Assynt House
Beechwood Park
Inverness IV2 3BW
Tel: 01463 717123
Fax: 01463 235189
www.nhshighland.scot.nhs.uk/

MINUTE of MEETING of the AREA CLINICAL FORUM	**6h November 2025 – 1.30pm Microsoft TEAMS**

Present

Emily Austin, Non-Executive Director
Helen Eunson, NMAHP Advisory Committee
Grant Franklin, Area Medical Committee
Calum Fraser, Area Optometry Committee
JoAnne McCoy, Non Executive-Director
Eileen Reed-Richardson, NMAHP Advisory Committee
Andrew Strain, Area Medical Committee
Allyson Turnbull-Jukes, Psychological Committee (Chair)

In Attendance

Isla Barton, Director of Midwifery
Louise Bussell, Nurse Director
Karen Doonan, Committee Administrator (minutes)
Boyd Peters, Medical Director
Janice Preston, Non-Executive Director
Dominic Watson, Head of Corporate Governance
Paul Nairn, Regional Planning Manager, Strategy and Transformation (Item 4.1)
Helen Perkins, Programme Lead for Trauma Informed Practice (Item 4.2)
Heledd Cooper, Director of Finance (Item 4.3)
Bryan McKellar, Whole System Transformation Manager, Strategy and Transformation (Item 4.3)

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting, apologies were received from L Currie, Z Ahmed and A Javed.

1.1 DECLARATIONS OF INTEREST

There were no declarations of interest.

2. DRAFT MINUTE OF MEETING HELD ON 11th September.

The minutes were **approved** as accurate and correct.

3. MATTERS ARISING

None

4. ITEMS FOR DISCUSSION

4.1 New Organisational Strategy – Paul Nairn, Regional Planning Manager, Strategy and Transformation Team

P Nairn provided an update on the development of a new 10-year strategy for NHS Highland. He explained the need for the strategy, noting that without change, health inequalities and chronic conditions such as cancer, cardiovascular disease and dementia would increase significantly over the next two decades. He highlighted that direct healthcare accounted for only 20% of health outcomes, with socio-economic factors and health behaviours having a greater impact.

The key challenges, including engaging staff, partners and the public, defining clinical strategies, and demonstrating delivery beyond simply writing the strategy were highlighted. Realistic medicine and value-based healthcare were also highlighted as guiding principles, alongside improved planning processes such as the "Ask Once" approach. The role of the Population Health Programme Board was discussed and the importance of measuring progress on prevention and health inequalities.

Innovation—both technical and conceptual—was identified as essential, and underpinning principles included working within financial resources, adopting place-based strategies, focusing on outcomes and prevention, and improving quality of life rather than solely life expectancy.

It was also noted that:

- The new 10-year strategy would prioritise quality of life improvements and prevention-focused approaches over reactive treatment.
- NHS Highland would adopt place-based strategies and population-focused planning, moving away from service-specific models.
- Engagement would be delivered through a digital Engagement Hub combined with face-to-face methods to ensure broad participation.
- The organisation would implement the "Ask Once" planning process to align workforce, finance and service planning.
- Measurement frameworks would include outcome-based and experiential data, not just activity metrics, with flexibility to evolve over time.
- Collaboration with external organisations would be essential to address socio-economic determinants of health.

I Barton highlighted her focus on women's services, including maternity, neonates and gynaecology. She emphasised the national strategy's strong focus on tackling inequalities and expressed concern about the health of women accessing services, particularly those of childbearing age. Outcomes indicated challenges in both physical and mental health, demonstrating the need for a broader public health approach before pregnancy.

She noted that while antenatal care had a public health focus, significant change could not be achieved within the nine-month pregnancy period alone. She stressed the opportunity to influence health behaviours earlier, leveraging families' intrinsic motivation to act in the best interests of their unborn child. She referenced involvement in national work on the Women's Health Plan and highlighted stark differences in health priorities and outcomes between men and women, including alarming statistics on self-reported healthy years lived. Data suggested that many people reported good health only up to around age 60, after which healthy years declined sharply.

