COVID-19 – Framework for Decision Making

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

Mobilisation Recovery Group (MRG7)

Note of Meeting

0900-1100 hours on Friday 9 October 2020

Via MS Teams

Members Present

Jeane Freeman (Cabinet Secretary)	Cabinet Secretary for Health & Sport, Scottish Government
Andrea Wilson	Convener, Allied Health Professions Federation Scotland
Angela Leitch	Chief Executive, Public Health Scotland
John Burns	NHS Boards Chief Executives' representative
Christine McLaughlin	Director of Planning, Scottish Government
Dave Caesar	Interim Deputy Chief Medical Officer, Scottish Government
David Garbutt	NHS Board Chairs Group representative
Elinor Mitchell	Interim DG, Health & Social Care, Scottish Government
Eddie Fraser	Chief Officers' Group representative
Heather Bryceland	Programme Manager of the 3R's Portfolio, NHS NSS
Carole Wilkinson	Chair, Healthcare Improvement Scotland
James O'Connell	National Staff Side representative - UNITE
Joanna MacDonald	Chair, Adult Social Care Standing Committee - Social Work Scotland
John Thomson	Vice President Scotland, Royal College of Emergency Medicine
Kate McDermott	UNISON National Staff Side representative
Peter Murray	Chair IJB, Chairs & Vice Chairs Group;
Paulin Howie	NHS National Boards Representative
Richard McCallum	Interim Director of Health Finance and Governance, Scottish Government
Tom Ferris	Chief Dental Officer, Scottish Government
Jason Leitch	National Clinical Director, Scottish Government
Amy Dalrymple	Deputising for Theresa Fyffe, Director, Royal College of Nursing (Scotland)
Andrew Cowie	Deputising for Andrew Buist, Deputy Chair, British Medical Association GP Committee
Annie Gunner Logan	Coalition of Care and Support Providers
Derek Bell	Specialty Advisor, Elective and Unscheduled Care, Scottish Government
Carey Lunan	Chair, Royal College of General Practitioners
Claire Ronald	National Staff Side representative - Chartered Society of Physiotherapy
David Quigley	Chair, Optometry Scotland
Joe Fitzpatrick	Minister for Public Health, Sport & Wellbeing, Scottish Government
George Crooks	Chief Executive, Digital Health & Care Institute
Dr Graeme Eunson	Deputising for Dr Lewis Morrison, Chair, Scottish Council, British Medical Association
Harry McQuillan	Chief Executive, Community Pharmacy (Scotland)
Clare Haughey	Minister for Mental Health, Scottish Government
Ian Welsh	Chief Executive, Healthcare & Social Care, Alliance Scotland
John Connaghan	Interim CEO, NHS Scotland
Karen Hedge	Deputising for Donald MacAskill, Chief Executive, Scottish Care
Peter Macleod	Chief Executive, Care Inspectorate
Miles Mack	Chair, Academy of Medical Royal Colleges and Faculties
Nicola Dickie	COSLA
Lewis Ritchie	Mackenzie Professor of General Practice

Sandra Campbell	Convenor, Scottish Social Services Council
Stuart Currie	Health & Social Care Spokesperson, Convention of Scottish Local Authorities (COSLA)

Apologies

Richard Foggo	Director of Population Health, Scottish Government
Iona Colvin	Chief Social Work Adviser, Scottish Government
Andrew Kerr	SOLACE, Health and Social Care Spokesperson
Cllr Kieron Green	Vice Chair, IJB Chairs & Vice Chairs Group
Diane Murray	Deputy Chief Nursing Officer, Scottish Government
Andrew Buist	Chair, British Medical Association
Donald MacAskill	Chief Executive, Scottish Care
Theresa Fyffe	Director, Royal College of Nursing (Scotland)
Andrea Wilson	Convener, Allied Health Professions Federation Scotland

