OFFICIAL REPORT
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Health and Sport Committee

Tuesday 7 November 2017

Session 5

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Pàrlamaid na h-Alba

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HEALTH AND SPORT COMMITTEE
25th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
Maree Todd (Highlands and Islands) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Graham Gault (Scottish Government)
Geoff Huggins (Scottish Government)
Shona Robison (Cabinet Secretary for Health and Sport)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 7 November 2017

[The Convener opened the meeting at 11:02]

Technology and Innovation in Health and Social Care

The Convener (Neil Findlay): Good morning. Welcome to the 25th meeting of the Health and Sport Committee in 2017. I ask everyone in the room to ensure that their mobile phones are on silent. It is acceptable to use mobile devices for social media, but please do not photograph or record proceedings.

The first item on our agenda is a final evidence session on technology and innovation in health and social care. I welcome to the committee Shona Robison, Cabinet Secretary for Health and Sport; Geoff Huggins, director for health and social care integration; and Graham Gault, general manager, information and communication technology, NHS Dumfries and Galloway, and head of e-health at the Scottish Government. I invite the cabinet secretary to make an opening statement.

The Cabinet Secretary for Health and Sport (Shona Robison): Thanks, convener. I welcome the very timely focus of this inquiry as we develop our new digital health and care strategy jointly with the Convention of Scottish Local Authorities. For many years our health and care system has been underpinned by information technology. There are very few aspects of care that do not involve at some point the use of electronic tools, whether it is to capture patient information for clinical decision making, to enable communication between professionals or to record data for vitally important research, our existing e-health strategies and investment over the years have resulted in every clinical or care professional requiring and using ICT to do their jobs effectively in a modern healthcare setting.

However, very little of what I have just listed is to do with how patients engage with the health service or manage their conditions remotely. In virtually every other industry, digital has transformed the customer experience. In a relatively short time, we have gone from, for example, watching someone else book our holidays at a travel agent to having a vast array of choice and control over what and how we book online. Not only that, thanks to advances in mobile technology, we can do so from the comfort of our own homes or at a time and place convenient to us wherever we may be. The evidence that this committee has received and heard, along with the extensive feedback that we have received through our own engagement, suggests a growing expectation for the same sort of flexibility, choice and control in health and social care, underpinned by effective core infrastructure across Scotland.

It is with that in mind that we shaped our draft vision for the new digital health and social care strategy around the individual, and I am pleased that it has been well received by your correspondents. Previous e-health strategies largely delivered the infrastructure that was required to deliver safe and effective care within the national health service, but our new strategy is shaping up to develop and deliver the infrastructure, tools and products that will now be required to underpin the radical transformation across health and social care that this Parliament has supported. Our new focus on digital health and care in the round will lead to greater information sharing across health and social care. It will enable people to take greater care of their health and wellbeing. It will lead to the shifting of the balance of care out of hospital and into the community and it will lead to greater remote working for staff and remote access to services for the patients.

Fundamentally, our new strategy will equip our health and care services with the tools that are needed to deliver a transformation into 21st century place-based care. In doing so, it will build on the excellent work that has been progressed over the past decade. We have successively rolled out mainstream telecare within social care. The emergency care summary provides a vital electronic summary of everyone's general practitioner records for out-of-hours care across Scotland. The number of remote interactions that are handled by NHS 24 continues to grow every year. Every secondary clinician in the west of Scotland can access a single clinical portal, and there are excellent examples of clinical portals everywhere in Scotland. Some services are routinely delivered via videoconferencing, including vital lifesaving stroke thrombolysis delivered over the national VC network. Primary care records are now entirely digital and we are well on our way to digitising all secondary care records. We have established a number of innovation centres, including one with a specific focus on digital health and care. Almost all referrals for primary care are electronic. Our renal and Scottish care information—diabetes collaboration project systems are recognised as world leading and we are starting to develop scalable approaches to remote monitoring and remote management of long-term conditions. We have an NHS-wide email system allowing for instant communication across staff teams.

That goes some way in highlighting the scale of what has been achieved over the past decade. Those are all essential systems and approaches that require continued development in use. It also provides an indication of the scale of the challenge that we face in shifting our focus and tools for our citizens. Furthermore, as the WannaCry ransomware attack highlighted, the sheer volume of devices and systems that are now connected to the internet presents a challenge in and of itself. Our new strategy has to balance the need for continually innovating and developing approaches to the delivery of care with the pressing safety issue of ensuring that our existing infrastructure remains secure and fit for purpose. In order to achieve that, we will set out an implementation plan and an infrastructure plan to accompany our strategy.

Finally, there are some good global exemplars of some of the individual digital solutions that are in use, including here in Scotland and in countries such as Finland and Estonia, which the committee has heard about. Every healthcare institution in the world now needs to manage the change in emphasis from a 1990s IT-focused approach to a 2020s digital citizen-focused approach. I look forward to discussing that with you in more detail.

The Convener: Thanks very much for that. Before we move to questions, I note that we have received apologies from Maree Todd. Could I ask members to declare any interests that they have? I will begin by declaring that a close family member works in the health IT sector.

Brian Whittle (South Scotland) (Con): I remind everybody that I am a director of a collaboration and communication platform across sectors that include healthcare. I do not take any remuneration from that post.

Miles Briggs (Lothian) (Con): Good morning to the panel. I cannot speak for the whole committee but, from the evidence that we have heard, it seems to me that clinicians are frustrated that changes in technology and the way of harnessing some of the technology, which could transform the way we deliver healthcare, are not happening. The clinicians we have seen have been quite clear about their frustration and about the missed opportunities. What is the Government's vision on this? You mentioned the approaches that are taken in Estonia and Finland; is that where you see Scotland going? Do you think that resources have to be allocated to achieve that?

Shona Robison: I get the frustration in that we all want things to have happened yesterday rather than tomorrow, but the scale of what we are trying to achieve is huge. In my opening remarks, I tried to lay out some of the successes that there have been and the progress that has been made, but I do not for a second claim that the job is done. In our new strategy, we are laying out that the focus is very much on the service user and the end user and their interaction with health and care services. We have spent a lot of money and time building up the infrastructure and I have laid out some of the successes that there have been in doing that. There has been a huge overhaul of the infrastructure in general practice—Graham Gault can say a little bit more about that if you want more detail, but we have talked about that at the committee before.

