COVID-19 – Framework for Decision Making

Re-mobilise, Recover, Re-design: The Framework for NHS Scotland

Mobilisation Recovery Group

Note of meeting 4

09:00-11:00, Friday 14 August, 2020

Via Cisco Webex

Members Present

Jane Anderson	National Staff Side representative, UNISON
Marion Bain	Deputy Chief Medical Officer
Andrew Buist	Chair, GP Committee, British Medical Association
John Burns	NHS Board Chief Executives' Group representative
Sandra Campbell	Convenor, Scottish Social Services Council
David Chung	Chair, Royal College of Emergency Medicine
Iona Colvin	Chief Social Work Adviser
Cllr Stuart Currie	Health & Social Care Spokesperson, COSLA
Amy Dalrymple	Royal College of Nursing Scotland (deputising for Theresa Fyffe)
Graeme Eunson	BMA Scotland (deputising for Lewis Morrison)
Joe FitzPatrick MSP	Minister for Public Health, Sport & Wellbeing
Eddie Fraser	Chief Officers' Group representative
Jeane Freeman MSP	**Cabinet Secretary for Health & Sport (Chair)**
David Garbutt	NHS Board Chairs' Group representative
Philip Grigor	Scotland Director, British Dental Association
Annie Gunner-Logan	Coalition of Care and Support Providers
Clare Haughey MSP	Minister for Mental Health
Pauline Howie	NHS National Boards' representative
Andrew Kerr	Health and Social Care Spokesperson, SOLACE
Angela Leitch	Chief Executive, Public Health Scotland
Jason Leitch	National Clinical Director
Carey Lunan	Chair, Royal College of General Practitioners
Donald MacAskill	Chief Executive, Scottish Care
Miles Mack	Chair, Academy of Medical Royal Colleges and Faculties
Peter Macleod	Chief Executive, Care Inspectorate
Richard McCallum	Interim Director, Health Finance, Scottish Government
Carolyn McDonald	Chief AHP Officer
Harry McQuillan	Chair, Community Pharmacy Scotland
Diane Murray	Deputy Chief Nursing Officer
Peter Murray	Chair IJB, Chairs & Vice Chairs Group
James O'Connell	National Staff Side representative, UNITE
Sir Lewis Ritchie	Mackenzie Professor of General Practice
Claire Ronald	National Staff Side representative, Chartered Society of Physiotherapy
Linda Walker	National Staff Side representative, GMB
Ian Welsh	Chief Executive, Healthcare & Social Care, Alliance Scotland
Carole Wilkinson	Chair, Healthcare Improvement Scotland
Andrea Wilson	Convener, Allied Health Professions Federation Scotland

Apologies

John Connaghan CBE	Interim Chief Executive, NHS Scotland
George Crooks	Chief Executive, Digital Health & Care Institute
Tom Ferris	Chief Dental Officer
Theresa Fyffe	Director, Royal College of Nursing (Scotland)
Cllr Kieron Green	Vice Chair, IJB Chairs & Vice Chairs Group
Joanna Macdonald	Chair, Adult Social Care Standing Committee, Social Work Scotland
Fiona McQueen	Chief Nursing Officer
Lewis Morrison	Chair of Scottish Council, British Medical Association
David Quigley	Chair, Optometry Scotland

In attendance

Anne Armstrong	Mental Health Nursing Advisor
Donna Bell	Director, Mental Health, Scottish Government
Alastair Cook	Principal Medical Officer, Mental Health
Aidan Grisewood	Interim Director, Primary Care, Scottish Government
Michael Kellet	Deputy Director, Scottish Government
Hugh McAloon	Deputy Director, Children & Young People's Mental Health Scottish Government
Rose-Marie Parr	Chief Pharmaceutical Officer, Scottish Government
Christine McLaughlin	Director, NHS Planning, Scottish Government
Elinor Mitchell	Interim DG, Health & Social Care, Scottish Government
Yvonne Summers	Head of Operational Planning, Scottish Government

Official Support

Andrew Fleming	Territorial Board Sponsorship & Ministerial Support, Scottish Government
Dan House	Territorial Board Sponsorship & Ministerial Support, Scottish Government
Marty Shevlin	Territorial Board Sponsorship & Ministerial Support, Scottish Government

Note of Meeting
Item 1: Welcome & Introductions

1. The Cabinet Secretary started the fourth meeting of the Group by welcoming attendees. Ms Freeman offered her apologies for not being able to attend the previous meeting and thanked John Connaghan for standing in as Chair.

