will bring greater certainty to NHS Scotland.

Opportunities for engagement
The June Communication will provide the information for a debate that will continue into 2008. The issue is controversial and each of the possible policy options has proponents and detractors. This issue would lend itself well to a reporter-led inquiry, given that there are a number of potential policy options. It would also benefit from awareness of the broader European experience, i.e. how are other countries likely to address this issue. It is likely also that the issue will be considered by Internal Market Committee of the European Parliament, to which the opinion of the Scottish Parliament should be directed.
Appendix II: extract from EERC report December 2006

Title: A European Union Strategy on Diet, Physical Activity and Health  
Nature of proposal: White Paper  
Expected date of proposal: April 2007

Background
The Scottish diet is generally recognised as poor. It is high in fat and low in fruit and vegetables. Scotland’s poor eating habits are a significant factor in many premature deaths. The Scottish Executive has begun to address this problem with the First Minster launching a ‘healthy eating campaign’ as part of a long-term commitment to change Scotland’s diet. An initial investment of £1.42m has financed an advertising campaign aimed at persuading Scots to choose a healthier lifestyle.

Poor diet and lack of exercise are responsible for a significant number of health problems across the EU (e.g. obesity, heart disease, type-2 diabetes, hypertension, and cancer). While health is an issue primarily reserved to Member States, there are a number of EU-level competences that can influence lifestyle; food labelling, food production and agriculture, consumer policy, internal market, transport policy, etc. In this context, the Commission launched a Green Paper on diet and physical activity (2005).

Details of proposal
The White Paper will set out a series of strategic Community level actions aimed at promoting healthier diet and physical activity, and at reversing current obesity trends. The paper will also set out a framework for Member State action to facilitate information sharing. The strategy will build on existing mechanisms such as the EU Platform for Diet and Physical Activity which promotes exchange and coordination between stakeholders.

The White Paper will seek to bring coherence to existing Community policies from an obesity perspective as well as introduce innovative approaches to exploit channels not normally responsive or reachable using traditional methods (e.g. new forms of partnerships at grass roots level, new approaches to private actors willing to support the nutrition/physical activity agenda). In addition, regulation is likely to be proposed in the form of new nutrition labelling, restrictions on advertising to children etc.

Opportunities for engagement
The Commission White Paper will be launched in April. Although there is unlikely to be time to comment on the paper itself, the initiatives outlined therein, which will be expanded and developed over the following 18 months, will provide an opportunity for engagement. There are a several ways that the EERC can contribute to this issue. The hosting of a stakeholder seminar to discuss the Scottish experience, and possible good practice, based around some of the initiatives in the paper could be valuable. Establishing how the Scottish Executive are engaging with the Commission would also be useful.