In attendance

Alison Strath	Interim Chief Pharmaceutical Officer, Scottish Government
Aidan Grisewood	Interim Director for Primary Care, Scottish Government
Michael Kellet SG	Head of Health & Social Care, Scottish Government
Christine McLaughlin	Director of Planning, Scottish Government
Sean Neill	Deputy Director, Health Workforce, Scottish Government
Nafees Ahmad	Clinical Fellow, Directorate for Healthcare, Quality & Improvement, Scottish Government
Heather Campbell	Interim Deputy Director, Primary Care, Scottish Government
Helen Maitland	Unscheduled Care Director, Scottish Government
Malcolm Summers	Head of Strategic Reform, Scottish Government
Mairi Cameron	Graduate Developer, Scottish Government
Michael Chalmers	Director of Children and Families, Scottish Government
Jonathan Cameron	Deputy Director, Digital Health and Care, Scottish Government
Naureen Ahmad	Deputy Director for General Practice Policy Division, Scottish Government
Carolyn McDonald	Chief Allied Health Professions Office

Official Support

Andrew Fleming	Official Support, Scottish Government
Leticia Martinez Garcia	Official Support, Scottish Government
Helen MacDonald	Official Support, Scottish Government
Marty Shevlin	Official Support, Scottish Government

Note of Meeting

Item 1: Welcome & Introductions

1 The Cabinet Secretary welcomed Group members to its seventh meeting, especially Kate McDermott who was taking on the role previously held by Jane Anderson as national staff side representative; John Thomson, who was vice president of New Royal College of Emergency Medicine (Scotland) and was replacing David Chung; Alison Strath who had taken up the role of Interim Chief

Pharmaceutical Officer at Scottish Government; and Dave Caesar who had taken up the role of Deputy Chief Medical Officer and would replace Marion Bain on the Group.

2 The Cabinet Secretary reflected on what had been a busy period, offering apologies for the late tabling of the paper on Unscheduled Care Redesign, which would be picked up under Item 6. She also noted that item 5, on the work of the Primary and Community Health Care Mobilisation Sub Group, had been rescheduled due to technical issues experienced during the last meeting.

Item 2: Note of meeting held on 18 September, 2020

3 Although no changes to the draft note were offered, it was highlighted that a lot of good points were raised within the simultaneous running chat box, which were not always captured in the minute. The Cabinet Secretary noted this point, proposing that **the secretariat should investigate how best to address the issue, e.g., by either incorporating or appending the chat narrative in future**.

4 The Note of Meeting of 18 September 2020, was accepted as a true and accurate reflection of the actual meeting and as such, was **RATIFIED**; and would be published on the Scottish Government website.

Item 3: Matters arising not on the agenda/actions

5 The Cabinet Secretary noted that the Alliance had circulated six updates from their People at the Centre series and invited Ian Welsh to comment on this. He advised that they were currently producing two editions per week and that he would liaise with the secretariat and Linda Pollock on options for circulating these more regularly moving forward. He noted that the Alliance was at the early stages of developing a paper on long Covid network and invited any interest.

6 The Cabinet Secretary continued to seek suggestions from members on possible agenda items. She noted that, as the next meeting of the group would come shortly after the current restrictions, commencing tonight, would be reviewed, she proposed that one substantive agenda item should be an update from both Gregor Smith, Chief Medical Officer and Jason Leitch, National Clinical Director on the pandemic. She also proposed that the second item should be on winter planning for both the NHS and Social Care. These proposals were endorsed.

Item 4: Digital Health & Care

7 The Cabinet Secretary then invited Jonathan Cameron, Digital Health and Care Team; and George Crooks, Digital Health and Care Innovation Centre (DHI) to speak to their presentation.

8 Jonathan spoke to the first part of the presentation which outlined the progress made in digital health and care and outlined next steps, with a short overview around current activity and areas for future focus, after which George would discuss what the DHI were leading on.