Item 2: note of meeting held on 31 July, 2020

2. Minor amendments to the meeting note were accepted from Jane Anderson and Andrea Wilson. With these changes made, **the note of the meeting on 31 July was agreed** and will be published on the Group's page on the Scottish Government website.

Item 3: Matters Arising and Future Meetings inc. Sub-Groups

3. There were no matters arising noted.

4. The Cabinet Secretary noted the recommendation that the ongoing work on unscheduled care redesign be taken as a standing item at future Group meetings, so members can receive updates on the progress made. **It was agreed that this should be added to the agenda of future meetings of the Group, starting with next meeting on 28 August**.

5. The Cabinet Secretary confirmed that there had been a number of suggestions on possible agenda items for future meetings which are under consideration. **Confirmation of agenda items will follow in due course.**

6. Ms Freeman said a number of members had raised with her that they would welcome the opportunity to contribute in more detail on certain areas of work the Group is covering; it was sometimes challenging to do so fully on the main Group given the limited time, number of attendees and wide range of topics covered.

7. The Cabinet Secretary therefore proposed that: (i) the full Group meetings be rescheduled to every three weeks, rather than the current two week gap; (ii) allowing members to join sub-groups (such as the one already established on primary care) that will take place in the intervening period and will cover specific agenda items in more detail. The outcomes from these sub-groups would then feed back to the main Group for consideration.

8. **The Cabinet Secretary's proposal was unanimously welcomed by the Group and, as such, was agreed. Members will be informed of the various sub-groups in due course and invited to join.** It was noted that most members would prefer to keep the existing slot (Friday mornings from 09:00) for sub-group meetings. **The main Group will meet on a three weekly cycle following the next meeting on 28 August, i.e. the sixth meeting will be scheduled for 18 September and the Group will meet every three weeks thereafter**.

Item 4: Mental Health Care & Support

9. The Cabinet Secretary introduced the agenda item by stressing that mental health care and support is priority for the Government. Ms Freeman acknowledged that one of the key impacts of the pandemic in general and lockdown, in particular, had been on mental health; and that there are potentially long term consequences; we need to carefully consider how we can effectively respond to these; providing a comprehensive range of services and support at a number of levels. Ms Freeman invited the Minister for Mental Health to say a few words before the presentation.

10. The Minister for Mental Health reiterated that mental health will be a key area of focus for the Government as we move into the next phases of responding to COVID-19. Our approach will be informed by the evidence of the different and evolving mental health needs of the population, as a result of the impact of: the virus itself; the period of lockdown and associated restrictions; and the continuing economic and educational impact. Ms Haughey explained that, as well as effectively addressing the negative impacts of COVID-19, we must seize the opportunity to continue to work together at pace and with maximum innovation; broadening and deepening the country's approach to mental health. The Minister referenced the significant strides made in a short time: on how services are delivered; on how we respond to emotional distress, as well as mental illness; and on how we address stigma; working with people and communities to help them manage their own health and wellbeing.

11. The Minister explained that the presentation would cover: the mental health response to COVID-19 and the lessons learned; the emerging evidence of the impacts on mental health; and the opportunities to take different approaches to delivering mental health services across primary, community and acute settings; part of the wider work on mental health services mobilisation and the transition to recovery and renewal. Ms Haughey asked Alastair Cook, the new Principal Medical Officer in the Government's Mental Health Directorate, to take the Group through the presentation.