Also emphasised was the importance of early intervention during the first 1,000 days of a child's life, noting evidence that this period significantly influences long-term outcomes. She highlighted the impact of deprivation and the lack of role models in some communities, stressing NHS Highland's role as an anchor institution in supporting families.

The Chair thanked P Nairn for his presentation and suggested forum members take some time to think over the presentation before feeding back at the next forum meeting. The Chair also invited P Nairn to come back to a future meeting which he agreed. P Nairn highlighted the need to look at how money was being spent and how it could be used to prevent ill health and how the organisation could become more efficient in order that success could be measured going forward.

4.2 Trauma Informed Practice – from Awareness to Response - Helen Perkins, Programme Lead for Trauma Informed Practice

H Perkins introduced herself and shared her background as an occupational therapist with extensive experience in mental and physical health. She explained that trauma was a normal reaction to abnormal circumstances and could result from a wide range of harmful events. While many people recovered over

time, others required ongoing support. She emphasised that trauma-informed practice was not limited to specialist services but was everyone's responsibility, and that the entire Scottish workforce should have at least a basic understanding to adapt practice accordingly.

She outlined the NES Knowledge and Skills Framework, which set out progressive training levels from informed to skilled, enhanced and specialist. Training was described as part of a cultural shift rather than a one-off event, requiring integration into policies, procedures and protocols. H Perkins introduced the Trauma-Informed Practice Roadmap, which included nine key drivers for implementation and highlighted the importance of leadership and management involvement.

Trauma-informed practice was embedded in multiple national strategies and frameworks, including those for children and young people, justice, health and social care, mental health, violence against women and girls, and substance misuse. This work was linked to the Population Health Framework, which focused on prevention, early intervention, maximising access and delivering person-centred care. The overall aim was to reduce barriers, improve engagement and achieve better health and well-being outcomes. She also highlighted the importance of staff self-care, noting high levels of stress, burnout and vicarious trauma within the workforce. Statistics showed that 27% of employees felt work negatively impacted their mental health and nearly half of Scottish social care staff reported psychological well-being issues linked to trauma. Resources for staff well-being were shared, along with details of the upcoming NES Scottish Trauma-Informed Leaders Programme, designed to support organisational change from both top-down and bottom-up perspectives.

The Chair stressed the importance of trauma-informed principles across all aspects of work. She noted the role of the Trauma-Informed Network in shaping Scotland's Witnessing Victims Reform Bill and encouraged embedding these principles throughout the organisation, including within subcommittees. Chairs were invited to reflect on how this could be achieved.

Discussion raised several key points. A Strain questioned the lack of focus on preventing trauma at its root causes, citing issues such as poverty, child abuse and substance misuse. He also expressed concern about expectations placed on GPs, noting that most were not trained to an enhanced level of trauma-informed practice and that significant resourcing would be required to upskill the profession. H Perkins acknowledged these points and reiterated that trauma-informed practice aimed to reduce barriers and prevent re-traumatisation during service engagement.

H Eunson linked trauma-informed practice to population health and prevention, emphasising that trauma existed on a spectrum and required nuanced understanding. She confirmed that nursing, midwifery and allied health professions were keen to embed these principles and committed to initiating conversations within her committees.

G Franklyn raised concerns about cumulative trauma among health service staff, including stress caused by delays and patient harm, which contributed to sickness absence and workforce loss. He compared this to the impact of COVID-19 and stressed the need for trauma awareness in daily practice despite current pressures. C Fraser highlighted the benefits for service users and staff and queried how principles could be implemented in optometry settings, given structural differences. H Perkins confirmed that she had delivered tailored sessions across the partnership and encouraged teams to contact her for support.