9 Jonathan commenced by highlighting work which had rapidly progressed over the past few months to deal with Covid-19; in particular roll out of Microsoft Teams to 200,000 NHS Users and now to staff in local government; on contract tracing, which George would expand upon; and also the Protect Scotland app which was being used by 1.4 million people. He also highlighted the deployment of a safety huddle tool in care homes designed to support safety.

10 A key focus has been the rapid deployment of hardware focussed on doubling bandwidth at some 600 sites and, for some, increasing this by up to 10 times. A rapid programme had been undertaken to ensure the right infrastructure was in place to enable patients to make contact through digital channels, such as NHS Near Me. Take up of video consultations had increased from circa 200 to, now 16,000 per week. The next step in roll would be to care homes. This work was supported by skills and training so that those not confident in using digital technology were not left behind.

11 In addition to systems, there has also been a lot of work around data sharing such that data sharing agreements and improvements in processes now take days rather than months to progress. An Ethics framework has been developed as part of the Protect Scotland app, which has been well received and was a good way of assuring the public around the privacy of their data. They have also stood up a data intelligence network to encourage collaboration across a range of people.

12 Lessons learned from Covid had highlighted rapid deployment at scale and speed across the systems as well as securing better management of data flows and would wish this to continue. Jonathan also highlighted the great collaboration, close working and fantastic engagement with multiple teams towards a common goal as a powerful and positive driver.

13 That said, there remain challenges, particularly as staff are becoming fatigued and it is necessary to take a break. However; teams continue to roll out more hardware and software, particularly so for NHS Near Me. The pandemic has highlighted the challenge of data managing and sharing data effectively and efficiently so there is an opportunity, going forward, to free up staff time to focus on other activity. He sought views on how data could be shared to improve our understanding and response to “long Covid”. **He invited group members to contact him directly with their views and thoughts as to how digital technology might support recovery for this group of patients.**

14 Moving forward, in relation to digital health and care, a refresh of the digital plan would be launched shortly, as part of Programme for Government. This work would link to remobilisation and artificial intelligence plans, which presented an important opportunity to ensure we are including the right things, including data and procurement as new topics. He went on to advise that more strategic direction on data was required and that work was ongoing with colleagues to address this. Scottish Government and COSLA were joint owners of the digital strategy refresh and would be working collaboratively to deliver the strategy.

15 Jonathan’s final slide outlined the key areas of focus for the digital strategy refresh where it was hoped to get into more of the detail around major programmes,

including care homes and ensuring the right priorities to link to. There were a number of technical aspects flagged too, including Cyber and local government integration. He lastly emphasised the importance of the workforce as people move to remote working so there is a need to support them in that process through digital leadership and skills development.

16 George Crooks picked up the next section of the presentation which discussed the digital response to Covid 19. He started the presentation by noting that he had worked with telehealth over a period of 15 years and during that time he had faced significant barriers in deploying digital tools. However, only over the last 6-9 months with the arrival of Covid, he had noted that these barriers were less prevalent. He thought this was reflective of experience of penicillin to day to day practice which required a World War to bring it into day to day use. He highlighted DHI role in supporting bringing digital solutions into the day to day practice of health and social care. The team had some 32 WTEs including design researchers from Glasgow School of Art who liaise with the citizens and all involved in the provision of health and care, either directly or indirectly to ensure that all digital developments have user centred design at their heart.

17 He provided an example of their involvement in the early days of the pandemic where problems had been identified around getting results to citizens through the national notification system, initially for negative results but where improvements have seen this system being used for positive results. He spoke of the Integration Hub within NSS and the DHI data exchange where data flows seamlessly to health and social care professionals to allow structured assessment of Covid symptoms and appropriate management. He went on to advise that use of this is spreading to other areas e.g., in acute admission units, at the Louise Jordan Hospital, by paramedics on the front line in ambulances, and in care homes.

