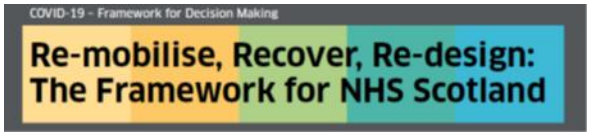

Mobilisation Recovery Group

Note of meeting 3

09:00-11:00, Friday 31 July, 2020

Via Cisco Webex

Members Present

Jane Anderson	National Staff Side representative, UNISON
Marion Bain	Deputy Chief Medical Officer
Donna Bell	Director of Mental Health, Scottish Government
Andrew Buist	Chair, GP Committee, British Medical Association
John Burns	NHS Board Chief Executives' Group representative
Sandra Campbell	Convenor, Scottish Social Services Council
Iona Colvin	Chief Social Work Adviser
John Connaghan CBE	**Interim Chief Executive, NHS Scotland (Chair)**
Cllr Stuart Currie	Health & Social Care Spokesperson, COSLA
Stephen Deans	National Staff Side rep, UNITE (deputising for James O'Connell)
Tom Ferris	Chief Dental Officer
Joe FitzPatrick MSP	Minister for Public Health, Sport & Wellbeing
Dee Fraser	Coalition of Care and Support Providers (dep. for Annie Gunner-Logan)
Eddie Fraser	Chief Officers' Group representative
Theresa Fyffe	Director, Royal College of Nursing (Scotland)
David Garbutt	NHS Board Chairs' Group representative
Cllr Kieron Green	Vice Chair, IJB Chairs & Vice Chairs Group
Philip Grigor	Scotland Director, British Dental Association
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
Edith Macintosh	Interim Exec Director of Strategy & Improvement, Care Inspectorate (dep for Peter Macleod)
Carolyn McDonald	Chief AHP Officer
Fiona McQueen	Chief Nursing Officer
Harry McQuillan	Chair, Community Pharmacy Scotland
Lewis Morrison	Chair of Scottish Council, British Medical Association
Diane Murray	Deputy Chief Nursing Officer
Peter Murray	Chair IJB, Chairs & Vice Chairs Group
Julie Mosgrove	Optometry Scotland (deputising for David Quigley)
Sir Lewis Ritchie	Mackenzie Professor of General Practice
Claire Ronald	National Staff Side representative, Chartered Society of Physiotherapy
Angela Thomas	Acting President of the RCPE (deputising for Miles Mack)
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
Becca Young	Scottish Care (deputising for Donald MacAskill)

Apologies

David Chung	Chair, Royal College of Emergency Medicine
George Crooks	Chief Executive, Digital Health & Care Institute
Jeane Freeman MSP	Cabinet Secretary for Health & Sport
Richard Foggo	Director of COVID Population Health, Scottish Government
Aidan Grisewood	Interim Director, Primary Care, Scottish Government
Annie Gunner-Logan	Coalition of Care and Support Providers
Clare Haughey MSP	Minister for Mental Health
Carey Lunan	Chair, Royal College of General Practitioners
Donald MacAskill	Chief Executive, Scottish Care
Joanna Macdonald	Chair, Adult Social Care Standing Committee, Social Work Scotland
Peter Macleod	Chief Executive, Care Inspectorate
Miles Mack	Chair, Academy of Medical Royal Colleges and Faculties
Richard McCallum	Interim Director, Health Finance, Scottish Government
Christine McLaughlin	Director of NHS Planning, Scottish Government
Elinor Mitchell	Interim DG, Health & Social Care, Scottish Government
James O'Connell	National Staff Side representative, UNITE
David Quigley	Chair, Optometry Scotland

In attendance

Derek Bell	Professor of Acute Medicine, Imperial College, London
Dave Caesar	Head of Leadership & Talent Management, Scottish Government
Heather Campbell	Interim Deputy Director, Primary Care, Scottish Government
Angiolina Foster	Chief Executive, NHS 24 (for unscheduled care item)
Michael Kellet	Deputy Director, Scottish Government
Rose-Marie Parr	Chief Pharmaceutical Officer, Scottish Government
Stephen Lea-Ross	Deputy Director, Health Workforce, Scottish Government
Helen Maitland	Director of Unscheduled Care, Scottish Government
Sean Neill	Deputy Director, Health Workforce, Scottish Government
Liz Sadler	Interim Director of Population Health, 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. John Connaghan, Chairing in the Cabinet Secretary's absence, started the third meeting of the Group by welcoming attendees; in particular, Andrea Wilson and Carolyn McDonald who were joining as full members for the first time.