As the strategy lays out, the focus will now be on taking a huge step forward into supporting our service users in health and care services to interact more readily and make use of not just their own data but their interactions with health and care, such as an out-patient appointment that is delivered through a remote system. We have had quite a lot of success with the roll-out of that. I think that there are about 2,000 users of attend anywhere video consultations. That is a big shift in the way in which very simple interaction happens, but it saves a huge amount of time for not just the consultant but the patient who might not have to do a five or six-hour round trip for that appointment. That is one example but the focus is very much on that interaction rather than the infrastructure.

We have a lot of the infrastructure in place and are putting the rest of the infrastructure in place, particularly in primary care, but the focus is on that end user and how we make it easier for people to interact with our health and care services and on the point that Miles Briggs made about the clinicians' use of the system and making sure that we drive the most efficient, effective use for them as well.

Miles Briggs: Mr Gault, do you want to mention your work?

Graham Gault (Scottish Government): To add to the cabinet secretary's response, there are a lot of frustrations in clinical areas. I do not think that we are going to sit and apologise for not trying to keep up with the latest innovative state-of-the-art gadgetry, because that brings with it a whole bundle of management around security, risk and information governance. It is common practice for people to say, "Well, if I could just do this quickly—I have an app that can do this and I can do it on a very small scale," but, although we are very conscious of trying to embrace that world, at the same time we are trying manage all the digital assets that we are building in Scotland.

Geoff Huggins (Scottish Government): There are a couple of ideas that are probably fairly central to what I think will be in the strategy. The first is the idea that we have a common platform across Scotland. At the moment, if you have an idea or an innovation, you have to customise it 14

or 17 times to interact with the existing systems. The idea of a single platform is pivotal. The second key idea—and it was very much at the front of what the cabinet secretary said in her opening remarks—is that digital is not a separate thing; it is how we do things. In things such as the modern out-patient work, the work that we are doing on elective care more generally or the work that we are doing on unscheduled care, it needs to be built into the thinking about how we are designing and planning services. It is not something that we do afterwards. That is a key shift in where digital fits in. Those two ideas are central to getting clinicians more front and centre on the style and nature of innovation that they want.

Miles Briggs: An aspect that was pressed home to us was the need for a once-for-Scotland approach, because, from the perspective of the individual patient, the fact that they have to tell that information constantly to different professionals does not seem to be changing. Do you think that you have heard that message and that that is being changed?

11:15

Shona Robison: As Geoff Huggins just said, we need to move away from doing things 14 or—if we include the national boards—22 times. We need to move from board-level implementation towards a once-for-Scotland national system. We are looking at how we do that and the implementation plan will set that out, but it may require the Government to do more from a strategic point of view, and that may mean that we hold more of the resources in order to be able to do that on a once-for-Scotland approach. We are discussing that with NHS chief executives, who agree that there are certain aspects of taking this forward that are better done at a national level and done once. There will still need to be resources flowing to boards for some infrastructure and making sure we have the training and personnel in place. That is a critical part of this.

Without a doubt, we have already heard that message and learned some of the lessons about that. As Geoff Huggins also said, the fact that this is going to be built in as a key part of every transformation that we make means that every transformation will be a Scotland-wide transformation. The modern out-patient changes and the new model of primary care, for example, are Scotland-wide reforms and transformations and it is quite right and proper that we do things in a consistent way. Of course, there are economies of scale in that as well, which are important. The short answer is yes, and we will be laying that out very clearly.

Geoff Huggins: The particular example that Miles Briggs asked about was people turning up at their GP or at accident and emergency and having to tell their story again. It is an interesting question. For many people, that is exactly the reaction—"Why do I have to keep telling my story? Why do you have to keep taking the data?"—and there is some data that can probably be held in a way that enables it to be available. At the same time, the experience that I have had of working with people in the mental health and other spaces is that quite often they are surprised that you know things about them and they are concerned. The interaction between having that functionality and protecting people's wishes as to how they want to be worked with is quite tricky and it is one of the big challenges around governance. It is not like Amazon or something like that, where you can decide simply to go to the shops. We are pretty much a monopoly supplier of health and care, so we have to find ways to interact with different people with their different expectations.

Graham Gault: It is probably worth saying that, although "once for Scotland" is a new term and it is quite a good concept for people to embrace, Scotland has been doing a lot of once-for-Scotland for many years now in the national health service. There is a single network across the entire NHS; there is a single way to refer patients between primary and secondary care; we have a single emergency care summary; and we have single business systems for payroll, human resources and time management solutions. We are already pretty far down this road. What is important now is pushing that to the coalface of where the clinicians interact with the patients. That is the exciting part of this going forward.

The Convener: Cabinet secretary, you said that primary care records are now digitised. We heard last week, I think, from one of the witnesses from a university who said that some practices do not even have wi-fi. Is that a correct and accurate statement?

Shona Robison: Yes. Graham, do you want to—

Graham Gault: Most of our patient records in general practice are already digitised. All general practices' networks allow access to those records via their local computer servers within the practices. The form that that usually takes is that all communications, all documents, all handwritten bits of paper as well as communication in and out of the practice between primary and secondary care and social care are digitised and accessible instantly when someone is presenting in front of a general practitioner.

The reference to wi-fi is different, because a lot of practices are not wi-fi enabled at this point. There are two parts to that. The first one is about

making sure that the environment is secure, but that is not a functioning part of having records digitised and accessible at point-of-care delivery. That is already pretty much taken care of.

The Convener: The submission from the Care Inspectorate says that the digitisation of primary care records is being done on a priority basis and that it is very difficult to go back historically because things are so patchy.

Graham Gault: I think that the inspectorate is probably referring to the case record that people build up over tens of years of visits to a general practitioner. It can be a relatively thick volume. However, what has been running alongside that for 12 years now is electronic processing of the exact same pieces of paper. Over that period, people have migrated from receiving, scribbling on or actioning things from paper to, as is happening now, doing everything online. However, some paper records in a practice might still be in storage and might not have been back scanned. I think that that is probably the point that is being made.

The Convener: But the Care Inspectorate says:

"Many of the acute and primary care records we scrutinised were hard copy paper records—often with handwritten entries by clinicians and other health professionals. Some hard copy patients' records were lengthy, and covered their treatment over decades from a wide range of health specialties."

That is what the Care Inspectorate is finding now. It is still finding a large number of hard-copy records.

Shona Robison: I think that there is a difference here. There is a basic patient record and a basic level of information on every patient that is in digital form, but not every bit of paper going back decades that relates to a patient will have been scanned.

The Convener: I do not think that that is what the Care Inspectorate is saying. It says:

"Many of the acute and primary care records we scrutinised were hard copy paper records".

It is not just long historic records; it says that it is seeing many records in hard-copy form. Could you look into that and come back to us with further information?

Shona Robison: We will do that.