18 George then took group members through the timeline for delivery of the solution which was designed, developed and handed over to NSS within 51 days. Similarly contract tracing tools to support health protection teams took 41 days from the problem being identified to solution handover. This clearly demonstrates how a clear policy intent and a bottom up desire to change can accelerate the deployment of innovative solutions to support health and social care in Scotland.

19 In terms of recovery, George spoke to the example of DHI working in partnership with NHS Western Isles, NHS Highland and NHS Grampian to undertake a service review around use of a camera pill for colonoscopy which currently requires patients to go to hospital for the examination. The procedure can now take place in their own home by swallowing a capsule. The camera will then take 300,000 pictures of the large bowel, the images being transmitted to a box held on the person's waistband and read by a central reading facility. This technology has transformed the management of groups of patients at risk from colon cancer. Further roll out is planned to take place in NHS Greater Glasgow & Clyde, then across the rest of Scotland. It is certainly more convenient and appreciated by patients and has highly effective clinical decision making.

20 Another example related to Chronic Obstructive Pulmonary Disease (COPD), which is a major issue for the NHS in Scotland where clinical decision support has aided the management of patients for many years. DHI is currently working on a group of tools to support primary care and general practice, to assess and diagnose patients through remote consultations to increase and improve the safety and effectiveness of hard pressed clinical services, particularly for patients at risk of cancer. This is a good example of how digital tools might be used to enable patients to make choices and relieve pressures on health and social care over winter. Specifically in COPD, there is the Dynamic Scot service which is patient self-management where patients are daily reporting their symptoms and have direct access to clinical support and review, remotely. If you blend consumer data on sleep and exercise with health data to flow through the DHI data exchange, into TrakCare, with data analysis supported by AI this is demonstrating a significant improvement in the management of COPD, preventing admission and reducing the length of stay by around 7 days and the face to face community reviews have actually halved, thus is reducing the burden on frontline staff but improving safety and effectiveness for patients. This example really demonstrates how allowing data to flow seamlessly to back end systems in a managed way can aid reduce the impact on hard pressed resources.

21 Moving forward DHI is looking at Hospital at Home services, proposing use of continuous monitoring systems to measure ECG, heart rate, temperature, oxygen levels and with an inbuilt accelerometer (to measure movement and falls) to manage patients who would normally be admitted to hospital. Consideration is also being given to how we can discharge patients and monitor them, in real time, in their own homes. NHS Lanarkshire are looking to monitor patients in this way, a week pre operatively to reduce the risk of cancelled operations and improve theatre utilisation, which is already reduced due to Covid restrictions.

22 Finally, George highlighted the work being progressed, focussing on the provision of services in primary and community care, where they were working alongside Community Pharmacy (Scotland). When medicines dispensing through the community pharmacy route is potentially being challenged by companies such as Amazon how can we maximise their input into the future provision of services that creates safe and sustainable service models for the future. Harry McQuillan expressed there was excitement around how community pharmacy contractors were able to contribute to the renew agenda in this way and be an enabler for improved patient outcomes. The first proposal being explored is for pharmacists to deliver the routine management of a digital monitoring service for high blood pressure.

23 George then turned to make mention of the work ongoing with MacMillan Cancer Care helping patients can access their services timely and appropriately, through the use of gaming technology, developed through the University of Abertay, so that those in need of the suite of MacMillan services can be referred at the right time and supported through day to day life whilst undertaking their cancer treatment. Next steps are to see how this approach might support Mental Health and the Healthy Ageing agenda.

24 George explained that the work of DHI was around how to empower citizens to access services, not only in health and social care but a whole host of government

services in new and innovative ways. Once there is a vaccine/vaccine programme in place for Covid-19, they would strongly advocate that citizens receive a digital token, validated by the NHS, which could be used to confirm that you have been vaccinated. This could then be used to enable visits to relatives in a care home, for example, or at airports to travel safely. There are benefits for both health and care but many more far reaching benefits including supporting safe working, assisting economic recovery.