2. John noted that Angiolina Foster will have to leave the meeting at 09:30 for another commitment; as such, the Group took the substantive agenda item on Unscheduled Care (on which Angiolina was the initial presenter) first.

Item 2: Unscheduled Care

3. Angiolina set the context for the discussion, explaining that she co-chairs a strategic advisory group on unscheduled care with Calum Campbell, Chief Executive of NHS Lothian. The group was commissioned by the Scottish Government to consider the redesign of unscheduled care to ensure that the people of Scotland continue to be able to access the right care, at the right time, in the right place, first time.

4. Angiolina explained that the Unscheduled Care Group quickly reached consensus on two core points: (i) that to fully deliver on the ask would require a detailed review over two years; and (ii) that there is a self-selecting, first phase of this programme, focusing on the circa 800,000 to 900,000 people per year who self-present at A&E Departments. As such, the initial phase is a sub-set of the larger redesign work for unscheduled care that will be undertaken over a longer timeframe.

5. The Unscheduled Care Group had agreed that, if possible, it was desirable to redesign the initial phase (self-presenters) ahead of this winter. The group had reached agreement on four drivers for their thinking, in this respect: (i) the need to design a safe and effective service model for the public and staff, especially in the current COVID-19 context; (ii) the evidence of the contribution that digital/virtual channels can make to delivering the first point, alongside being more convenient for patients; (iii) an acknowledgement that the current system does not make best use of the clinical and other capacity, nor does it offer a reliably good patient experience; regardless of COVID-19 considerations; and (iv) an onus on leaders to share and apply the learning and lessons from managing the pandemic, to date; especially the effectiveness of the pathways put in place for COVID-19.

6. Angiolina further explained that this latter point focused on the provision of a single, national access route for the public: offering consistent initial triage, followed by locally appropriate next stage clinical consultation, predominantly undertaken virtually. During the three month period from March-May, there had been 110,000 cases triaged by the 111 single national access point; and the number of patients who needed to go to a clinical site was only 11,000. From the initial 110,000, 30% were fully dealt with via NHS 24; with 68,000 patients moving to the next stage of community hubs delivering virtual assessment; 80% of this cohort were fully dealt with at that stage; leaving the final 11,000 who required face-to-face clinical assessment. Angiolina was clear that there is not an expectation that this can be replicated in full with A&E self-presenters. However, the Unscheduled Care Group felt the design principles do translate; supported by very strong and clear public messaging: maximising digital/virtual consultation to minimise footfall at A&E Departments and ensure these services are focused on those that require that level of care.

7. Angiolina concluded her introduction by providing assurances about what this work is not intended to do: it is not designed to impact on the existing roles and relationships in primary care (specifically, general practice); nor is it proposing any change to emergency pathways (e.g. via 999 and the small number of self-presenting emergencies).

8. Professor Derek Bell took the Group through the model that the Unscheduled Care Group is now proposing; emphasising that this is based on the recent learning from how service provision had been adapted to address the COVID-19 challenges; delivering a safer and more effective system for the benefit of all. Derek set the context in terms of recent activity: for emergency admissions to hospitals in Scotland, we are currently at around 94% of historical activity; with Emergency Department attendances at around 80% of historical precedents; and paediatric emergency activity is returning to seasonal norms.

9. Derek pointed out that the principles underpinning this redesign work had been fully informed by input from the NHS Board Chief Executives; acknowledging that different Boards will be at different stages and have different needs. It will require a whole system, multi-agency and multi-disciplinary approach to be successful.