Graham Gault: We are happy to do so.

The Convener: I am sorry—I did not intend to bring that up now. It just seemed like the right moment.

Shona Robison: We will come back to you on that.

Brian Whittle: I am interested what happens after technology is approved for use within the NHS. According to the evidence that we have heard, the issue then is rolling out and encouraging the adoption of such technology, particularly given the autonomy that individual clinicians have. We might bring technology up to date, but what is the plan to roll it out and encourage its adoption by clinicians?

Shona Robison: This is an area where the balance is going to shift to the more strategic, once-for-Scotland approach that we have just been talking about. The things that we agree need to be done—and need to be done everywhere—will be done through a once-for-Scotland approach, and we will ensure that they are done well and done everywhere. We might still have innovation and we might still test the water in other aspects, but the core and absolutely essential things that need to be done everywhere will be done on a consistent basis. That is essentially where the balance will lie; there will be a shift to a more national strategic role.

Graham Gault: The Government is looking to fund a different approach to clinical leadership in this area. For example, we are looking to appoint a chief clinical information officer who will be the pinnacle of how we disseminate standard practice and try to get this once-for-Scotland approach deployed in a truly once-for-Scotland way. In support of that, we are appointing five new staff to go into a digital academy, and all four nations are contributing financially to allow that energy to be used.

I think that the issue that Brian Whittle has raised is a real one; at times, we allow too much variation, and now is the time to put in place our once-for-Scotland approach and try to improve standardisation.

Brian Whittle: Do you envisage giving clinicians time in their working day to learn about innovation and technology in order to encourage their adoption?

Shona Robison: Everybody has a basic level of expertise, because they all interact in some way or other with electronic digital systems. Of course, the roll-out of any new system brings with it a training requirement for those that are using it. I would point out, though, the huge amount of time being saved by the secondary care clinicians in the west of Scotland who are accessing a single clinical portal, because of their ability to access remotely test results and so on. It is well worth while investing up front in time to enable those clinicians to do that sort of thing, given the huge amount of time that they gain through easier access.

Geoff Huggins: We also need to think about how we take the change process forward. What we have done historically has been to make

changes to service design and delivery in one space—quite often through Healthcare Improvement Scotland—and provide support for changes in tech in another. These things really need to be brought together, because they need to be part of the workflow.

Another big ambition is to increase automation to ensure that people take less time over data transcription and entry and thereby get more time back as part of the process. That is one of the things that we always hear about but which we do not always get, and a clear objective is to see that as part of the process so that people get that time back.

There is a real design component to this, because people will engage with technology if they believe that doing so will give value. At the moment, however, a lot of people feel that it does not, and they see it as an additional task over and above what they have to do. Until this becomes part of clinical care and until people see a return on their engagement with technology, doing this sort of thing will always be hard. Again, it is part of the change that we have to make.

Shona Robison: Perhaps the reason why the west of Scotland approach has worked so well is that clinicians talked to each other about the benefits of it. It took on a momentum of its own and everybody wanted to be part of it.

Brian Whittle: A couple of weeks ago, we heard about an NHS trust that adopted quite simple technology and bought a vast number of the instruments in question. However, the clinicians kept the old technology, because that is what they were used to and, as you have said, they did not feel that the new instruments would be beneficial. How do you overcome that sort of inertia?

Shona Robison: There has to be clinical buy-in. Clinicians have to see the purpose and benefit for themselves and their patients. There is clinical involvement in all of these innovations to make sure that they are right, because if that does not happen, there is a dislocation between what is happening at the coalface and the use of that technology.

Clinicians are therefore very much involved in this work, and clinical leadership in taking it forward, rolling it out and scaling it up is hugely important, because clinicians are the best advocates for change. Ultimately, that will be critical. The modern out-patient programme is a good example of that, because clinicians, particularly those in the Highlands and Islands, understand the purpose of technology that allows them to have straightforward and simple interactions with patients in an outpatient context. It is a bit of a no-brainer.

Geoff Huggins: You have to make this sort of thing easy to do and give the impression that the technology will offer better care. I imagine that the clinicians who have talked to you about this are probably not going down to the high street to book their holidays anymore, and they are probably buying most of their books online. They have made the switch in those areas; they are not saying, “I want to keep the ability to speak to someone at a desk who will book my holiday for me.” This is a problem of design and of making the benefits clear, and a lot of that comes back to how we take this change forward.

The Convener: You mentioned the appointment of the CCIO. A number of the submissions have pointed out that there is no named, accountable body or person for scaling up and implementing new and successful innovation and technology. Is that what this CCIO is going to be accountable for? Is there now, so to speak, a named person with whom the responsibility will ultimately lie, or are we still going to have this crowded field with all the health boards, all the integration joint boards and everybody else involved?

11:30

Shona Robison: The field is crowded, and that is something that will need to be fully resolved by simplifying the governance and accountability structure. That is happening, and it will happen. The chief clinical information officer will be, if you like, at the pinnacle of driving these changes forward; they will play a strategic role in driving the strategy forward and making sure that there is pace to its delivery. The governance structure will obviously contain linkages to boards and IJBs to make sure that all of this happens, but the leadership role is going to be critical. It will also be important for me to have as a single point of contact the person who will head up driving all this forward and ensuring that there is pace to delivery.

Geoff Huggins: The CCIO role has to be seen as a package that includes not only technical knowledge and expertise but appropriate governance of the system at a national level with regard to interoperability and data standards and overall oversight of the architecture. It might be part of the process of rolling innovation forward, but we must remember that not all innovation is about IT; some of it relates to other products—say, a new type of scalpel—that do not come into exactly the same space. Again, we have recognised the need for appropriate governance to allow the quick and safe adoption of technologies in this space. I think that you are going to see quite a change in overall governance and how this is taken forward.

Alex Cole-Hamilton (Edinburgh Western) (LD): I do not for a minute doubt the integrity of

your vision for the deployment of tech and innovation in the health service. My sense of it, however, is that it seems to be happening at different rates and that although, in some fields, we are racing ahead to great effect and with great impact, other aspects of the health service are still stuck and are dragging along behind. The greatest sense of that came from GPs, who made representation to us about individual practice software sometimes being still stuck on operating systems that are 15 years old.

Last week, we heard a quite eloquent representation about a GP who is, while prescribing, literally having to wait for the hourglass on his computer to tick round before he can access patient records or prescribing software. We interrogated that and learned that it is not the fault of the GP practice, as the software was brought in by the health board. How does the Government—and how do we, as a Parliament—put that right? It strikes me that that is having an impact not just on patient experience but on GP morale, throughput and the time taken at appointments.