12. Alastair Cook explained that the emerging findings of the impact of COVID-19 on mental health, as summarised in the presentation, has been informed by a very active advisory group, chaired by Andrew Gumley, Professor of Psychological Therapy at the University of Glasgow and Interim Director of NHS Research Scotland's Mental Health Network. Alastair acknowledged that, before the outbreak, we were in a position where the rising public awareness and demand for mental health treatment was outstripping supply; and that, during the pandemic, we have seen an acceleration in the rising awareness and need for an effective mental health response. In terms of the early impacts, Alastair explained that there is a higher level of distress, and our current best estimate is of around a 8%-10% rise in the incidence of mental health demand. However, we expect to see further evidence of distress as a result of lockdown restrictions and economic impact going forward.

13. Alastair outlined that a joint focus will be required on both population wellbeing and mental ill health. The transition and recovery plan, which is being developed with stakeholders, covers both of those key aspects: whole population approaches alongside targeted support for at risk and vulnerable groups; increasing the awareness and proactivity of the population about how we manage our own mental health. Comprehensive support will be required to ensure the effective management of mental health and wellbeing: across the whole of Government; within and out with the health and social care system. Our understanding of people's mental health needs will also continue to evolve in the months and years ahead; as such, our mental health care, distress, trauma and population wellbeing response will need to continue to be flexible and adaptable.

14. Alastair took the Group through the next slide which covered the mental health response during the initial lockdown period. Mental health patients were one of the biggest users of *NHS Near Me* as services moved rapidly to virtual appointments, ensuring some treatment continuity, especially for the most vulnerable patients and those at higher risk. In terms of population mental health, there was the rapid development and implementation of the *Clear Your Head* campaign and website. There was also a significant amount of work that went into the development of wellbeing hubs for health and social care staff. Alastair reiterated how the Mental Health Research Advisory Group had been a very helpful development in keeping an informed overview of activity during the pandemic. He also mentioned that, whilst there was good engagement with stakeholders prior to COVID-19, the

fortnightly calls with the Mental Health Stakeholders Group during the pandemic has broadened and deepened this involvement, and helped to meaningfully inform the ongoing response.

15. Alastair talked to the next slide which set out, in detail, the principles and standards for decision making that were issued during the initial response to COVID-19. Alastair confirmed that the principles were well received and accepted by mental health services across Scotland; they were not overly prescriptive and very much a development of the work already underway as part of the Mental Health Strategy.

16. The next slide covered achievements during the initial phases of the COVID-19 response. Alastair referenced the extraordinary reorganisation of services across the whole health and social care system during the initial mobilisation, including those for mental health; and that there is a significant amount of learning to take from the rapid, unprecedented reconfiguration of services which ensured that urgent and emergency care was protected. Two key factors that Alastair highlighted were the use of telephone/video consultations which could make a huge difference for a significant number of (though admittedly not all) appointments; and the shift in the public's understanding and acceptance of using alternative methods of information, access and self-help, such as NHS Inform.

17. Alastair moved on to talk about the Mental Health Care Group, emphasising that the term 'mental health' applies to a huge range of different services: from infant mental health through to end of life care with dementia; interacting with almost all other public services in a number of ways; from crucial primary and community services through to highly specialist forensic services. Alastair explained that the focus going forward should be on the full range of these services rather than a select few.

18. The next slide covered remobilisation and recovery to March 2021 with mental health identified as a clinical priority. Alastair explained the aim is to move beyond a crisis response to using the learning and momentum to address priority issues we were already working on; re-mobilising to meet demand and building on the innovations and work undertaken; supported by strong relationships and stakeholder engagement.

19. Alastair talked to the mental health service priorities for renewal and future reform; citing the need for greater engagement on the full range of services; recognising that this must be a whole systems approach; in order to develop and deliver more mentally healthy communities. This will involve bringing forward the review of the Mental Health Strategy and deliverables, and the development of an action plan to support recovery; based on the improved availability and use of management data and intelligence to support performance improvement and service redesign, including the development of quality standards for all mental health services.

