PA Consulting is privileged to work extensively across Scotland’s health and social care system. We also work in health and social care across UK as well as in Europe and the US. Our work in digital health and care covers strategy, solution development, implementation, and digital and Agile capability building. We also deliver an award winning telecare service in Hampshire.

We have set out below our responses to the 7 questions raised by The Scottish Parliament and in the spirit of providing open and honest feedback, we have been candid in our responses. We trust this is both helpful and informative.

1. What do you consider have been the main successes of the existing Scottish Government’s eHealth and telecare/telehealth strategies and why?

The existing eHealth and telecare/telehealth strategies have established and communicated the importance of technology in Health and Social Care in Scotland. Specifically, the principles of good digital health and care are well understood, the right strategic intent has been established and there has been a great deal of activity and engagement.

From this there is clear intent to do more with digital health and care, which is well evidenced by pockets of good practice that we see across the system, a great many of which have been documented in the case studies that sit behind the draft vision.

2. What do you consider have been the main failures of the existing Scottish Government’s eHealth and telecare/telehealth strategies and why?

We have identified three areas where the health and social care system has failed to deliver on the eHealth and telecare/telehealth strategies as outlined below.

2.1. We are not getting the basics right

- There is a ‘disconnect’ between the strategies and local delivery by IJBs, Health Boards and Local Authorities. Many hospitals still use paper records; the ‘wannacry’ ransomware attack exposed extensive use of Windows XP (first released in 2001 and unsupported by Microsoft since 2014); and the system as a whole has been incredibly slow to adopt mobile devices and digital technologies.

- There is no repeatable process for bottom-up software development, COTS deployment and delivery of technology-led business change. Across health and social care there is a true mixed economy of national, regional and local implementation strategies; large scale technology programmes continue to be predisposed to failure; and very limited support is made available to staff and users to deliver the business change required to achieve the new models of care made possible by technology.

- There is very limited understanding of the outcomes or benefits being delivered by digital technology. Whilst in many instances business cases are developed in order to release funding for technology initiatives, these rarely calculate the associated cost avoidance or cash releasing savings in detail. Equally, the outcomes that result from the new technology are very rarely measured, by way of an example the Technology Enable Care Fund distributed to Local Authorities during 2016 sought to understand the number of users impacted by the technology but not the improvement in the quality and/or cost of the care being provided to the user.

2.2. Organisations are not ‘holding their own risk’
A large number of Scotland’s health and social care organisations have sought to transfer their technology risk to Systems Integrators (SIs). When things go wrong, this transfer of risk tends to be of limited value to the buyer and invariably the contract change required to resolve the issue results in additional cost.

Traditional commercial models struggle to meet the changing demands of the health and social care system. Contracting for a system or a service with a supplier is one thing, however fixed price/fixed scope contracts become problematic when commissioners are looking for innovation and to achieve new models of care, because as much depends on changing the health and social care system as it does on delivering the technology.

Multiyear contracts are tying the health and social care system into outdated technologies, for example analogue button and box telecare devices, mainframe hosted business systems and fixed physical technology infrastructure.

2.3. It feels like we are stuck in the 1990s

We are still talking about systems integrators, on premise hosting, waterfall methodologies, heavily customised COTS software and static BI Business Intelligence reports.

Meanwhile, the rest of the world has moved on. We know that we should be talking about: secure N3 connected cloud hosting services (like Amazon Web Services or Microsoft Azure which can now store patient and personal identifiable data in UK data centres); Agile software development as a means of quickly developing high quality software that focusses on business value and user experience; Software as a Service as a means of adopting best of breed off the shelf technologies and highly standardised processes and services; and Big Data to join up data-sets and generate new insights into Scotland health and social care challenges.

3. How well does the Scottish Government’s draft Digital Health and Social Care Vision 2017-2022 address the future requirements of the NHS and social care sector?

The vision is articulated as a number of user stories which are expressed from a citizen’s perspective, this is a good start, however it is worth noting that the language is still very ‘civil service’ and is therefore unlikely to resonate with the general public. Service users don’t relate to an integrated health and social care system, they relate to their interactions with the system, for example a visit to the GP, a visit from a carer or a stay in hospital, so perhaps the digital vision should focus more on these interactions?

The vision does not indicate what the health and social care system actually needs to (or is going to) do, for this reason it is difficult to have assurance that some of the issues noted in our response to Question 2 are going to be resolved.

We also found it concerning that the case studies that sit behind each user story infer that we have the answer, but actually few of these initiatives have had a system wide (scaled) impact or deliver measurably better quality and cost outcomes.

4. Do you think there are any significant omissions in the Scottish Government’s draft Digital Health and Social Care vision 2017-2022?

We do think that there are a number of omissions in the vision, specifically:

- How innovation and digital technology will enable new models of health and social care, transform the way that service users interact with services and improve the quality of the care that they receive;
• How the system will justify investment from Scottish Government and measure the resulting outcomes and benefits in order to release funding (this seems particularly important given that in real terms budgets for delivering health and care are reducing while demand is increasing);

• How the current barriers to good digital technology (procurement, information governance, digital skills and leadership etc.) will be removed; and perhaps most importantly

• How the health and social care system will capitalise on the use of digital technology and encourage citizens to engage in their own wellbeing and ‘self-care’ from a young age in order to reduce the demand placed on physical care services.

5. What key opportunities exist for the use of technology in health and social care over the next 10 years?

Rather than opportunities, we are of the view that the health and care system will have a number of critical dependencies on technology as a means of addressing reducing budgets and increasing demand over the next 10 years. We anticipate that these will include:

• Delivering better quality care for less cost;
• Introducing modern, supportable, interoperable, technologies that deliver ROI;
• Encouraging citizens to engage with technology to improve their own wellbeing and health from childhood;
• Automating transactional processes and administrative activities using Software as a Service;
• Using Artificial Intelligence to drive decision making and diagnosis;
• Increasing use of bio/med/translational technology in clinical treatment;
• Increasing use of remote/at home consultation, diagnosis, treatment and monitoring; and
• Using digital platforms as a means of disintermediating physical care services.

6. What actions are needed to improve the accessibility and sharing of the electronic patient record?

This is a difficult question to answer because logically the actions are easy to identify, however as we have learned from patient record initiatives in England and Scotland over the last 10 years, they tend to be incredibly complex to deliver.

The principles that Scottish Government and NHS Scotland have already established for the development of a Citizen Portal appear to be heading in the right direction.

In taking this work forward we would encourage Scottish Government to not only ‘hold its own risk’ but also to use a robust Agile delivery methodology as a means of ‘containing the risk’ within short iterations and therefore costs commitments in future delivery. We would also emphasise the importance of having strong leadership and governance in place and investing in the right skills and experience, in order to have assurance the work will deliver on the outcomes expected of it.

7. What are the barriers to innovation in health and social care?

There is already a great deal of innovation in health and social care and in most instances the technology that we need already exists. In our experience the challenge is in establishing the right conditions to bring the technology into service quickly, which includes:

• Having senior commitment and strong leadership to drive delivery from the top down and hold and manage the risk;
• Building the digital skills and capabilities required to deliver the and support the technologies;
• Engaging clinicians, front line staff and users throughout to ensure people and patient centred services and technologies;
• Understanding the benefits at the outset in order to secure investment and then measuring and realising them once services and technologies have been deployed; and
• Taking a proactive and pragmatic approach to information governance, tackling the issues head on and potentially our risk thresholds.