25 The Cabinet Secretary thanked Jonathan and George for their presentations which had been very fascinating and were a reminder of how much more digital approach offered if tied into a person centre approach together with inter clinical decision making.

26 Miles Mack welcomed the presentation as the Scottish Academy had felt this was a useful area for the group to look at. He had also shared a document with the Cabinet Secretary which highlighted some issues and which he looked forward to discussing with Jonathan in due course. However, he first wished to pay tribute to the staff of all Health Board IT departments as they had put a lot of effort into enabling home working so any comments around accessing digital services should not imply criticism of them. He was cognisant that "long Covid" would be a real challenge for all given that it would affect multiple systems and require a fully holistic approach to patient care across general practice but also acute and other areas of healthcare. Current practice was to use email but this had limitations – e.g., was not linked to the electronic patient record. He suspected this is relevant to other clinical diseases, as patients have multiple comorbidities and one illness may be contraindicated by another.

27 Alison Strath advised that digital prescribing had been very high on the agenda of colleagues in primary care and in particular general practice colleagues. She was thankful to Jonathan and colleagues in digital health around electronic prescribing – initially on paper and then to remove the paper at a later stage. NSS have done a lot of work to scope, plan and progress this in a thoughtful and managed way, initially with an electronic signature on paper over six months and then a more end to end process, where it is all electronic.

28 Karen Hedge advised that there were so many pieces of work ongoing in the data sphere so she was pleased to hear of the strategy refresh. She expressed her willingness to be involved. Secondly, she was pleased to hear about the work taking place in the home care sector and that, as mentioned by Annie Gunner Logan and Peter MacLeod, it would be useful to tie in with the work ongoing in Scottish Care.

29 James O'Connell welcomed the presentation but emphasised the importance of communicating these innovations not just to employers but also employees, patients to build confidence. Jonathan had made reference to training but James flagged the fear factor about the use of technology so there was a need to be mindful of this and linking it to improvement in terms and conditions. He would welcome some understanding about communication and training strategy.

30 The Cabinet Secretary agreed that this was a really important point around the role of technology in improving people's terms and conditions, which sometimes don't meet fair work principles and where, there is work still to do.

31 Carey Lunan thanked Jonathan and George and reflected of the phenomenal work which had taken place over a 7 month timescale where new models working and data sharing had been implemented. She was glad to hear there was a focus on digital exclusion as this remains a complex area for many patients and she echoed Miles' thoughts around what more could be done to build interfaces, such as 3 way consulting options, dedicated emails, phone lines, rapid access to specialty or other colleagues where there are nuances which don't fit with guidelines. There had been a lot of positivity but also a lot of negativity around the digital first approach. We all understand why this is necessary in a pandemic but it should be recognised that the public may not. She felt that we need to ensure face to face engagement still takes place where clinically necessary and safe. Some patients were struggling with the loss of this engagement. Therefore there was a need to consider the unintended consequences when moving towards a more digital model and recognise the requirements of training.

32 Stuart Currie expressed his thanks for the presentation. He felt the fair work point was valid and that this must be embedded in discussions from the beginning. He agreed that IT and technology was not for everyone but was thoughtful about how quickly people adjust to new services. He advised there were a large number of community facilities where contact with the public in accessing services could be dealt with using digital means and the Community Planning Partnerships had an important role in embracing the possibilities.

33 Peter Macleod spoke about his role as chair of the Digitally Enabled Citizen Board. He felt that one of the real opportunities is around housing and care. He felt that each time new housing is built we should have an eye towards technology with a focus to enable people in the future to remain at home. This also connects with the point around acceleration of Near Me targeted for Care Homes with the next step being Care at Home. The point made by James is front and central to success. Technology enabled care is already provided through personal alarms etc., but can be modernised through predictive analytics for health and lifestyle patters. He referred to the "Clever Clogs" system used by Blackwood Housing Association which offered a whole range of health alerts and a safe platform for living. **Peter to share the Plan developed by the Digitally Enabled Citizen Board to members for their perusal, through the secretariat.**