Shona Robison: You are right in saying that things have happened at different rates and paces. I would have been surprised if that had not been the case, given that some things are harder to do than others. Given the extent of the primary care estate and the GP estate, there are a lot of sites in a lot of different areas and some of those face more connectivity challenges than others. Nevertheless, it has been a priority for us. Graham Gault can lay out some of the detail of the procurement that has just taken place around the GP IT systems, which will make a huge difference.

Graham Gault: What you have observed is correct. We are doing a number of things. First and foremost, the technology layer delivering general practice software is changing and it is now all web based. As you probably know, that means much less reliance on local processing and local hardware—it is all done remotely.

To support that, an upgrade to the Scotland-wide area network, which every general practitioner is connected to, is being implemented, and that has minimum upgrades and download speeds. That is another big improvement opportunity.

There is no doubt that, in the extreme areas where GP services are delivered, such as in very rural Scotland, there are challenges with infrastructure and even getting signals at very basic transmission rates. There will be an on-going challenge in that area, but everything that we are doing regarding infrastructure for general practice is aimed at making radical, centralised improvements.

Shona Robison: The commitment to broadband will also help us to ensure that the connectivity in those more rural areas is improved, which will have a huge knock-on effect on health and care.

Geoff Huggins: We have recognised that, if we move to a new type of architecture, quite an extensive transition will have to be made from the legacy systems. We have asked the expert panel, which is chaired by David Bates from Harvard University's school of public health, to advise us on prioritisation within that, so that we do things in the best order to get the best outcome.

The other challenge that we face is that, certainly in my directorate, much of the time that is spent on digital resources is spent making what you might describe as small fixes and fixing small problems. Although we will need to do some of that, we must focus more on the big, strategic changes and the architecture that we need to create. We need to strike an important balance between things that we absolutely must do now and things that will take us to the next stage, and we are trying to make that shift through our strategy. That is the clear platform on which we can do better things—fundamental architecture things rather than lots of small fixes.

Alex Cole-Hamilton: That is gratifying to hear, and it links to my next question, which is about not the siloed mentality but the siloed nature of the IT systems that exist across the whole health service—not just in primary care but among allied health professionals and community pharmacists. We have heard, not just in this inquiry but in previous inquiries, that that is a barrier. For example, community pharmacists having incompatible software and no access to patient notes—which is a structural problem caused by the IT systems that are being used—is getting in the way of patient care and is a barrier to giving community pharmacists more of a role. I use that as an example, but there are many examples of that kind. We have heard about a system that the NHS in Greater London is using, which is described as a spinal column software platform that all the other, necessarily different, software structures that other groups are using can plug into, and via which they can share a lot more easily. How far is NHS Scotland from doing that, and is it a priority?

Shona Robison: I will make an observation and will then let my officials cover more of the detail.

The technical solution to that issue is probably not the biggest challenge. The biggest challenge is the data sharing and making sure that that is done within governance. We need to make sure that we meet all the required standards for the sharing of data between professionals who need to share it for the right purposes in order to deliver a safe

service for the patient. Those issues are absolutely critical and are being worked through. As you know, there is a huge appetite to get on with multidisciplinary working in primary care. However, in order to facilitate that, those things need to be done at a level that will enable data sharing.

Alex Cole-Hamilton: I agree with you. As a Liberal, I naturally would, because it is important to me that patients have a right to confidentiality. They need to know how their data is being used and shared. We have examples of that occurring elsewhere—it must be happening in the NHS in Greater London—and it is about getting that right. We have talked a bit about citizen ownership of health data, either through their giving their permission for the data to be shared by inputting a password in, say, a community pharmacy, or having about their person something on which their data is stored. There are solutions like that. Do we need to enact primary legislation that sets that out, or is that something that we need to adopt through a more piecemeal approach?

Shona Robison: I do not think that we want to do it piecemeal, and I do not think that there is necessarily a requirement for different legislation, although there are European Union regulations around the governance of all such information, which we all have to comply with and which are important.

The Scottish primary care information resource, which is a good example of involving patients in what their data is going to be used for, has been quite a good lesson for us. It is about transparency and making clear what the detail is going to be used for—and, importantly, what it is not going to be used for. If you were to encapsulate what people's fear would be, it is that their data is somehow going to be passed on to third parties for use. We must be absolutely clear about the purpose of sharing data and about the governance and safety of that. Most patients would expect health professionals to have enough information about them to share in order to deliver the best-quality care for them, and I think that most patients would not have an issue with that. They just want assurance that that is the purpose of sharing the information.

Geoff Huggins: At the moment, that is probably one of the most tricky areas in working through the issues of data governance. It also interacts with the different way in which we might structure data in the future. At the moment, we have hundreds of systems and we have to make choices about whether we share or do not share. If the number of systems was reduced, the question would become one of governance, access and control.

You have different questions to answer. As the cabinet secretary says, as we bring that up to national level, we would expect to have greater clarity and fewer occurrences of information being shared in one area but not in another because those areas have come to different views about what can and cannot happen.

The big question is how quickly we can move to that new style of architecture—you described it as a spine or a platform, and that is a good way of understanding it. The building blocks of such systems are in place in other industries and other businesses, but it takes time to build the architecture.

The bigger challenge will be the transition, particularly with lots of legacy systems and legacy contracts. In effect, there will be a two-part process. The first part is to build the new platform and the second is to work across the system to bring the data and the existing systems there safely on to it.

The challenge in that is illustrated by the pharmacy example that you gave. It is a really good example because, historically, we would have gone out and found 17 different solutions to the problem—one for each health board, one for the Scottish Ambulance Service and one for NHS 24. I am sure that there is another board that also uses data. We must try to solve the underlying problem by having an appropriate platform rather than just providing fixes all the time.

Shona Robison: The advice that we are getting, which Geoff Huggins referred to, is about prioritisation and the sequence in which we must do things in order to do them in the quickest, most effective way. The best brains in the world are advising us, and we are very fortunate to have them. They are advising us to start with one thing, then do something else and then do something else. That is the quickest route to getting these tricky problems resolved. It may point towards what has been done elsewhere, but we are not shy of taking on good ideas.

I do not know whether Graham Gault wants to say anything about that.

Graham Gault: There have been references to the spine in England, and there is a history to the creation of that spine. There have been some benefits—even significant steps forward—out of a lot of failures to achieve. You are referring to one of them. It is a good idea and it is on our agenda, but, as the cabinet secretary said, it is not something that we will rush towards. It is something that we will have to pace, bringing people with us.