10. Derek talked to the 'conceptual framework' flow slide; explaining that it is a high level representation and an iterative document, subject to change as further information and insight is available. It sets out how access to urgent care can be made available through a national, single point of access, e.g. via NHS 24/111; with local Boards implementing a flow/navigation centre, directly receiving referrals from NHS 24 and offering rapid access to a senior clinical decision maker; avoiding the need for attendances at A&E, where possible and appropriate. It was envisaged that this approach could result in around 20% of historical attendances at A&E Departments being safely and effectively dealt with elsewhere; either in another clinical setting or virtually.

11. Helen Maitland continued the presentation by reiterating that there are no plans to change the GP or emergency care pathways; this work is about ensuring that people who may have previously self-presented at A&E can get the right care, in the right place, at the right time; via a single point of contact (NHS 24) and flow centres in each Board area. On timeframe, Helen explained that the proposal is for the redesign to be in place by the autumn; ahead of any potential winter and COVID-related pressures. It is recognised that this will have an impact on the workforce and will require further recruitment and training.

12. Helen set out the key priority work streams and explained that the approach should be flexible to ensure that local needs and resources are full taken into account. The single point of access and flow centres form the first two work streams, with the remaining streams covering digital/virtual healthcare and the scheduling of care. On maximising digital care, Helen responded to a text chat query by confirming that this will be subject to an Equality Impact Assessment to inform decision-making and minimise the risk of unwittingly increasing digital exclusion. On the scheduling of care, Helen explained that systems are being looked at to schedule referred patients and minimise variation in surge by hour of the day and day of the week; and to manage the flow of previous self-presenters who flow centres refer for face-to-face consultation. A large public information campaign is planned with clear messaging to ensure that both the public and staff understand how this new approach will work and what it means for them.

13. Helen concluded the presentation by assuring members that this work sits within the wider unscheduled care programme, building on the foundations of the *6 Essential Actions*, and that this will continue to be refined and developed; as informed by data monitoring and analysis, and by the sharing of best practice and innovation. Helen confirmed that user groups had been widely consulted about how and why they had accessed unscheduled care services and this had informed the proposals and redesign work.

14. John Connaghan thanked Derek and Helen and summarised the key principles of the initial phase redesign work on which Ministers will be advised: the single point of contact; having fully resourced flow and navigation centres in each Board area; and the importance having agreed changes in place sufficiently in advance of winter and any COVID-19 related pressures. John then invited questions from the Group.

Discussion

15. Andrew Buist commented that the proposals were not without risk and had the potential for unintended consequences. Whilst he agreed with the four key drivers for change, he felt the proposed approach needed to be carefully considered with key stakeholders over a longer timeframe to ensure it would be sufficiently robust. He felt that the key aim (to address inappropriate self-presentation at A&E) could be dealt with in other ways. Andrew also questioned whether the activity data presented by Angiolina (referenced in paragraph 6) could be meaningfully applied to the wider context under discussion. He further queried whether the GP Out of Hours service would be de-stabilised by this approach; whether the workforce is available to staff the proposed model; and whether the changes would attract the support of the public.

16. Harry McQuillan, in respect of community pharmacy, commented that they continue to have patient contacts, including out of hours, outside the proposed model; so care will need to be taken to ensure robust and smooth patient flows. Harry offered his assistance in contributing to the ongoing redesign work.

17. David Garbert commented that, as the former Chair of the Scottish Ambulance Service, he fully recognises that action is required now, and that there is evidence from similar approaches in Europe to support the proposals. He felt the current system does not provide the best care for patients and would support the redesign as an improvement. David also felt that the public messaging signposting the alternatives to A&E is key and should be deployed widely as a matter of urgency. This was a point that attracted considerable support in the text chat from the Group.

18. Eddie Fraser confirmed that the proposals pose no difficulties to the Integrated Joint Boards; noting that IJBs had been largely responsible for running the COVID-19 assessment hubs. He agreed that a different approach is necessary to ensure that A&E Departments can be safely and effectively managed; and that the pre-COVID approach is plainly not sustainable. He agreed that there will be risks involved but that was not a reason to reject the redesign proposals; rather, the risks need to be openly acknowledged and effectively mitigated.

19. John Burns confirmed that the NHS Board Chief Executives' Group had discussed these issues frequently and at length: they feel there is an urgency to address the issues outlined and are fully supportive of the direction of travel proposed. John was clear that local systems will need to work together to support the safe and effective delivery of the proposals. He agreed that robust risk management and effective public messaging will be essential in delivering what the Chief Executives considered to be necessary service redesign.