34 Graeme Eunson agreed with many of the comments, particularly in relation to digital exclusion and equity of access, acknowledging the opportunity to rebuild the NHS from the ground up and improve access to services. He felt it important to highlight how far we had come but that we also had to recognise that technology had its limitations and that people missed human interaction. He felt that there is a need to look at the provision of undertaking diagnostics, blood pressure, bloods, ultrasound; and even chest x-ray, which would mean a single package rather than patients having to travel back and fore to various healthcare settings. He noted that it is also more challenging to deliver training to junior doctors and staff through video and telephone conversations.

35 David Garbutt made a plea that the strategy refresh should seek to ensure all of the diverse elements are brought together in a single strategic approach, acknowledging the large number of stakeholders involved. He felt that this improve delivery on the ground. John Burns was impressed at how much work had been delivered, but was concerned around how this pace might be maintained going forward. He felt that the point around connecting clinicians was important agreed that digital skills were also important too.

36 Dave Caesar pointed to safeguarding against the creation of new institutions and to focus on how we can embrace citizen health technology for pre habitation as opposed to reactive measures. We needed to use technology to allow citizens to manage their own wellbeing and foster a good enabling environment which needs to be owned by communities, rather than government and other bodies.

37 The Cabinet Secretary welcomed an excellent and most enthusiastic discussion. She noted that the speed of the work undertaken has been phenomenal across health and social care with a huge amount of shared purpose and pragmatism. She invited Jonathan and George to offer some closing comments.

38 Jonathan thanked the Cabinet Secretary and members for their comments and would relay the positive comments to digital teams across Scotland. George felt that the discussion had been helpful. He reflected that just because you can use technology, doesn’t mean that you should – it was more a matter of appropriateness. It was about listening to the needs of service users, patients and balancing these to understand and learn. Both Jonathan and George invited members to contact them for further discussion outside the meeting should they wish to further discuss.

Item 5: Report from Primary & Community Health Care Mobilisation Sub Group

39 Aidan Grisewood set out the purpose of the Group was to identify key primary and community health care priorities for re-mobilisation and recover, and develop a plan for implementation that maximises impact against outcomes through the recovery period and beyond. He noted that a lot of members of the sub group were also members of this group and that it had been a collective effort drawing on a range of expertise and engagement, noting that Sir Lewis chaired a Remote and Rural Special Meeting. The group identified the critical system-wide enablers to “lock-in” or “build on”, including data/evidence, workforce capacity and multi-disciplinary working, digital/Information sharing, communications, and health Inequalities/mental health.

40 One of the actions from the group was to set up a primary and data care intelligence group, intent of getting data, focusing on general practice and nursing and ensure this is fit for purpose. He went on to advise that Scottish Ambulance Service (SAS) data was a good example of good data which was used across the area.

41 The group were advised that little time had been spent to focus on remobilisation, as much work had been undertaken already, but that it was important to flag the restart of dental services in November, together with new services and

those critical to public health, such as flu vaccines etc., bringing in pharmacy, SAS and remote and rural issues, as well as other key elements of primary and community health care both in the pandemic and moving forward.

42 Aidan advised that communications are seen as an important early priority and highlighted the earlier presentation to this Group in the past. In terms of next steps, there would be a focus on Pharmacy First which has been launched and will continue to be promoted through media work in local radio with each of the clinical contractors involved.

43 Workforce was another key theme of the group with collective recognition that staff are tired, need to take leave and rest, Also noted were risks of self-isolation. However, there were huge gains derived from working across the system in care homes and community hubs, along with the role of prescribing and independent prescribers. There had been a package of support identified, thematically with three key areas for continued progress:–

1. Maintaining the recruitment pipeline and training/placements was seen as a priority, although challenging in the short term;
2. Maintaining the development of staff. Specific actions are needed to ensure capability and maintaining staff, which would be picked up through Wellbeing; and
3. Sharing good practice and maintaining efforts to ensure boards have processes in place.