The Convener: Thank you. A number of members want to ask questions, and we are very short on time. There is one point on information sharing that I want to raise. Last week, the information commissioner's representative said

that it is not the information commissioner that is preventing the data sharing; it is reluctance based on a bit of fear in different sectors about whether they are allowed to share information. I am not asking for a comment on that; you could perhaps comment on that in a later answer. I am trying to catch up on some time.

11:45

Colin Smyth (South Scotland) (Lab): Cabinet secretary, you mentioned in your opening comments the issue of resources and the major investment that has already taken place. However, the committee has received quite a lot of written and oral evidence expressing concern at what is being described as the limited resources that are being spent on IT. Andy Robertson of NHS National Services Scotland commented:

"We put 2 per cent of our NHS revenue into IT, but the US ... is at 6 per cent".

He went on to say:

"we have to spend more on technology and innovation in order to fund the service transformation that has to take place."—[*Official Report, Health and Sport Committee*, 3 October 2017; c 40, 41.]

Will the forthcoming e-health strategy include specific detail on what resources will be allocated to it to make sure that it is delivered?

Shona Robison: You make a fair point. People are sometimes fearful, and that fear sometimes goes beyond what the reality is. One of the issues that we are addressing is the need to be more permissive about what can be done within the existing legislation. You make a strong point there.

At the moment, the amount that is spent globally is around £257 million. In the e-health division budget, £69 million of e-health funding is allocated directly to boards; £160 million is spent on IT by individual boards themselves; and, on top of that, local government spend on IT and digital systems will take the figure further. We need to prioritise having the right spend made in the right way in the right places.

Some of the £69 million that we allocate directly to boards will have a more national strategic direction in order to get away from having 14 or 22 varieties, including the national boards. There will also be a re-prioritisation of the existing funding to ensure that we spend the right money in the right places. We will want to make sure that we have sufficient resources for any additional spend that is required for the new digital health strategy—that will be part of the budgeting process going forward, to ensure that the strategy is adequately resourced.

We are re-prioritising existing spend in order to be more effective with that and, if more spend is required to deliver the strategy, we will set that out as part of the budget process.

Colin Smyth: As well as specifying what additional resources will be provided, will the e-strategy include specific details of objectives and evaluation? I think that that came from the written evidence from NHS Dumfries and Galloway. Graham Gault talked about the need to make the provision of clear evidence of positive outcomes and benefits mandatory. Will there be specific outcomes within the strategy? How will those be measured and evaluated?

Shona Robison: Yes, they will be measured. I am a firm believer in having milestones. We do not start off by saying, "We're going to go from there to there, and we'll see if we get there in five or 10 years' time". We need to plot a course and have milestones—where we expect to be in a year's time in terms of infrastructure, systems and governance—and to plot a course based on very clear milestones and the outcomes that we expect to achieve along the way.

Graham Gault is closer to the detail.

Graham Gault: To extrapolate the idea, have we spent money in the past as efficiently as we could have? The answer to that question may be no, but that was done purposely. We have pushed money out to health boards—that was our plan seven years ago, when we did that—and it is about health boards maturing. A decade ago, there was a lot of immaturity in their IT delivery. That allowed the boards to cluster and get their own environments up to a certain level. That was what the last look back delivered.

What about the situation going forward? As the cabinet secretary has said, if we now have a level playing field and people are able to embrace new ways of working, the spend profile should be more efficient notwithstanding the challenges that we have in the area. I think that we have mentioned previously to the committee the procurement challenges that we face. The minute that we scale things up, it becomes tougher.

However, we are now able to take things forward more efficiently by doing things once, through having single contracts with software and hardware suppliers. Sharing things is certainly how we want to proceed. Measured outcomes are also essential, and we will be looking for a plan that is measurable by health board and by region to ensure that the national standards are achieved.

Colin Smyth: How will that be monitored?

Shona Robison: The new chief clinical information officer will have a role and we will have a role. I will have a role in making sure that we are delivering at pace what we have set out. I am sure

that the committee will also take a continuing interest in the matter.

The Convener: Geoff Huggins said that there will be a reporting mechanism as well.

Shona Robison: Yes.

Geoff Huggins: The intention is that there will be a national governance group, which I will chair, that will monitor implementation of the strategy according to clear milestones. As the cabinet secretary said in her opening remarks, one of the issues that you have identified in the evidence that you have taken is the absence of an implementation plan for the 2014-17 strategy. When we publish the new strategy, it will have a clear implementation plan with milestones in it for when things will happen.

In terms of the return on benefit, things that are in the space of out-patient services, unscheduled care or what happens in accident and emergency departments are more likely to sit within other strategies and with other lines of work. That takes us back to the idea of looking to embed technology as part of the normal business process rather than treat it as a separate thing. The strategy is intended to be an enabler and a platform. It is a major undertaking in itself, but it will enable us to benefit in other areas of service delivery such as cancer care and primary care.

Shona Robison: In terms of reporting, I see no reason why we could not produce a yearly report either to the committee or to the Parliament if that would be in line with your thinking.

The Convener: I am sure that we would appreciate that.

Clare Haughey (Rutherglen) (SNP): Coming back to the issue of data sharing, the committee has had a lot of written and oral submissions on access to data; indeed, we have had some discussion about that already. One proposal that has been put forward is to give the individual ownership of their data so that they can make the decision about who to share it with. Does the panel have any comment on that?

Geoff Huggins: The starting point of the work that we do is that the individual owns their own data. However, the situation is complicated, because the NHS in some shape or form or other bodies will be the data controller. In doing the work on the patient portal in the west of Scotland, we face a challenge in that owning your data does not give you a lot of value. It does not give you use value of your data; in other words, you are not able to interact with it, and you are not able to use it meaningfully.

We think, therefore, that one of the key components of transformation is not only putting the person front and centre in the strategy but prioritising the use value of data for individuals, because once people are able to use their data, they will manage their health in a different way. Indeed, that has been the experience in all other areas. We therefore agree with the proposition that you have highlighted.

We have already had some conversation about this, but such an approach brings in issues of consent, management and control and the need to understand that different people have different expectations in that space. We are becoming increasingly familiar with that sort of thing. For example, if I go on to the Scottish Parliament website after a certain period of not being on it, I will get asked whether I will accept cookies. In other words, do I allow some of my personal data to be shared with the server somewhere in this building? I then get the chance to say yes or no. We are increasingly literate about these issues, and we need to build those kinds of simple systems to enable people to give consent to how their data can be used. We welcome many of the responses that you have had on that issue, and we think that they are part of the way forward.