20. Theresa Fyffe agreed that change is required but was concerned about the proposed pace, noting that other local services would need to be in place first for the flow centres to refer patients to. Theresa was also concerned that the full implications for the health and social care workforce has not been considered, and that considerable additional staff numbers may be required to deliver a safe and effective service under the proposed approach.

21. Stuart Currie commented that the proposals do not appear to fully cover the social care sector and the alternative patient pathways; and that all potential alternative services and pathways across both health and social care need to be identified and considered. This then needs to be appropriately communicated via a comprehensive public messaging campaign.

22. Sir Lewis Ritchie commented that a very similar model is currently being adopted in England and that we should pool the evidence as it emerges; continuing to refine and develop our approach. Sir Lewis agreed that careful workforce planning and effective public messaging will be critical to the success of the proposals.

23. John Connaghan asked Derek Bell and Helen Maitland to sum up this agenda item and, in particular, to comment on any appropriate comparisons/learning from across the UK and wider afield.

24. Derek Bell acknowledged the Group's questions and that we are dealing with a highly complex system. The clear aim is to deliver a safe and effective service, with our approach underpinned by robust evidence and data. Derek confirmed that relevant expert literature internationally for a number of years has identified 20% of the level of attendances at A&E Departments that might best be dealt with elsewhere. Further, there is considerable further learning to consider from other countries (e.g. Denmark, Netherlands) which can continue to help with informing our approach. Derek concluded by noting that the two parts of the health system that changed the most during the initial COVID-19 outbreak, and that have informed the suggested redesign, were the triage processes adopted by NHS 24 and the Ambulance Service.

25. Helen Maitland reiterated that the proposals reflect the key priorities that have the potential for the greatest positive impact if implemented ahead of winter; they nonetheless exist within the wider programme of work around unscheduled care which has not been stopped; retaining the core aim of delivering more care closer to home, where it is appropriate to do so.

26. John Connaghan concluded this part of the discussion by recognising that the proposals reflect important and necessary change that have the potential to deliver significant benefits for all; not least, patients. Nonetheless, John recognised the concerns that had been expressed and the need for this work to be taken forward carefully. As such, **John is going to make a recommendation to the Cabinet Secretary that this work be taken as a standing item at future Group meetings so all members can receive updates on the key progress made**.

Item 3: note of meeting held on 14 July, 2020

27. Suggestions for minor amendments to the meeting note are to be made separately to the Group Secretariat. No substantive points were made. As such, **the note of the meeting on 14 July was agreed, subject to any minor amendments. The note of the meeting will be published with the note of the previous meeting on the Scottish Government website.**

Item 4: matters arising not on the agenda/actions

Update on next steps for Primary and Community Care

28. John commented that, at the previous meeting of the Group, there had been a useful discussion on work we would like to take forward on primary and community care. There had been reflection on that discussion with a view to deciding the next steps. A sub-group has now been established, chaired by Aidan Grisewood, to take this work forward with a wide range of representation including GPs, Dentistry, Optometry, Pharmacy, Community Links Workers, as well as representatives from national and territorial NHS Boards.

29. The sub-group has been tasked with presenting a report with recommendations to the Group at a later meeting, possibly in September. Heather Campbell confirmed that the first meeting of the sub-group is scheduled for Wednesday, 5 August.

Forward agenda planning

30. The next meeting of the Group is scheduled for Friday, 14 August with three planned agenda items covering: (i) Mental Health, (ii) Public Health, and (iii) initial feedback on NHS Board Mobilisation Plans, including a potential readiness assessment against future surges in COVID-19.

31. The fifth meeting of the Group is scheduled for Friday, 28 August with a potential agenda item from the ALLIANCE on securing a wider person-centred user focus on the Group.

32. The longer list of potential agenda items at future Group meetings include: lessons learned from COVID-19 to date; longer term strategic planning; developing the Digital Strategy; and an update on delivering planned care. It was agreed that any thoughts on other potential agenda items should be emailed directly to the Group Secretariat.