20. Alastair commented on two specific pieces of work that will form part of the transition and recovery plan: the approaches to unscheduled care and primary care. For unscheduled care, we know that in recent years there have been significant rises in mental health attendances at A&E Departments; with these individuals twice as likely to breach the four hour emergency access standard as those with any other condition. Alastair explained that this patient group is split between those with diagnosable mental illness and those in distress; the latter may be distressed as a result of homelessness, substance and/or alcohol misuse, domestic violence or another condition. What is required is a wider response to address this demand with early, rapid assessment and support; offering the right care either from a mental health or other professional. The proposal is to embed the mental health response within the wider redesign of unscheduled care that was covered at the last meeting of the Group; including the presence of mental health professionals at NHS 24 and the

proposed local flow and navigation hubs. Alastair talked to a slide that covers some of the emerging thinking about possible patient entry points to ensure that the right care is delivered in the right place at the right time, first time.

21. In terms of primary care, Alastair explained that a large amount of mental health morbidity is managed in these settings: a 2018 survey estimated that this accounts for around a third of total GP workload; noting that people with mental health symptoms have a highly variable experience when they present in practices. Alastair explained that the aim is to improve the experience for GPs and their patients by providing support to deliver an appropriate range of care options, at a suitable scale to meet demand; that can be delivered or accessed directly from the practice without the need to refer to specialist services. The next step is to commission a short life working group to describe 'what good looks' like in terms of mental health provision in primary care; including the development of primary care mental health principles and standards of care. This approach recognises that the focus of attention in effectively and sustainably meeting the greater demand for mental health services needs to be based in primary and community care.

22. In conclusion, Alastair summarised: that the *Mental Health*? *Transition and Recovery Framework for Scotland* will be published shortly, building on COVID-19 learning to date and as informed by engagement with stakeholders; that the emphasis is on both population well-being and wider approaches to the recovery and reform of services; ensuring measurable, high quality outcomes; and that, underpinning this, will be the need for sufficient resources, commitment and leadership at the national, regional and local levels.

23. The Cabinet Secretary thanked Alastair for his presentation and invited comments and questions from the Group.

<u>Discussion</u>

24. Ian Welsh welcomed the presentation and reiterated the need for a whole system approach, including community services and third sector activity. Ian also referenced the learning from the Strang Report in NHS Tayside as this will be crucial in how services are effectively re-mobilised and re-designed, for the benefit of all.

25. Donald MacAskill reflected that older people's mental health is about more than just dementia so was very pleased to see that recognised in the presentation. Donald also noted the particular impact of COVID-19 on older people's mental health, both in the community and in care homes; as well as the significant psychological impact on health and social care staff; for the former, he noted the bereavement of losing a significant number of residents that care home staff may have formed close bonds with over sometimes long periods of time; this demonstrated the need for sufficient and effective bereavement/grief support as part of the planned programme of work.

26. Miles Mack was grateful for the presentation and, in particular, the focus on primary care. Nonetheless, he was concerned that the proposals were to commission more scoping work rather than to deliver an explicit action plan. In his view there has been very limited progress in the provision of primary care mental health services in the last 20 years; with a particular need to improve the interface of services between community, primary and secondary care; ensuring that high quality, multi-professional support is easily accessible across the full range of care settings, including specialist mental health nurses. This all needs to be carefully considered from the patient's perspective; many of whom will access the system via primary care. Miles was also concerned that mental health funding intended for primary care should be spent in secondary care.

27. Andrew Buist felt the 10% increase in mental health cases referenced in the presentation were likely to be largely as a result of stress, distress and anxiety. He agreed that resources need to be brought up stream to primary care to ensure that patients can be treated effectively and quickly. He did not favour the proposal for the mental health assessment centres; reiterating the same concerns he raised with the similar centres proposed under the initial phase of unscheduled care redesign: he felt these should be piloted and properly evaluated first. Andrew welcomed the focus on wellbeing; however, he was clear that online access will not suit all, with a significant cohort of patients continuing to require face to face treatment and care.

