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| **DRAFT MINUTE of MEETING of the AREA CLINICAL FORUM** | **Thursday 31 October 2024 – 1.30pm**<br>**Microsoft TEAMS** | |

**Present**

Catriona Sinclair (Chair)
Andrew Strain, Area Medical Committee
Frances Jamieson, Area Optometric Committee
Grant Franklyn, Area Medical Committee
Helen Eunson, NMAHP Advisory Committee
Linda Currie, NMAHP Advisory Committee

**In Attendance**

Ann Clark, Non Executive Director
Boyd Peters, Medical Director
Garret Corner, Non Executive Director
Sammy Clarke, Lead Health Analyst, Planning and Performance (Item 4.1)
Elspeth Skinner, Senior Programme Manager, Strategy and Transformation (Item 4.1)
Hannes de Kock, Team Lead (Item 4.2)
Duncan Railton, Associate Specialist, Oral and Maxillofacial Surgery (Item 4.3)
Louise Bussell, Nursing Director (Item 4.5)
Karen Doonan, Committee Administrator (Minutes)

## 1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and welcomed Dr Andrew Strain who had taken over from Dr A Miles as Area Medical Committee (AMC) rep. Apologies were received from E Caithness, A Turnbull-Dukes, P Hannam, Alex Javed, Zahir Ahmad and K McNaught

It was noted that the forum was not quorate, and no decisions could be made by the forum.

## 1.1 DECLARATIONS OF INTEREST

There were no declarations of interest.

## 2. DRAFT MINUTE OF MEETING HELD ON 4 July 2024

As the meeting was non quorate the minutes would go to the next meeting for approval.

The Forum could not approve the minutes as the meeting was non quorate.

## 3. MATTERS ARISING

There were no matters arising.

## 4. ITEMS FOR DISCUSSION

Due to time constraints the order of items did not follow that of the published agenda for the meeting.

**4.1** **GP Wait Data** – Sammy Clarke, Lead Health Analyst, Planning and Performance, Elspeth Skinner, Programme Manager, Strategy and Transformation.

S Clarke spoke to a short presentation for the new dashboard which would go live over the coming weeks. It was noted that pre pandemic there had been GP Wait data available for GPs and clinicians within the organisation showing the wait times for the past year, however during the pandemic this had been put on hold. Within the presentation it was highlighted:

- The dashboard no longer used the Excel format of previous versions
- The dashboard would go live in a couple of weeks and had been renamed "completed waits dashboard" rather than "gp wait" data.
- Communications would go out across the organisation giving information on how to access the data which would be via a nugget on the intranet page.

S Clarke gave a few examples of how to filter the data within the dashboard. L Currie queried whether data related to the Allied Health Professionals (AHPs) was within the dashboard. S Clarke confirmed that at present it was not as data sat across various systems at this time. A Strain queried if data for patients seen by other health boards was available citing Greater Glasgow and Clyde where some Argyll and Bute patients were referred to. It was noted that data was only relevant to within NHS Highland Board area at present.

F Jamieson queried access by those working in community as they did not currently have access to the intranet. In discussions around access, it was noted that other health boards had made the decision to place the dashboard on public facing internet pages, the forum felt that if other health boards had made this decision then NHS Highland should follow suit.

It was noted that the dashboard would go to the Executive Directors Group (EDG) for approval, but communications would go out through the weekly bulletin and the primary care bulletin advising staff of the new dashboard. Staff were encouraged to access the dashboard and send feedback/questions to the team. This would help shape the dashboard going forward.

The Forum **noted** the update.

**4.2** **Long Covid Study** – Hannes De Kock, Team Lead

H De Kock spoke to a short presentation within which it was highlighted:

- The team was a small part time team consisting of a clinical psychologist, physiotherapist, occupational therapist and an administrator. There were also two doctors who each did a half day a week with the team.
- The World Health Organisation (WHO) definition of long covid is the development of new symptoms three months after the initial infection that last for two or more months without explanation.
- Any delayed clinical care for patients impacted both their quality of life and their recovery from the symptoms.
- Approximately 6% of those who got the infection would go on to develop long covid. Vaccination was shown to prevent covid turning into long covid within patients who had the infection.
- Studies have shown that patients who developed long covid had not only cognitive dysfunction but ongoing medical issues. .
- Long covid was a global phenomenon and there was a need to look at what can be provided for patients within a community setting, there required to be a multi disciplinary team approach to patients in order to support them.

L Currie commended the work that had been done at a multi-disciplinary team level within the study and highlighted the funding issue citing the reduction in funding in the coming year. It was noted that there was a lot of political interest in the long covid service and it

was hoped that some funding would continue to be achieved in order that work would continue.

In discussion it was highlighted the need to integrate long covid within established specialities in order to maintain the levels of care that patients required. It was noted that within the Highland area there had to be slight changes in the way that services were delivered due to the spread of population across the remote and rural areas. In response to a query around the continued spread of long covid within the population it was noted that the study had found that the rate of long covid infections was dropping within the population and that vaccination gave a level of protection against developing long covid.

