Dear Sir/Madam,

Re Health and Sport Committee - Technology and Innovation Call for Views

Thank you for allowing us the opportunity to comment on the above. Please see our thoughts below.

1. Main successes:

- Use of national systems across NHS Scotland (e.g. SCI Store, SCI Gateway, etc) ensures resources are used more efficiently and promotes standardisation and integration across NHS Scotland. Expertise held at centre, NSS, with local expertise means that resources are used most effectively.
- Data sharing between systems helps ensure that data is not entered multiple times and means that information is available to staff as and when they need it. Application of uniform standards across NHS Scotland ensures that information can be more quickly collated and analysed.
- Providing an increased number of services and systems within a reduced cost envelope, we are better at identifying priority areas for investment.
- Greater regional working and collaboration for example NHS Orkney and NHSS Trakcare hosted at NHSG, regional collaboration is becoming much more the norm, there is less silo working eHealth and IT teams across NHS Scotland collaborate formally on a monthly basis and informally on a daily basis.
- National hosting has enabled NHS Scotland to focus on systems with the hardware/software being looked after by ATOS, better clinical services to patients, the national videoconferencing service has enabled smaller Boards such as Orkney to benefit from the infrastructure and expertise held within larger NHS Boards.
- National PACS - as a remote and rural hospital we could not function without it. There have been significant problems at times and the technical management by Carestream could be better, but the fact of having a national system is vital to us. Team at NSS work very hard at managing the system and co-ordinating departments around the country.
2. Main failures:

- Vendor lock-in i.e. we are tied to contracts with large corporations e.g. Intersystem's, Carestream, etc. We have not taken the opportunity to seriously look at in-house open source development.
- There is a mixed playing field with regards to hosting of national systems, e.g. some national systems managed by NSS, others managed by individual boards (e.g. SCI DC is hosted at NHS Tayside). There has been limited progress to single instances of systems e.g. A number of NHS Boards have local Trakcare implementations
- The lack of bandwidth (fixed line and mobile) across Scotland, but particularly in Remote and Rural areas which are even more dependent on connectivity due to remoteness/ travel difficulties, is a constraint on effective working across all sectors
- eHealth is still seen as a 'cash cow' with services expecting eHealth budget to pay for their systems – both initial and ongoing.
- There needs to be clarity on ownership of systems – e.g. eHealth is still responsible for many business systems such as Payroll, eFinancials, eESS, etc – should these systems be passed to service areas?
- There could be more direction at a national level e.g. IT security, information governance where policies, procedures, etc vary between NHS Boards – scope for 'Once for Scotland'?
- Information governance presenting barriers to eHealth solutions rather than presenting opportunities for data sharing. Real need to be able to share information where this is in interests of patient care / safety rather than having to ask.

3. Omissions:

- No omissions but each area needs greater focus otherwise the message will be lost amongst all the service sectors.

4. Draft Health and Social Care Strategy:

- Strategy is high level and aspirational. There is a need for more co-ordination/information on how this will be done and what it means for Health and Social Care in the long term.
- Keen to see a matrix type approach to implementation, e.g. focus on high impact, low cost solutions much the same as in use for the primary care digital strategy.

5. Key opportunities:

- Opportunities to have single instances used across NHS Scotland hosted in secure data centres and accessible as and when required by staff.
- Streamline primary care systems on back of the re-provisioning exercise and then spring board onto a national community system. This would offer a significant opportunity to implement more seamless management of patients between primary and community care, where the majority of treatment occurs.
- Service users able to access services equitably regardless of geographical location, more treatment delivered closer to home.
- Patients and service users able to communicate more easily with health and social care staff, enabling self care.
- Increase videoconferencing so can extend the availability of group work to those who live remotely.
Being able to use patients and staff own technology (BYOD) for messaging, group texts etc.
Smart NHS Board technology in acute services being used to monitor patients virtually so can avoid crisis or prevent admission.
Improving administration and taking lag out of the system (e.g. electronic communication with patients & remote clinicians). Reducing duplication of recording of information, and improving searching and availability of information - but needs intensive work with staff who are used to the way things are to ensure they engage and systems are fit for purpose.
Break down silos.

6. Actions to improve accessibility:

There needs to be a single solution across Scotland, with universal access regardless of geographical location, demographic, etc.
Investment in training and infrastructure.

7. Barriers to innovation:

Local Authority interpretation and implementation of PSN has been a significant barrier to effective collaboration.
Service providers, both within NHS and LA have different strategies.
BAU services have to be maintained which impacts on the ability to be innovative.
Huge patient, user and service expectation.
Differing technologies, information sharing protocols, differing systems which don’t link up the various professions involved in the same patient/clients care resulting in disjointed care.
IT resources - crucially including staff who specialise in user requirements and training, and are involved at an early stage in projects, as well as technical staff. Better to have a mixture of staff from clinical and IT backgrounds. IT people who know how to listen to users, and have time to listen and communicate in flexible ways with users, and clinical people who are enthusiasts for technology and are prepared to contribute to make systems usable and promote to other colleagues.

I trust this is helpful.

Yours sincerely

Cathie Cowan
Chief Executive