28. Carey Lunan thanked Alastair for the presentation and getting in touch recently to set up the short life working group on primary and community care mental health services. She echoed the points made by Miles Mack and Andrew Buist about how mental health is a very significant part of a GP's workload; currently, over 50% of all appointments have a mental health component in the practice Carey works in. She too was mindful of digital exclusion: we need to be careful about a model that is heavily reliant on digital access when some patients will require human contact and interaction. Carey strongly promoted the use of mental health nurses in primary care practices: with three such nurses in her own practice, the number of referrals to specialist services had reduced by almost 50%; the number of unscheduled attendances across the system has reduced by over 50%; and the patient feedback has been extremely positive.

29. James O'Connell explained that trades unions and other stakeholders had been heavily involved in the very well-received PROMIS website and that this could be used as a model for further developments. In terms of the mental wellbeing of health and social care staff, James envisaged a time soon when many may be impacted by the experiences, challenges and stresses of the extraordinary recent period; and that there must continue to be appropriate services and support available to them. He advocated a comprehensive, fully resourced mental health strategy delivered across the whole system, for the benefit of all.

30. David Garbutt referenced earlier comments about mental health funding earmarked for primary care being spent in the secondary sector and explained that it had previously been difficult to track the full benefit of funding for link workers to some NHS Boards. In relation to the work ahead, he therefore felt there is need for a specific piece of integrated workforce planning across health and social care to ensure that the right level of training resource is provided in the right place; and flagged that this may require a shift in some of the under-graduate and post-graduate training presently offered.

31. Peter Macleod welcomed the presentation and endorsed other Group members' comments about the need for a number of service delivery solutions that meet patient needs; guarding against an over-reliance on digital/virtual access. He also stressed the urgent need to provide comprehensive mental health support to staff in care homes. Peter felt that this work was an opportunity to tailor services to people's needs; stressing the links between addiction, mental health and well-being.

32. Graeme Eunson reflected on the capacity across services to meet the increased demand for mental services that has been identified and the pressure this is putting on staff; he would like to see a greater focus on the well-being of staff and what proactive work will be undertaken to support them and make their roles attractive and fulfilling; thereby promoting staff recruitment and retention in this priority area.

33. The Cabinet Secretary thanked the Group for the points made and asked Donna Bell for any further comments. Donna assured the Group that their comments had been noted; that the working groups will be very important in carefully considering the detail; and that they will be charged with identifying robust actions for implementation, particularly in

community and primary care; alongside the work underway on unscheduled care, and with stakeholders. She recognised the need to work at pace and maintain momentum.

34. The Minister for Mental Health concluded this agenda item by thanking the Group for their helpful contributions. Ms Haughey commented that it is most encouraging to see mental health recognised by so many as a key priority, and that she is very much looking forward to working with Group members, and indeed all stakeholders, in developing and delivering services that the workforce can be proud of; for the benefit of all in Scotland.

Item 5: Board Re-mobilisation

35. The Cabinet Secretary introduced this agenda item by explaining that the presentation would flag the key issues highlighted in our initial assessment of the latest iteration of the NHS Board re-mobilisation plans, which have been received over recent weeks. These plans cover the period until the end of March 2021 and it is important to keep in mind that they are not final versions: they will continue to be refined through detailed discussions with Boards, and as more information and evidence becomes available. Nonetheless, it was felt helpful to give the Group an initial overview of the work underway and planned next steps. The Cabinet Secretary invited Christine McLaughlin to deliver the presentation.

36. Christine McLaughlin explained that the responses received from NHS Boards and their planning partners have been very substantial and demonstrate the considerable work that is underway. The key emerging messages include a recognition of the importance of true whole system working, with expanded and integrated roles for primary care, community based services and social care essential to the effective resumption of services that were paused in the initial phase of the response to the pandemic, as well as to mitigating seasonal winter pressures and any resurgence of COVID-19. There is also widespread recognition of the key role of public health going forward, both in terms of health protection and population health. The plans reflect how staff have worked very flexibly over the initial response but also note concerns about their ability to maintain this over the longer term; it is clear that staff wellbeing must be a focus over the coming months. There are also understandable concerns, particularly in planned care, about the impact of the significant capacity reductions due COVID-19 to date and how this is likely to continue to affect Boards' ability to deal with the accumulated backlogs. Similarly, the plans reflect concerns about the additional resources – both financial and workforce – that are likely to be required over this period.