The Forum **noted** the update.

**4.3** **Cone Beam Computer Tapography (CBCT)SBAR** – Duncan Railton, Associate Specialist, Oral and Maxillofacial Surgery.

D Railton spoke to a short presentation within which it was highlighted:

- CB CT scanner gives 3D imaging for teeth, jaws and facial bones which is vital to provide a safe diagnosis and treatment planning for patients. NHS Highland is the only board in Scotland that does not have this piece of equipment. Approx 250 scans have to be outsourced.
- Requirement to be able to offer the scan to patients in order to gain consent for procedures from patients as CBCT gave the level of detail required.
- At the moment some patients could get scans done privately but scans are not always of good quality.
- Patient pathways were too complicated at the moment with patients having to travel to Dundee to get a scan, before then being seen again within NHS Highland, this added more steps to the process.
- The item of equipment had been identified and would be a like for like replacement with regard to size of equipment.
- Challenging to provide the level of dental care required within Highland without this piece of equipment.

It was noted that the business case had not been finalised and that support from the forum would be welcomed. Discussion within the forum queried the role of the forum with regard to requests for items of equipment as this was not within the remit of the forum and the Chair suggested that the route forward was through the Asset Management Group.

A Clark queried why patients had to travel to Tayside when there was a service offered within Grampian which was geographically closer. It was noted that the agreement had been in place prior to NHS Grampian being able to offer the service. To date no agreement to alter this had succeeded.

In further discussion it was noted that the business case had not been signed off and therefore could not go to the Asset Management Group. It was unclear why the process had not completed other than the financial challenges that NHS Highland was facing had had an impact. Discussions covered some suggestions of the routes that could be taken in respect of replacing equipment that was reaching the end of its life cycle.

The Forum **noted** the update.

**4.4** **People and Culture Portfolio Board** – Helen Eunson, Professional Lead Nurse, Mental Health and Learning Disabilities (NMAHP rep)

The Chair introduced H Eunson who attended the People and Culture Portfolio Board meetings as a representative of the forum. H Eunson asked for any questions from the forum on the papers circulated and whether there was anything that they wished highlighted at the meetings going forward. The forum was encouraged to contact H Eunson directly.

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| The Forum **noted** the Update |

**Quality Framework –** Louise Bussell, Nurse Director

**4.5** The Chair introduced L Bussell to the meeting explaining that a Joint Development Session had taken place prior to this paper coming to the forum.

L Bussell shared a short presentation wherein it was highlighted:

- The toolkit was set around 5 domains – Person Centred and Care, Safe, Effective and Efficient, Responsive and Well Led.
- Each domain was given a definition with local and Board measures stated and how this was to be reported through the IPQR.
- Well led within the framing of the toolkit covered all levels to reflect the responsibility that everyone has within the framework.

G Franklyn highlighted concerns around the pressures on acute staff within secondary care and stated that whilst it was appreciated that a framework required to be put in place there was a concern that staff on the frontline were under too much pressure already and would not see this toolkit positively. H Eunson asked for clarification on how the toolkit would be rolled out initially with L Bussell confirming that the toolkit would be tested with feedback taken on board before it was rolled out across the entire organisation.

L Currie welcomed the toolkit citing that there was a lack of data that was collected in respect of the Allied Health Professionals (AHPs) and as a result the measurement of quality and performance was not accurate. This toolkit would identify where there were gaps in quality and performance which could then be addressed, and services improved.

Within the discussion the point of measuring the patient experience and whether it was positive or not was highlighted with it being noted that as the patient experience was not being captured this was not giving a full picture of the services delivered. Discussions covered the requirement to identify the strengths and weaknesses within teams and it was felt that the toolkit would help identify these going forward.

Guidance was sought by L Bussell and B Peters in how to embed the toolkit positively. H Eunson asked for clarity in how the toolkit fitted into the measurement of quality within the organisation. L Bussell stated that the toolkit would not be used across the entire organisation but could be adapted for use by non-clinical staff in areas where issues had been identified and used in targeted areas for clinical staff.

G Franklyn cited the recent Health Improvement Scotland (HIS) inspection where the verbal feedback was very positive from HIS but where staff had felt that the pressures within acute services had increased dramatically over the last few years. Without the challenges being addressed and the pressures reduced quality of care would be challenging to improve.

Highlighted within the discussion was the need to have the toolkit locally driven to enable the toolkit to be used more effectively. A Clark stated that the Board were aware that quality improvement measures would require to be locally driven and that the toolkit would

help with this process. It was noted that this toolkit was a way in which feedback from the patients could be captured and successes could be identified. It was important to recognise the human element within the processes and not place focus entirely on the process itself. Understanding how the services were being received by the patient would help in the delivery of services going forward.