Clare Haughey: Earlier on, Alex Cole-Hamilton talked about community pharmacies and interacting with data at GP practices. An issue that has been raised, certainly in my constituency, is the added value that community pharmacies could bring to patients who presented there if they were able to access this data. At the moment, GPs are the data controllers; indeed, you have just mentioned the term. Have you given any thought to changing that position?

Graham Gault: What has been referred to with regard to community pharmacists has been access to emergency care summary data; that is the extract from GP systems that relates mostly to medication, and it goes hand in hand with pharmacy work. The logic and governance behind the emergency care summary and what it was designed for are in conflict with its use case—its potential—at the moment, but the important point is that the emergency care summary was designed for emergency and secondary care. We have pushed that boundary a little bit further in clinical portals to make that information available not only throughout secondary care but to individual pharmacies and independent contractors. As the data controllers, GPs have expressed major concerns about that move, but we are working through that with them, and I think—I hope—that it is also part of the discussions on the new GP contract that is to be announced imminently.

The landscape is positive, because I think everyone recognises the value of and the need for this. It is just that how we have set this up and what we have done in the past mean that rolling it

out willy-nilly to everybody is not quite straightforward.

Shona Robison: We are pretty confident of a sensible resolution to the issue.

Ivan McKee (Glasgow Provan) (SNP): I realise that you covered some of this in your response to Colin Smyth a moment ago, but clearly, we are putting this IT in place not only to improve patient experience and services, but because to make things more efficient. In earlier evidence, we heard some examples of other countries where savings had been made, but have you taken a view on the potential for making cost savings—or perhaps it is better to talk about freeing up resources to be put into more effective directions—from people are not having to spend all their time double and triple-keying stuff and being able to treat patients instead? That would mean not having to solve some of the resource issues that we have and would lead to other efficiency gains. Do you have a macro view of that? What kind of mechanism do you have for tracking that at a more micro level?

Shona Robison: That sort of thing will be built into each transformation outcome. With the modern out-patients programme, the saving is time. For example, a huge amount of time can be saved if return appointments can be delivered through the telephone, in particular, or through videoconference interaction with a consultant. Given the pressure that we know is on the system with the increasing demand for out-patient appointments, we need to reform interaction with patients, ensuring, of course, that it happens in a safe way—after all, safety comes first. A six, seven and eight-hour round-trip for a routine return appointment is not good for the patient, without a doubt, but clinicians, too, would be able to spend their time better and see more patients who needed face-to-face contact. I think that, for those who could have a phone or VC consultation, that sort of thing will become routine.

That is one example of one change that can be made through technology. You can put a number on that, and the modern out-patient programme outlines the efficiency gains that can be made for the system. If we can get this right, we can multiply that by 1,000 or even 100,000. It is absolutely about delivering a more efficient system, but for the purpose of being able to reinvest that time in better patient care.

12:00

Geoff Huggins: We will also be able to do different things. We will not only be able to run the existing system more efficiently, but do things that we currently cannot do. Part of the challenge is to get to a place where we enable people to manage their own care directly, make choices about their lifestyle and how they engage, understand better how to manage their condition with feedback from monitoring in the house, stay in contact with friends and family and avoid isolation and loneliness. If we can do those things, we will be delivering a different health and care service.

It is not that straightforward to make a simple comparison. The advice of John Halamka, one of our expert advisers—and also one of Obama's advisers at Harvard—is that we should not presume that we will make a cash saving from this. We will probably not, but we will be able to do different things better. We will give time back to people; we will take a lot of the hassle out of the system by not having people, say, enter information into different systems or doing other things that wind them up; and we will empower people to do better. Most of the gains are going to be in that quality space. After all, people who use Amazon buy more books. We will see other changes in what happens, and we will see all this interacting in different ways with people's engagement with healthcare systems. I am sorry, but I think that it is very reductive just to focus on whether we are going to save money.

Ivan McKee: Indeed. I said at the start that the patient experience will improve, and I understand that you will move to a different dynamic in which things are done differently.

At the end of the day, though, time is money; if you make consultants 10 or 20 per cent more efficient, they will be able to see more patients or whatever, which means that, at the other end, we will not have waiting lists or feel to the same extent the pressure to hire more practitioners. You cannot get away from the fact that there has to be a pay-off there. Frankly, I think that, if you do not have a view on that, it will be hard to quantify how successful you have been.

Shona Robison: We have such a view, and we have expectations of what would be delivered. Let me take, again, the example of the multidisciplinary team and the support that pharmacists are providing to general practice. A GP could save two hours a day by having the pharmacist do the medicine reconciliation. Frankly, the GP probably finds it very frustrating to have to do all that at the end of the day, so if someone else with the skills can do that, it has a benefit and gain. If a GP can gain anything up to two hours a day, it does not take a lot to imagine the huge knock-on effect that that might have, either in their ability to see more patients or in matters of recruitment and retention.

We are working through the efficiency gain from that, and there will be a projected number somewhere at the end of all that work, but everybody knows that there is a gain and a prize to be had, potentially over a fairly short period.

That is the sort of territory we are in. This is not theoretical at all; it is all for the purpose of coping with continuing demands on a system that needs these efficiency gains to ensure that it keeps providing the same quality of care.

Alison Johnstone (Lothian) (Green): Alzheimer Scotland and the Mental Health Foundation have emphasised the importance of staff skills and training to ensure that we make the most of digital technology and that these new interventions are used as effectively as possible, but other submissions have commented on a shortage of digital skills in this country. What importance will the strategy place on ensuring that staff are trained properly? How are we going to ensure that staff, who are already very busy and pressured, have the time to undertake that training? What steps are you taking to address any skills shortage?

Shona Robison: You make an important point: there is no point in putting the technology or the systems in place if people are not trained to use them. A sub-group called the digitally enabled workforce group is looking to ensure that we know what the current skill level is and what additional skills and training are needed, and ensuring that that work is done as part of any transformation. As Geoff Huggins has said a few times—and it is a point worth emphasising again—this is not an add-on; you do not put everything in place and then say to people, "Here's your one-day course on this." That sort of thing has to be built into the changes to the way in which things are done, whether in primary care or in out-patient procedures, and it has to be on-going. It cannot just be a one-off.

Graham Gault: The key point is that, as the cabinet secretary has said, if you get the product correct, its consumption becomes easier. It is the same with iPhones; no one showed us how to use them, and we did not go through any formal training for them. It is all about finding the correct solutions. NHS Education for Scotland has a very interesting role to play in this, and it has already set up some of the groups that the cabinet secretary has referred to and is looking to explore new ways of enabling the workforce. It is early days but the issue is certainly high in our thoughts at the moment.