44 Compelling information had been heard around mental health, in addition to the positive impact and investment in mental health in communities. Primary care improvement plans are being developed to maximise impact in this area and take forward some early priorities, however, a short life working group would meet to take forward a package of proposals separately, as this was a larger piece of work.

45 In relation to health inequalities, headline messages in terms of the impact of Covid demonstrated exacerbating issues but also shone a light to ensure the we maximise the impact to reduce health inequalities by remobilising services that the most vulnerable rely upon. A series of short term actions were presented and a dedicated short-life working group was set up. The particularly important role of community link workers was celebrated.

46 A user centred/citizen focus approach had been taken and there were wide links with teams and broader into the community, as well as critical links to connect information flows. Finally, the sub group were tasked with creating an action plan which had been circulated at the last meeting and again at this and he invited comments on this noting that the action plan needs to be agile and adaptive.

47 The Cabinet Secretary thanked Aidan for his presentation and expressed her gratitude to the sub group for the huge amount of work which had taken place, in such a short space of time. She invited comments from group members.

48 Carey Lunan thanked Aidan for bringing this all together. The sub group had been afforded the opportunity to form lots of new relationships with various discussions around building back better, mental health and had involved the whole of the primary care team. Public messaging needs to be realistic and be aware that capacity is down across the sector and we need to be honest with the public that some services are not going to be available for a while if not urgent. This will be which is a struggle for primary care services to manage, particularly as we are about to go into a second wave.

49 Carolyn McDonald advised that allied health professionals had very actively involved in Aidan's work and continue to showcase excellent examples e.g., in NHS Lanarkshire occupational therapists are undertaking mental health. The Framework for Rehabilitation would be a good item for a future MRG meeting.

50 Sir Lewis Ritchie advised that he was encouraged by the breadth of work being undertaken in both digital and primary and community healthcare. He reflected that the wellbeing of workforce was critical and that digital for remote and rural was particularly important. Finally, in regard to data intelligence, he advised, that as we aspire to a world class service this must be informed by world class intelligence.

51 David Quigley, for community optometry, advised that 63% of capacity had been remobilised well and much of that was due to the co-ordination of other providers and provision of PPE and regards to home care services, in remote and rural this is getting back towards normality.

52 Harry McQuillan felt that all of social and primary and community healthcare should come together to share ideas. He would be keen to see a forum encouraged as this was key to ensuring that each contributor knows their role in the system.

53 Annie Gunnar-Logan welcomed the recognition given in the presentation and work of the role of the wider third section, such as community support groups.

54 Aidan thanked the group for their contributions and comments.

55 The Cabinet Secretary thanked everyone for their involvement and the pace of work. Moving forward she was keen that the enthusiasm is sustained to ensure actions are progressed, without losing sight of the future endeavours.

Item 6: Updates from Established Groups

Primary & Community Care

56 See Item 5 above.

Redesign of Unscheduled Care

57 Helen Maitland apologised for the late circulation of the paper, advising that regular updates have been circulated as the programme moved towards the 31 October milestone. NHS Boards have been submitting their readiness

assessments but the programme was taking a short pause to assess its delivery risks. A number of options are being considered for a stock take meeting next week prior to feeding back to the Cabinet Secretary and moving forward. These were as follows some of those considered are outlined below:-

1. *Do Nothing*: although this is not seen as an option with significant attendances at accident and emergency seen in the past and that it would be a great concern for patients keen to enable access to the right care at the right time in the right place;
2. *Full implementation:* with a delayed start to allow more time to recruit and set up;
3. *Incremental approach:* – looking at timescales and options for this. They are already providing direction for the out of hours Covid pathway, mental health and minor injuries.

58 John Connaghan advised that the state of readiness was more green than amber, however there was a need to be ultra-cautious. The objective was safety, and landing the programme well so there was a solid basis for the future.