Item 5: Workforce

33. John Connaghan introduced the next agenda item by commenting how Workforce is a critical area for the Group's consideration. There were two presentations on key issues: Steve Lea-Ross and Sean Neill would lead on Workforce Planning; to be followed by Dave Caesar on Leadership, Culture and Wellbeing.

Workforce Planning

34. Steve Lea-Ross took the Group through the associated slide presentation on the approach to workforce planning being taking forward. The presentation has been informed by input from the NHS Board Chief Executives, the Scottish Partnership Forum and the Workforce Planning Programme Board.

35. Steve explained that the presentation covers emerging thinking in response to the commission from Ministers for a COVID-19 supplement to the Integrated Workforce Plan. The driver diagram (slide 2) refocuses activity and attempts to draw out a thematic link between the workforce planning objectives and the two primary aims to: (i) eliminate COVID-19 whilst reducing non-virus harms in the Scottish population; and (ii) promote resilience and preparedness across our health and social care system. Steve commented that the key drivers operate across the whole health and social care landscape; promoting an informed, engaged and participating workforce, with a particular focus on their health and wellbeing.

36. Steve confirmed that existing workforce supply arrangements had been under review to ensure that they remain fit for purpose: an internal exercise would be shared with stakeholders shortly. The presentation sets out 'change ideas' which could be variously employed to ensure that we benefit in the longer term from the flexibilities in how staff have been deployed during the COVID-19 outbreak; and how recruitment could be best re-orientated. Other factors such as Brexit remain key considerations in how they are likely to affect workforce supply and demand in key areas, such as social care.

37. Steve then outlined some of the service planning scenarios for the rest of the year and how workforce requirements could be estimated against these, based on lessons learned to date from the pandemic.

38. Steve outlined the three time frames for the work on the Integrated Workforce Plan: (i) the short term covering the period until the end of March 2021; (ii) the medium term to June 2021; and (iii) the longer term horizon to 2025 and beyond. The COVID-19 Integrated Workforce Plan supplement assumptions were outlined to the group, which had been developed through engagement with stakeholders. A particular focus was placed on the required workforce growth factor and Steve set out an initial assessment of the bridging WTE Health and Social Care demand to 2024, noting that this would be subject to validation and revision, including through the next phases of the re-mobilisation of NHS Boards.

39. Steve concluded the presentation by returning to the key principles underpinning this workforce planning: taking a holistic approach, rooted in fair work and the values and culture of health and social care services. Having effective retention strategies such as delivering respect, security, opportunity, fulfilment and the use of flexibility in employment will be crucial whilst growth factors are limited, not least due to constraints in training supply.

40. John Connaghan thanked Steve for the presentation and commented that the content will be of critical importance to all those in the meeting. John felt that one of the key factors was how we balance the effective suppression of COVID-19 with service re-mobilisation, in the context of a finite workforce. He then invited questions from the Group.

Discussion

41. David Garbert recognised the UK dimension to this discussion in terms of recruitment of certain staffing cohorts. He welcomed the approach that had been outlined but cautioned that, given the nature of training programmes, there would be limited flexibility to release staff in training in the same as way as during the initial response to the pandemic. He felt the most challenging aspect is the placement capacity across the system, given the restriction on the ability of staff who would have acted as mentors due to current working restrictions, such as physical distancing.

42. Stuart Currie and other Group members, via the text chat, raised concerns about how the previous workforce plan had been delayed several times because the focus was on health and less so on social care staff, employed by Local Authorities. He felt this work had to be taken forward collectively or we risk the same issues and delays.

43. Andrew Kerr agreed with this and added that there needs to be a considered discussion with private sector providers in care homes and care at home to inform this.

44. Andrea Wilson commented, from an AHP perspective, that there may be limitations on how staff can work as flexibly as they had been during the initial COVID-19 response in the next phase/s, as more regular services come on stream with re-mobilisation; particularly addressing the increased demand for rehabilitation services. She also noted that there is currently a significant restriction on placement training which could significantly impact on future workforce.

45. Theresa Fyffe welcomed the approach to workforce planning that had been presented; particularly the focus on staff wellbeing. She noted some concerns about the modelling and any suggestion that we may have less demand for staff as a result of technological innovations. Whilst Theresa accepted that technology will bring changes in some areas, she felt it will not affect the core requirements for staff in community, primary and social care.