Alison Johnstone: Can you give me any specific information about the skills shortage that has been raised in a few submissions? Do you agree that there is a skills shortage and, if so, is specific action being taken to address it?

Shona Robison: There are two aspects here, the first of which is the specific technical skills required to deliver the clever stuff. There is huge competition in private industry and the public sector for those skills, and we have to make sure that we can get those people. The second aspect is the skills of the workforce that is going to use the technology. The two things are different.

Graham Gault: We face a number of challenges, but we see standardisation and doing things together as health boards as a key way of getting through them. We do not have an abundance of highly articulate, educated, experienced staff in Scotland. This is about health boards training people up and, indeed, about investing in our own staff, which is a big part of the discussion among the health leads. It is a fundamental issue, because, although ours is now an IT-driven business and industry, what we do is still pretty specific to health. We are not working in some general widget-processing environment; we need to bring our end users with us. They design the systems, and we work with them on that. Building that skill set is already well under way in the way that we are embracing our staff and supporting them in becoming the champions of the future.

Brian Whittle: A lot of the systems and platforms that we work with are older ones that have been upgraded by bolting on a lot of software, but, inevitably, that can cause a system's integrity to decline. As the cabinet secretary suggested earlier, the problem here is not building the architecture. Are you confident that the architecture of the current system has the scalability to deliver the Government's initiatives, or are we looking at having to deliver a new system?

Graham Gault: There are some fundamental systems that are national; a good example of that is the national community health index, which is on a mainframe computer that is, I think, 23 years old. That might sound to the man in the street like something you would not want to use, but it has worked without fail for 23 years. It has never been offline, and it delivers a robust platform that allows us to deliver care safely and effectively by offering unique numbers on every interface of healthcare. The issue is not how old these things are, but how interoperable they are. The reason why the CHI is being reformed is not so much that we do not think that it can carry on doing what it does very, very well; it is more about its interoperability. It is just not as flexible as we foresee that it will need to be in the future.

To support innovation, we need to build and enhance application programming interfaces that allow small businesses to interface with the NHS so that we can maximise the investment from the economic side of Scotland for some of the great ideas that those small businesses come up with. As I have said, the most important issue is not the age of the infrastructure, but how interoperable things are. For the past half a dozen years, a key

plank in everything that we have done is standardising things—having sharing and interoperability and putting in place standards that allow us to do that in the future.

Geoff Huggins: However, as we develop these things—certainly the reformed CHI—what we want is a product that gives us significantly more than we had previously. For example, it will give us indexing and other services that enable us to do more. You should also expect to see more activity in health and care to be based in the cloud rather than in physical systems. That will be quite a transition. Although there is an existing architecture and although we will take many elements of it into the new system, we will need a new architecture in order to put this platform in place. That will require not a single big IT project, but a number of small projects, all of which will work together.

Things are different now from how they were 15 years ago when people went out and bought big mainframes. Now you buy services. You do not buy kit, and you do not buy product; instead, you buy products. Getting the sort of capability that we want for the future will require quite a change. Some elements of that are already in the primary care modernisation programme; for example, through CHI, we have single identifiers that operate not just across health but across health and care. The issue is also how you tie all this together with, say, a single log-on or sign-on so you do not have to sign on to 27 different systems and have to remember 30 different passwords. These things are about enabling you to interact with the system, and they go beyond simply preserving what we have. As I have said, it is quite a change.

The Convener: I feel your pain. I recently got a password manager to manage all my passwords, and then I forgot the password for the password manager.

I have a final question, which is on health inequalities. Given that, in Scotland, there is quite significant digital and IT inequality in communities, will going down this route exacerbate or narrow health inequality?

Shona Robison: We want to narrow inequality. We must make sure that we take that issue on board, particularly when we look at how patients interact with the systems. We need to ensure that this is not just for young folk with smartphones; it has to be for everybody. I am sure that Geoff Huggins agrees that we are very mindful of making sure that there is equality of access and that people are able to use their own data.

Geoff Huggins: I am glad that you think of me as one of the young folk, cabinet secretary.

Shona Robison: It is just that I was looking at you when I said that. [*Laughter*.]

Geoff Huggins: I think that the work with regard to the social security agency is really good in this respect, in that those involved are looking to put in place highly digitally-enabled services on the understanding that such an approach will not work for everyone. They are thinking about having navigators and people to support those going through the social security process who might not have that degree of literacy or are not that comfortable with such things.

The Convener: I might not have chosen the social security system as an example, given the problems that people are experiencing.

Geoff Huggins: I was thinking about the developments and the proposals that the Scottish Government has brought forward.

The Convener: Sorry.

Geoff Huggins: The people involved want a digital-first approach but on the understanding that that will not work for everyone.

Shona Robison: And for the very reasons that you were highlighting, convener.

Geoff Huggins: It is in the same sort of space as health. We know that there are challenges with deprivation with regard to how people interact with services at the moment, but things might change as you offer services in different ways or put in place different platforms. The fact is that people use smartphones. There are challenges for different cohorts with regard to the use of technology, but you need to be able to play all the different lines. You need to have the technology as well as face-to-face interaction.

The Convener: I thank the panel very much for attending this morning, and I suspend the meeting briefly to allow them to leave.

12:14

Meeting suspended.

12:16

On resuming—

NHS Governance

The Convener: Agenda item 2 is a chance for the committee to discuss the informal evidence session that was held this morning with NHS patients to discuss NHS clinical governance. I invite comments from members on that session.

Alex Cole-Hamilton: First, I thank the clerks for arranging the session. It is important for us to have such sessions periodically, so that we can meet patients who have had bad and good experiences of the NHS. It is important to strike a balance in hearing such perspectives, and to be proportionate.

Clare Haughey and I were with a group of patients, and their supporters, who had had very bad experiences of care in the health service. The overriding thing was a cultural problem: in some cases, procedures in hospitals are just not fleet of foot enough to deal with aspects of care that are particular to patients' needs. One gentleman had to have medication at a specific time, but because practice in the hospital was to give out medication only at medication time, he was suffering. The system was not flexible enough to accommodate his particular needs.

Similarly, there was a very concerning view from another family whom we saw, who had had almost a lifetime's worth of experience of the NHS because of the daughter's condition. They had had cause to complain several times, to the extent that the daughter had asked the parents not to complain anymore because she felt that it was impacting on her relationships with NHS staff. It is very worrying if parents or patients themselves are concerned about complaining. If they think that complaining will have a tangible negative impact on their care, we are doing something wrong.