The Forum **noted** the Update

## 5 MINUTES FROM PROFESSIONAL ADVISORY COMMITTEES AND EXCEPTION REPORTS

**5.1 Area Dental Committee meeting –** 24 September 2024

**5.2 Adult Social Work and Social Care Advisory Committee meeting -** 5 September 2024

**5.3 Area Pharmaceutical Committee meeting** –7 October 2024

The Chair advised that most of the discussion held within the meeting was in respect of operational matters. Workforce analysis for Pharmacy was underway from NHS Education for Scotland (NES), there was no update at the moment.

**5.4 Area Medical Committee meeting** – 15 October 2024

- G Franklin noted that his tenure as chair of the AMC ended in September and that a new chair had been sought. The AMC chair alternates between Primary and Secondary Care and therefore the next chair would be from Primary Care. A Strain would assume the chair on an interim basis until the formal governance processes of the committee could be fully addressed.
- A Strain noted that there had been an ask made by AMC members that the ACF be made aware of the need for an integrated patient record system with an integrated eHealth service point. This was noted as a potential patient safety concern.
- G Franklin and A Strain noted that the AMC had proposed that a short paper be brought to the ACF in connection with travel and associated expenses for staff travelling on behalf of NHS Highland in particular for travel to remote areas. Members of the GP Subcommittee and the AMC had noted that the matter had not been reviewed for some time and that there was a perception that there was a level of inequality between different staff groups which also needed to be addressed.

In discussion, the Medical Director advised that if the proposal would be of relevance to staff beyond medical staffing then the proposal would need to be seen by the Director of People and Culture and eventually the Staff Governance Committee in order that an assessment could be made in relation to national rules and a comparison made with other NHS Scotland boards. Discussion also noted that these expenses had not risen with inflation and increasing costs.

**Action**: G Franklin agreed to take the item forward with the AMC and in discussion with the Director of People and Culture.

Discussion was had around the need for an integrated patient record system and it was noted as a possible agenda item for 2025 due to the wider impact on a number of service areas. A number of risks were commented on regarding the current systems and working across different teams and partner organisations. It was noted that the Head of eHealth planned to set up a meeting with Argyll and Bute Digital Health Group to explore the system needs.

**Action**: The Chair recommended that a relevant contact be invited in the new year to meet with the ACF to discuss the issue, and that the advisory groups be encouraged to discuss the issue and provide a summary of needs.

**5.5 Area Optometric Committee meeting –** 28 October 2024

F Jamieson asked for the support of the forum and clarification as to who to contact in respect of access to Care Portal. The Area Optometric Committee (AOC) would be writing a letter expressing their concerns in relation to access but were unsure of the point of contact. The Chair advised contacting I Ross within the e-Health department as I Ross was involved in the role out of access to Care Portal. The Chair advised that the forum were supportive of access to electronic patient records and this was an issue that the forum had previously discussed.

- F Jamieson advised that a representative from the AOC would be sent to the forum on a rota basis, this would give other members an opportunity to engage with the forum.
- Work had restarted on the stroke pathway after it had been paused due to staff being on long term sickness absence.
- Due to software issues there was now a delay in the role out of the community glaucoma service of approximately 12 to 18 months.

**Action**: F Jamieson to contact I Ross offline.

**5.6 Area Nursing, Midwifery and AHP Advisory Committee meeting –** 26 September 2024

- L Currie noted that the July meeting minutes had been circulated and that the September meeting was cancelled due to a scheduling clash for members with an Scottish Patient Safety Programme (SPSP) Event.
- It was noted that L Currie would commence a secondment with Health Improvement Scotland (HIS) From the end of October and that H Eunson would assume the chair in the short term.

**5.7 Psychological Services Meeting – no meeting held.**

**5.8 Area Health Care Sciences meeting – no meeting held.**

The Forum **noted** the circulated committee minutes and feedback provided by the Chairs.

**6 ASSET MANAGEMENT GROUP**

No update

**7 HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE –** Minute of meeting held on 26 September 2024
Kara McNaught, Team Manager, Adult Social Care

The Chair advised that there were challenges with attending both herself and K McNaught attending this meeting as it clashed with other meetings being held. K McNaught had not been able to attend this meeting nor had the chair. There may be calls for other members of the forum to attend this meeting and to this end the Chair suggested that the committee administrator circulate the dates of this meeting for the year ahead. Encouragement was given to forum members to attend these meetings if required.

**Action**: Committee Administrator to circulate the dates of the HHSCC for the coming year to forum members.

The Forum **noted** the circulated minutes.

**8 Argyll and Bute IJB minutes**

There were no queries raised.

**9 Dates of Future Meetings 2025**

9 January
13 March
1 May
3 July
4 September
9 November

**10 FUTURE AGENDA ITEMS**

**Leadership and Culture Framework update**
**Discussion over Physician Associates**
**Invite to F Davies to address Forum –** proposed start of 2025

**11. ANY OTHER COMPETENT BUSINESS**

H Eunson highlighted that the 1st November was officially Learning Disability Nurses day and that communications had gone out in the weekly bulletin.

**12 DATE OF NEXT MEETING**

The next meeting will be held on 9 January 2025 at **1.30pm on Teams.**

**The meeting closed at 4.10pm**