59 The Cabinet Secretary advised that this piece of work was really important and she strongly supported it. However, she wanted to ensure that public confidence is maintained. Thus her view was that it was sensible to hold to the end of October date, whatever the approach. Her view was that an incremental approach, which adds on services; to sustain us through, seems to be more sensible.

60 Johns Burns advised that he was in agreement with the points made by John and that he had had a discussion with Angelina Foster and Callum Campbell who had been involved and offered a further option of a test of change in a geographical area, i.e., NHS Ayrshire & Aran for a month.

61 Miles Mack advised that this had been discussed at the Academy meeting on Tuesday where concerns around a too rapid launch had been expressed. The view was that the workload had not been scoped and there were also concerns around the public message and the potential for unintended effects on general practice.

62 Graeme Eunson felt that it might be a bit rushed. He did not feel the systems were in place. Covid Hubs worked well and were able to redeploy staff effectively but these staff are needed back. Pathways for same day ambulatory care are not in the place required to implement. He felt that it was better to delay.

63 Carey Lunan expressed her appreciation of the enormous amount of work to get to this point and that it was of real importance to pause the work and take stock which was the sign of a strong and listening system. She suggested using well developed systems to dispatch patients who present with either minor injuries, Covid and mental health which seemed to be less of a risk and an easier message to provide to the public, whilst professional to professional lines are built up. She was keen not to see patients who would previously have called at their general practice for advice now thinking that they have to call 111. Urgent care is a big part of the

work of general practitioners who can offer a realistic approach and she would not wish patients to become snarled up in a system where they call 111 and then present later in the day in the community when it is too late.

64 Sir Lewis echoed the words of Carey advising that we could do flow centres with impunity, however, it was better to build up and assist colleagues on the ground through improved professional to professional links which could be done without any detriment. There was a need to be mindful of any unintended consequences. To hasten slowly is what he would advise as a principle and that this needs to happen but in a measured and resolute way.

65 Derek Bell noted that all large change programmes has risks and benefits which had to be balanced.

66 Eddie Fraser advised that it is not about taking work away from general practice. Hubs to support pathways are already in place and this is about how to build on this including access up from general practice as well as what’s coming down. There are concerns around displacement of work and to give general practice assurance, the impact of flow on working alongside people would be monitored. David Thomson noted that the academy of emergency medicine were supportive of the programme but echoed concerns around workforce. They were also supportive of this being tested in NHS Ayrshire & Arran.

67 Dave Quigley advised that the 55,000 community eye care teams has been asked to support but that the request was not accompanied by any details, so whilst they are looking for health boards to come up with plans, he was concerned that they have yet to hear what they will be asked to deliver. It would be helpful to have a common Heads of Terms/Terms of Reference to enable them be more prepared to assist in future.

68 Harry McQuillan agreed and that it was necessary to understand what the patient flow would be after 6pm and out of hours pathways, so that community pharmacy contractors had an understanding of the system and where to signpost people for support, rather than counteracting on changes.

69 The Cabinet Secretary agreed that it was critical that David and Harry were involved in these discussions as they were a critical part of its success. She summarised that colleagues were all strongly supportive but that there were clearly some issues to be resolved and decisions made around how to move forward. These issues should be tackled in relatively short order so that changes could be made prior to winter and there was a need to make a clear decision, collectively around how to progress this in either a phased way across the country or through a the offer of a test of change which both John and Eddie have offered to undertake.

70 John Connaghan agreed that all members were backing change but that it was an important week coming up at which a full and proper risk evaluation would been undertaken which would provide collective advice on best way forward.

Item 7: Any Other Business

None.

Item 8: Date of Next Meeting(s)

71 The next meeting (8) of the Group is scheduled to take place on 30 October, 2020 at 0900 hours.

72 The meeting concluded at 11:30 hours.

Scottish Government
12 October 2020