37. In terms of the resumption of routine services paused in the initial response, Christine explained that Boards are looking to cautiously do so across most areas, but this will not necessarily be in the way services were delivered before, nor in the same volumes; this is clearly impacted by continuing and necessary infection prevention and control measures such as altered patient flows, appropriate bed spacing, distancing, and PPE requirements. Early estimates are that up to 50% of operating theatre throughput could be impacted by this.

38. The plans also seek to embed new arrangements and innovations which should positively impact on patient pathways and experience, such as *Pharmacy First*, *Home First*, *NHS Near Me* and the planned redesign of unscheduled care. Some examples of innovation include NHS Greater Glasgow & Clyde's online patient portal for test results and NHS Highland's delivery of 70% of all outpatient consultations virtually. NHS Lothian are also providing personalised information, advice and support to COVID-19 survivors; with a single point of access to tailored rehabilitation services.

39. Christine talked to a slide that confirmed a comprehensive range of routine care had been resumed in all Board areas; reiterating that this does not mean that these services

have been restored at the same scale as previously. Indeed, for planned care, activity levels are projected to be significantly down on the same period last year. Boards are signalling that both new outpatient and inpatient activity is expected to be around 50% of last year's levels in the quarter ending September 2020, rising to approximately 66% of last year's levels in the quarter ending March 2021. The number of patients treated on a 31-day cancer pathway are projected to recover at a faster rate than outpatients and inpatients. For the quarter ending September 2020, activity levels are predicted to be at 78% of the previous year's levels, rising to 93% by the quarter ending March 2021. Further work would be undertaken to better understand this and there will of course be variation between Boards but this will clearly have a significant impact on some patients waiting for treatment.

40. On delayed discharges, management information shows these have reduced by over 40% since the beginning of March; Boards and their partners are committed in their plans to maintaining these reduced numbers. In mental health, psychological therapies activity is expected to be lower than last year (79% of previous year's levels in the quarter ending September 2020, rising to 89% in the quarter ending March 2021) whilst CAMHS activity is projected to be higher than last year; this is driven by large increases in a small number of Boards which will be explored with them further in the ongoing mobilisation plan discussions.

41. Christine talked about the impact of clinical prioritisation on routine elective cases, based on information received from Boards on four categories ('P1'-'P4') developed with Royal Colleges. Category P1 splits into two sub categories - P1a (emergency) refers to cases requiring an operation within 24 hrs and P1b (urgent) requiring an operation within 72 hrs. P2 refers to cases requiring surgery to be undertaken within 4 weeks, P3 to cases requiring surgery within 3 months, and finally P4 to cases requiring surgery beyond 3 months.

42. The information received to date estimates that, by the end of March 2021, those patients in the higher clinical priority 'P1', 'P2' and 'P3' categories will be treated. However, those in the 'P4' category – which includes high volume specialties such as orthopaedics and ophthalmology – will wait longer; and with available elective activity projected to reduce on average by 30-40%, lists will increase as demand is growing at a faster rate than activity. It was reiterated that these are early estimates but the data will allow officials to have more informed discussions with Boards about how best to plan the resumption of routine activity in the next period, including the use of national resources as NHS Golden Jubilee and NHS Louisa Jordan; as well as capacity in the independent sector. The data will also be refined as our modelling and intelligence is developed and updated.

43. The key risks to the safe and effective resumption of paused activity remain a challenging winter and/or COVID-19 resurgence. Work is underway to assess Boards' preparedness for this, including the availability of deploying surge capacity to ensure COVID, emergency and urgent resilience (noting that this would clearly impact the resumption of more routine activity which will increase non-COVID harms); *Test and Protect* and effective regional working will be key in managing any resurgence. A range of other factors also need to be considered, including but not limited to: the longer-term health impacts of COVID-19; how we will effectively treat and stream patients with symptoms of seasonal respiratory ailments that are similar to those presented with COVID-19; the continued impact of the pandemic on staff health and psychological well-being; the ability to deliver mass vaccination programmes; the continuing need to protect and support the social care sector; and a potential no deal or limited deal Brexit that could impact supply chains, e.g. supplies of certain medicines, and workforce.