L Bussell shared an example of mandatory trauma training in a previous organisation and suggested exploring a similar approach within NHS Highland. H Perkins welcomed this idea and confirmed efforts were underway to expand access to face-to-face training and monitor uptake of NES online modules. She noted that Scottish Government guidance required all workforces to have access to trauma-informed training.

Further discussion addressed the risk of awareness campaigns generating demand that services could not meet, potentially leading to re-traumatisation. L Bussell clarified that the aim was not to increase referrals but to equip staff with understanding to respond empathetically. H Perkins concluded by emphasising the importance of widening access beyond acute services and leveraging community resources, third-sector organisations and initiatives such as green health to support well-being.

4.3 ADP and Financial Plan – Heledd Cooper, Director of Finance, Bryan McKellar, Whole System Transformation Manager, Strategy and Transformation

H Cooper started by explaining that the meeting was originally intended to focus on the finance and ADP planning cycle, but circumstances had changed significantly as the financial year progressed. She noted

that she would provide key messages rather than go through the full presentation and would leave time for questions.

Current Financial Position

- The initial plan which had been submitted to Scottish Government in March showed an opening deficit of £56 million, reduced from around £80 million in January. This assumed a 3% savings target, adult social care breaking even, and Argyll and Bute IJB breaking even.
- Scottish Government had rejected the £56 million deficit and had requested a revised plan delivering a £40 million deficit. NHS Highland had responded by identifying non-recurring actions and technical adjustments to achieve this without major organisational impact.
- At month six, NHS Highland continued to forecast a £40 million deficit. Savings delivery remained behind target: £36 million was required, but only £17 million had been identified at month five, leaving a £19 million gap (now reduced to £16 million). Efforts were underway to close this through tighter controls on discretionary spend and further non-recurring measures.
- The health position was considered manageable, but adult social care still faced a £20 million gap with no clear recovery plan, requiring ongoing discussions with government and the council.

Escalation Framework and Future Expectations

- NHS Highland was at Stage 3 of the Scottish Government's financial escalation framework. Recent assessments highlighted weaknesses in financial sustainability, though leadership and governance were rated positively.
- Government had expected NHS Highland to maintain a £40 million deficit for 2026–27. This had been challenging given reliance on £16 million of non-recurring measures this year and a £16 million shortfall against savings targets, creating a £32 million gap before any new pressures.
- Failure to meet targets could trigger further escalation, with increased scrutiny similar to Grampian's experience, which was described as highly intrusive.

Next Steps and Clinical Engagement

- H Copper stressed that there was no additional funding and that the organisation must change how it operated. She called for collaboration between finance and clinical teams to redesign pathways, improve outcomes, and reduce waste.
- Work was underway to implement patient-level costing systems (PLICS) to support benchmarking and identify efficiencies. Clinical engagement was essential to interpret data and drive change.
- She emphasised that improving quality naturally reduced waste and improved financial performance and urged colleagues to consider opportunities for clinical benchmarking and service redesign.

Key Messages

- There was no more money; the organisation must work differently.
- Government expected NHS Highland to hold its position at a £40 million deficit next year.
- Clinical decisions drove resource use, so partnership between finance and clinical teams was critical.
- Benchmarking and data-driven approaches would support efficiency and sustainability.

G Franklyn acknowledged the scale of healthcare costs and said large figures were inevitable. Drawing on long experience in the health service, he argued that current efficiency strategies were fundamentally flawed. Hospitals operating above 90% capacity, such as Raigmore and other Highland sites, faced compounded inefficiencies. He stressed that healthcare was not like a factory – running at full capacity did not equate to maximum efficiency. While reducing waste mattered, he believed true efficiency would come from easing hospital pressure. Many patients stayed unnecessarily because community care was under-resourced. Until health and social care staff were properly funded and paid, hospitals would continue to suffer avoidable inefficiencies and poorer outcomes. He criticised small-scale tweaks that created an illusion of progress but ignored systemic issues, urging ministers to prioritise investment in community care to break the cycle of overcrowding.