46. Angela Thomas was concerned about the physical distancing restrictions for doctors in training, including taking exams and how this may affect their progress and wellbeing. She asked what large public facilities might be considered to accommodate medical exams under COVID-19 restrictions by September, with commercial establishments currently unavailable.

47. Sean Neil concluded this agenda item by reflecting on the comments made. He welcomed the Group's general support for the proposed approach and direction of travel but noted the concerns raised and emphasised that this is an iterative process, underpinned by collective views and the prevailing evidence/analysis. Sean offered an assurance that all key stakeholders including COSLA are being involved in this work, and that their input will continue to meaningfully inform its development. He noted the concerns about training and placements; providing an assurance that this will be carefully considered. Sean offered to return to a future meeting of the Group to provide an update on progress, if that was thought to be helpful.

Leadership, Culture and Wellbeing for Health & Social Care

48. John Connaghan thanked Sean and Steve and moved on to the final agenda item of this meeting: the approach being adopted on leadership, culture and wellbeing. John noted that the proposals align with the staff and carer wellbeing objective in the Mobilisation Framework, i.e. supporting people to recover including their mental health and wellbeing; capturing the interventions currently in place; identifying additional actions required to support staff and include in the plan for recovery; emphasising the importance of wellbeing and kindness; including physical and psychological needs; and developing a new compact and systems to support staff across health and social care. Noting that the presentation had been informed by input from NHS Board Chief Executives, the Scottish Partnership Forum and the Workforce Planning Programme Board, John asked Dave Caesar to proceed.

49. Dave Caesar took the Group through the slide presentation; reflecting that the ambition set by the Christie Commission in 2011 ("unless Scotland embraces a radical, new collaborative culture throughout our public services, both budgets and provision will buckle under the strain") still needs work to be fully realised; and that this will require constant attention, recognising that the way we develop strategy is only as sound as the culture of the system in which we are strategizing; in turn, the ability of models of care to be enacted are only as effective as the people's mind set in which that activity will be undertaken.

50. Dave referenced compassionate leadership and how, during the recent experience of the pandemic, we have seen the way we enact leadership is intertwined with the culture we are enabling and create; linked to the wellbeing of staff at every level; emphasising that this is not about leaders; rather, the practice of leadership. Dave outlined the fundamental importance of this: the need to be fully aware of it and to understand it; as all of the issues raised during the meeting and which will be considered by the Group require us to collaborate effectively and to work across teams, systems, different employers, professional and territorial boundaries; to make sound decisions based on mutual respect and collectivism.

51. Dave set out that, if our colleagues are psychologically well and engaged in a single, common purpose, as recently with the pandemic, it will generate positives across a range of factors including the quality of care, financial performance, productivity and fulfilment whilst reducing negative outcomes, and maximising recruitment and retention; and that this is equally essential for both staff in health and social care, and the people they care for.

52. Dave set out data that supports this approach; where effective team working in hospitals had demonstrated a reduction in patient mortality: the cited study showing that 5% more staff working in 'real teams' can be associated with a 3.3% drop in mortality; and that for an average acute hospital, this represents around 40 deaths per year; in line with the expected number of lives that will be saved by the introduction of the major trauma network in Scotland.

53. Dave covered the central role of culture; it has to be interlinked with strategy: if the strategy is not married to the way in which the culture is operating, and employee experience not understood, then it is unlikely that we will see a successful implementation of the strategic goal which has been set.

54. The next slide covered the work of the Ministerial Short Life Working Group that followed the Sturrock Report. Dave explained that the approach developed from this learning is highly challenging: requiring both formal and informal interventions; and the notion of creating a social movement rather than mandating change from the top is hard to realise in a system which has relied on a centralist approach to strategy and operational delivery. To understand this is to recognise that how we enact strategy is crucial to the uptake and potential success of that strategy. Dave explained that the notion of a national conversation on this is gaining some traction and that he is looking forward to working with colleagues as this is further developed.