44. Christine reflected on the lessons learned from the pandemic to date and how this will be used to inform how we plan for the next phases. This included the recognition that we need to build on, and invest in, enhanced community based services and extended use

of digital technology to provide assessment, treatment and care closer to home; the need to continue to work with and support the social care sector, including the promotion of *Home First;* the critical importance of effective, consistent communication (for staff, patients and public); and the power of a single, shared sense of purpose.

45. Christine commented on the initial mobilisation plans received from the National Boards. They are playing a key, co-ordinated role in supporting territorial Board delivery, including: collaboration on the primary care reform agenda and improved public health activity through shared data and improved intelligence; through a digital first approach to supporting self-care, the management of population health and working with GP practices to accelerate remote access. In addition, NHS Golden Jubilee is supporting the safe resumption of elective services through increased core capacity and cancer surgery provision. NHS 24's 111 service is now acting as the national point of entry for COVID-19 related care both in and out of hours and NHS Inform is enabling people to access self-supported care whilst signposting relevant services.

46. The Scottish Ambulance Service continues to grow their clinical workforce and are working to improve response times for the highest acuity patients. Healthcare Improvement Scotland is providing practical support for the implementation of redesign, alongside the improvement of services, capitalising on digital advances. Public Health Scotland has a key role in the development of *Test and Protect,* as well as vaccines for seasonal influenza and COVID-19. National Services Scotland are playing a key supporting role on procurement and infrastructure. NHS Louisa Jordan also stands ready to provide a facility for planned care activity (including vaccinations), whilst retaining the flexibility to operate as a COVID-19 facility at short notice.

47. Christine concluded the presentation by commenting on the role of the Government and summarising the next steps. It is clear that Boards, their planning partners and others are looking to the Scottish Government to ensure there is: effective, co-ordinated, consistent national messaging around public health, self-management; how the health and social care system is changing and how to access it; prompt and consistent guidance; and continued investment and support for the workforce, and in digital technology/innovation. In terms of next steps, there will be detailed reviews and discussions with all Boards to understand variation and ensure that their plans are as robust as they can be; as such, the plans will be reviewed and updated quarterly; as informed by emerging and updated evidence and intelligence.

48. The Cabinet Secretary thanked Christine for the presentation and reinforced that this is an iterative process with key risks that need to be carefully and continuously considered, balanced and mitigated, where possible, such as: winter pressures; a significant resurgence in COVID-19 activity; and the current and expected demands on the system: from *Test and Protect;* from a significantly expanded vaccination programme; and from Brexit.

<u>Discussion</u>

49. Andrew Buist commented that the pausing of routine elective care has significantly impacted general practice which has remained open throughout. He felt that Boards had not resumed elective activity quickly enough. He was concerned that cataracts were grouped in the 'P4' designation of clinical priority; noting the risks of falls are likely to increase and cause trauma (as well as having a significant impact on quality of life) if elderly people suffer for longer with diminishing eye sight. Andrew supported the further development of community treatment centres as part of modernising outpatient care. He agreed that public messaging is absolutely essential and that the population needs to be fully engaged on what the 'new normal' means for them. Andrew also requested the urgent development of respiratory centres, building on the model of COVID-19 assessment centres, to keep those

with coughs and fevers away from A&E Departments and general practice; thereby avoiding cross-contamination and safeguarding capacity in the system.