Clare Haughey: I record my thanks to the many patients, carers and families who came along today. They were very honest with us: they shared some very difficult experiences and some very personal details about what had happened in their lives. It must have been difficult for them to come along and speak to strangers about such intimate details.

The Convener: We would all definitely agree with that.

Brian Whittle: I want to thank the two ladies who gave me evidence. The experience is very raw for them. Both their husbands died a year ago, on the same day, on the same ward, from sepsis. They were very forthcoming about their experiences, which cannot have been easy. They spoke about their understanding of serious incident reviews. Although they had not made an official complaint at the time when a serious incident review was instigated, they felt that the review was driven by them and that there was very little information coming back from the NHS.

When the report came out—such people have a year in which to make a complaint—they felt they were put under pressure to not complain. They were given the results of the report almost on the year. The report was difficult for anyone without a medical background to understand. It did not run in chronological order and there was no conclusion. Worse was that the internal report itself was quite damning about the processes. It described "missed opportunities"—the women did not like that terminology, I have to say—that led to the death of the two men.

There was then an external report that went completely against that, so there were two conflicting reports and there was no process in place to establish why. The NHS is not coming forward with any next steps. It cannot tell the ladies what recommendations have been made, who will do what, how it will be done and how it will be measured. The women also saw a report from five years ago that basically stated exactly the same recommendations, which still have not been implemented.

I believe that there is a cultural issue. For the record, it would also be quite useful to speak to the trust in question, to get it to give its side and to see how it will reconcile the two reports and take the matter forward.

The Convener: Do you mean the health board?

Brian Whittle: Yes.

Colin Smyth: Like other members, I think that it was a very good session. I thank the people who came along and gave evidence. Ivan McKee and I heard of very harrowing experiences from two patients' family members, which had very different outcomes when it came to how the health board approached them in the long term.

In one example, a family member had, after the harrowing incident, played a key role in helping to shape services in their health board, and in implementing changes to the way in which the hospital was run, which are being rolled out across the health board. From a very unpleasant and harrowing experience for a family, it was possible to deliver real change. That was a good example of a positive outcome in the long term, and it is certainly worth the committee's while to consider how that could be rolled out elsewhere.

The other case highlighted some of the cultural challenges that we face, in that patients and their families are not being listened to properly.

Ivan McKee: I want to back up what Colin Smyth said and to thank the two women, who were relatives of patients, and who came along and gave, at length, their take on the situations that they had been in. Both are working hard to drive improvement for the benefit of the health service as a whole, which I think is commendable.

One thing that came out was the need for care to be person-centred. We talk about that, but it was clear from the evidence that the women gave us that often that is not the case, and that in some ways we have a long way to go. However, as Colin Smyth said, it is very positive that concrete specific things have happened in one case in particular, which bodes well. That shows what can be done; there is significant scope to roll the improvements out across the health service in Scotland.

Alison Johnstone: The convener and I met a gentleman who was representing his family's tragic case and his experience with his NHS health board. It made for very difficult listening. He was incredibly well prepared and his notes would do a committee clerk justice: they were immaculately presented and well researched. He is someone from whom the committee—indeed, Parliament and probably the Government—could learn a lot.

Despite the emotionally difficult nature of his evidence, he taught us a lot. We learned that the way he and his family had been described by professionals—clinicians, I think, and management—was completely and utterly unacceptable. The matter should be looked into. No health board should feel challenged by questions; they should welcome them and must be in a position to answer them fully and honestly. That has been lacking in this case.

The gentleman brought up the fact that a lot of data gathering is not up to scratch. He mentioned that 11 per cent of Scottish data is illegible, so there are issues there. He also pointed out that—as I think Brian Whittle mentioned—draft data look markedly different from what was accepted and published in the final report.

I thank him very much for the evidence and information that he shared with us this morning.

Miles Briggs: Jenny Gilruth, Tom Arthur, and I met two groups who had not made specific complaints. Our experience—certainly, mine—was that because ongoing treatment is taking place, they did not want to share their negative experiences. However, as Alison Johnstone suggested, and as was highlighted in both cases, in which there are mental health concerns, the people felt that they are being blamed for part of their experience of meeting professionals, and are seen to some extent as troublemakers.

I took from that that although there is a welcome move towards a patient-focused approach in our health service, in many mental health cases the family focus needs to be a key priority for those who are putting support in place. Families feel that they have been cut out and that the care and support that they provide at home are not valued.

Finally, as this committee has consistently heard, pathways to getting to mental ill health before the situation becomes a crisis were certainly not in place.

Tom Arthur (Renfrewshire South) (SNP): I would add that the two points that Miles Briggs has made are related. If concerns had been taken seriously at an earlier stage, there could have been intervention. That opportunity was missed, which is similar to what Brian Whittle highlighted.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): I add my thanks to the individuals to whom we spoke this morning. A disconnect was highlighted in relation to accessing mental health services for children, and family members not being listened to. That issue needs to be looked at because family members are closest to the patient and are often able to flag up to the relevant professionals concerns that the affected person might not be able to flag up. The system needs to take more cognisance of the impact that families can have in sharing information, whether in the medical sector or in schools, and it needs to join information together. What we heard this morning is that information is not being shared.

Miles Briggs: Specifically in mental health services—it goes beyond this piece of work—if there had been early assessment, there could have been early intervention. What is of real concern is that despite the GP giving a huge amount of support, his referral finally resulted in the individual not being seen; instead, a letter came back saying that nothing was wrong, in which the language that was used about the family was unacceptable, and which had been written by someone whom they had never met. That needs to be pursued.

Tom Arthur: In one case, what was alarming was that there was only a substantive intervention when the individual's physical health was threatened. That could have been avoided. There was no intervention relating to the individual's mental health; the intervention was only at the stage at which her life was threatened as a consequence.

Jenny Gilruth: Also, this was a family that was seeking help: they were putting their heads above the parapet. They were asking for assistance but were being batted away, for whatever reason.

Tom Arthur: As was their GP.

The Convener: Thank you very much for that. In the case that Alison Johnstone and I heard about, there were very serious issues of governance that resulted in significant adverse events. We will speak to the committee clerks about that to ensure that we cover it. If members have issues that came up during the conversations that they think may be missed, please speak to the clerking team about them.

It was a very worthwhile session this morning and I record our thanks to the people who came. It must have been very difficult for them, given some of the circumstances that were discussed, but they eloquently put their cases, which are helpful in informing our discussions and deliberations. I ask the clerk to write to them to thank them for their efforts this morning. We now, as agreed, go into private session.

12:30

Meeting continued in private until 13:02.

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