55. In terms of staff wellbeing, Dave explained that there is an established 'wellbeing champions' network, bringing together 84 'wellbeing champions' from Health Boards, Local Authorities, HSCPs, the third sector and COSLA, to promote the psychological wellbeing of the workforce. The National Wellbeing Hub (www.promis.scot) was launched on 11 May: a single site free to access with digital resources, advice, communications toolkits, and signposting to additional support for all health and social care staff. It has had over 30,000 visits since its launch. In addition, 'Coaching for Wellbeing' has been offered via the Hub and has delivered around 1,500 hours of coaching to date. Interest has come from NHS, Local Authority, third and private sectors. In terms of demographics, all levels of seniority from team member to executive leader are represented.

56. Dave outlined the specific work on a health and social care mental health proposal. This will develop the digital tools available and enhance the support already provided at Board level for staff across a range of locations. Further, there will be national resource via the helpline which launched last week and the workforce specialist care response, to address any unmet need from regulated professions in particular that may face stigma/professional issues in accessing this assistance from their own organisation.

57. Dave concluded the presentation by summarising the approach: we have momentum in promoting health and social care as a great place to work in Scotland; this is based on having a coherent programme of work, focussed on: inclusion and how we listen (nationally, organisationally and individually); equalities and diversity, including career progression and recruitment; compassionate leadership at all levels; supporting staff to be well and to thrive at work; to incorporate formal and informal/social processes; to value psychological safety and trust as key markers of effectiveness; and to develop wellbeing measures and understand the effect of interventions. Dave emphasised that this is a work in progress and it will be informed by as much collaboration with colleagues across systems as possible.

58. John Connaghan thanked Dave for his presentation and invited comments and questions from the Group.

Discussion

59. Joanna Macdonald commented that compassionate leadership has been essential in the initial response to COVID-19 and will continue to be so through the next phases of remobilisation. This position was supported by a number of Group members. Joanna had personal experience of the Sturrock Review in NHS Highland and the follow up review in Argyll & Bute which highlighted bullying and intimidation in a high proportion of staff who responded. As such, the culture of the organisations and behaviours have been very high priorities locally, with an emphasis on effective communication and connections with staff.

60. Ian Welsh commented that the presentation resonated with ALLIANCE work streams over recent years; particularly relating to courageous leadership, leadership at all levels, engaging, and including local people as well as staff in the conversation; to change culture we need the whole 'house of care': out with and not just within health and social care. Ian emphasised that, for the approach to be successful, it needs to be 'people up' and not 'top down'; it needs to be fully community inclusive; it needs to embrace wider paradigms and it needs to be a genuine social movement.

61. Claire Ronald commented that we need to take account of what we are learning from the Black Lives Matter movement about the inherent racism that exists subtly in all our health and care systems; noting that a disproportionate amount of BAME staff face disciplinary cases; and further noting the apparent lack of diversity of the Group members that were discussing cultural change. Claire also pointed out that this ties into workforce: how do we build time for training into our workforce planning for all levels of staff; recognising that short staffing can impact adversely on culture.

62. Kieron Green agreed that, whatever the reasons underlying the issues identified in Sturrock and other similar reviews across Scotland, addressing the perception of staff is just as important; ensuring that they feel supported and are able to express opinions.

63. John Connaghan invited Dave Caesar to round up this item of the agenda. Dave welcomed the considered comments of Group members. He wanted to assure the Group that there are both formal and informal actions that are being taken forward quickly in this area, including: the service to allow health and social care staff whose mental health has been significantly adversely affected to have access to prompt, evidence-based, high quality treatment; work to ensure that all voices are heard, including BAME voices; and developing proper 'listening': at both a national conversation level and on an individual basis. Dave offered to return to a future meeting of the Group to provide an update on progress, if that was thought to be helpful.

64. John Connaghan thanked Dave and confirmed with the Group that there was no further business for the meeting.

Item 6: Date of Next Meeting(s)

65. It was confirmed that the next (fourth) meeting of the Group is scheduled for 09:00 to 11:00 on Friday, 14 August. Subsequent meetings of the Group are scheduled for Friday, 28 August, Friday 11 September and Friday 25 Sptember; all between 09:00 and 11:00.

66. The meeting closed with John Conngahan thanking all presenters and Group members for their valued contributions.

Scottish Government
31 July 2020