50. John Burns thanked Christine McLaughlin for the presentation and recognised that it reflected very clearly the Board mobilisation plans, and the work that is underway across the whole system. Indeed, John felt that continued, meaningful whole system working with a focus on public health – beyond health and social care and including community planning partnerships – will be essential in meeting the many challenges of the period until the end of March 2021 and beyond. In terms of the longer timeframe, John explained that the mobilisation plans are an important stage in the wider development and reform of the health and social care sectors. He noted that this will inevitably involve some challenging considerations around resourcing. In terms of routine planned care, John was clear that this is an area of concern to all Boards; they would very much like to undertake higher volumes of activity more quickly but the safety of patients and staff is of paramount concern and they must comply with the expert, professional guidelines in relation to infection prevention and control. He felt digital technology had been a very important enabler, whilst recognising that it is not suitable for all treatments and interactions. It is, nonetheless, now an integral part of service delivery and key to ensuring that services remain resilient and sustainable. John concluded by highlighting how important it is for Boards and their planning partners to maintain that single, shared sense of purpose; remaining agile and responsiveness to existing, new and emerging risks over the coming period; and that this will be fully reflected in the iterations of the Board plans.

51. Amy Dalrymple reiterated the pressures that the workforce had been under since the pandemic started and asked for an assurance that the mobilisation plans fully recognise that; particularly when considering the additional pressures of the coming months. She felt that the need for staff respite and ongoing psychological support will be critical.

52. Peter Macleod suggested that the next iteration of the plans presented to the Group for discussion should be on a wider whole system basis, with a demonstration of how wider sectors beyond health have contributed to tackling COVID-19; and how they will be key in the future recovery and renewal of services.

53. Graeme Eunson echoed Amy Dalrymple's points about the importance of staff well-being being written through the mobilisation plans; noting the potential for burn out and high risk to resilience over the coming months, should it not be fully recognised and responded to. A particular example was the public health teams who have been critical to the response to date and who have had very little respite. Graeme also raised public messaging: he felt the public need to receive an honest and frank assessment of the likely limited health capacity available in the coming months; and to help them navigate what will be a very complex system. The Cabinet Secretary agreed that clear and honest communication is essential but that further work is required to ensure the messages are as clear and informed as possible; as noted, the planning for the coming months and associated communications will continue to be developed and refined as more information and evidence is available.

54. Eddie Fraser commented that the response to the pandemic to date had demonstrated the importance and value of the integration of health and social care; from the support offered to care homes to the operation of COVID-19 hubs and assessment centres; also noting the important links to local authority and third sector services.

55. The Cabinet Secretary asked Christine McLaughlin to conclude the discussion. Christine noted that the first iteration of these plans are helpful in establishing where support may be required and how efforts should be prioritised. All Boards are now being engaged in detailed, follow up discussions and the plans will continue to be developed and refined, as will our data, evidence and intelligence; which will help us all to make informed decisions

that will ensure services are as robust as possible in the coming months; and that we have a coherent approach to the longer-term recovery and renewal of health and social care services.

56. In terms of next steps, Christine explained that the proposal is to take this work forward under four care programmes and how this could be progressed under respective sub-groups for the input of Group members, covering: (i) healthy living and well-being: with a focus on enabling people to take responsibility for their own well-being; understanding and mitigating the healthy living and well-being impacts of COVID-19; (ii) preventative and proactive care: moving from a situation in which proactive and preventative care is diffused and most care provided is reactive (those who choose to access it rather than those who might most benefit from it); (iii) integrated unscheduled care: where the response will be coordinated and increasingly in people's own homes; and (iv) integrated planned care: with greater cohesion, co-ordination and coherence of primary, community and hospital services. **Christine undertook to provide more detail to the Group on the four programmes and respective sub-groups in the coming weeks.**

57. The Cabinet Secretary thanked Christine and confirmed with the Group that there was no further business for the meeting.

Item 6: Date of Next Meeting(s)

58. **It was confirmed that the next (fifth) meeting of the Group is scheduled for 09:00 to 11:00 on Friday, 28 August. Subsequent meetings of the Group will be scheduled for Friday, 18 September and Friday, 9 October; all between 09:00 and 11:00**.

59. **The Cabinet Secretary indicated that two of the substantive agenda items for the next Group meeting on 28 August will be (i) public health and (ii) public messaging/communications**.

60. The meeting closed with the Cabinet Secretary thanking all presenters and Group members for their valued contributions.

Scottish Government
14 August 2020