H Cooper agreed that acute hospitals were becoming factory-like, chasing activity rather than value. She emphasised prevention and community investment to keep people well, warning that funding continued to follow acute targets, creating waste. She noted the KPMG report offered only transactional savings and risked focusing on minor process changes instead of whole-system reform. The priority, she said, should be better outcomes, not just efficiency.

B Peters highlighted the complexity of health economics in Scotland, stressing that solutions were not as simple as shifting money or closing services. He said bodies like the ACF must provide advice on difficult choices to enable meaningful change and avoid repeating mistakes seen elsewhere, such as NHS Grampian.

C Fraser queried how frontline staff could raise concerns or suggest savings. He wondered if there was an easy route for NHS employees or contractors to share ideas, even outside their own area. H Cooper admitted there was no simple process and explained that suggestions usually went through managers or finance teams. She acknowledged the challenge of managing ideas fairly and committed to exploring practical options, such as finance clinics or anonymous suggestion boxes.

B McKellar explained that the finance update linked directly to the Annual Delivery Plan (ADP) and the operational improvement plan, which together set out this year's priorities for change and improvement. He noted that the ADP outlined high-level objectives for all activity across Highland, including partnerships, and was the board's commitment to the population. It aligned with the current strategy, Together We Care, while planning had already begun for the next strategic framework.

He highlighted that the Scottish Government had introduced the NHS Scotland Operational Improvement Plan, which focused on four broad areas: improving access to care, shifting the balance from acute to community services, driving digital innovation, and strengthening prevention. These priorities aimed to deliver equitable services and reduce health inequalities.

He outlined examples, including expanding Hospital at Home services in Argyll and Bute and North Highland, improving flow in emergency departments, and rolling out digital initiatives such as the Digital Front Door app, digital dermatology, and community glaucoma services. He also mentioned prevention work in primary care for cardiovascular disease and frailty.

He stressed that the operational improvement plan was ambitious, combining strategic transformation, efficiency work, and digital developments. Progress would be monitored through governance channels, reported bi-monthly to committees, and aligned with six-monthly updates on the ADP. Both plans linked closely to the financial plan and formed part of an ongoing cycle, with planning already underway for 2026–27. He concluded by emphasising the importance of performance oversight and reporting, noting that the integrated performance and quality report (IPQR) tracked key areas such as planned care, cancer, and diagnostics.

Comfort break 3.45pm until 3.55pm

4.4 Revisiting Terms of Reference / Feedback from last meeting

At the last meeting, it was agreed to revisit the terms of reference and check whether the forum had the right representation, particularly for Nursing, Midwifery and Allied Health Professionals. the need for proper clinical expertise had been noted with an agreement to review this in January. The Terms of Reference (ToR) had been recirculated for forum members to consider. Also discussed was whether Associate Directors could attend for representation without voting rights and it had been agreed to explore flexibility.

The Chair had offered to gather suggestions by email and speak with N Ware and D Watson, since then, the Chair and Vice Chair had met with three advisory committee Chairs and gained valuable insights, which would be presented in January. They had also met with the Board Chair and the Chief Executive) to strengthen the influence both vertically and horizontally. Both had been supportive, and discussions continued on clarifying the forums' purpose, visibility and alignment with organisational priorities. The Chair reminded forum members about the upcoming Annual Review and asked for any additional issues to be sent to her via email. She emphasised patience during this transition and assured the forum that comments had been taken on board.

5. MINUTES FROM PROFESSIONAL ADVISORY COMMITTEES AND EXCEPTION REPORTS

5.1 Area Dental Committee meeting – 8th October 2025

There were no additional comments.

5.2 Adult Social Work and Social Care Advisory Committee meeting – meetings on hold until new chair appointed

5.3 Area Pharmaceutical Committee – 16th June and 11th August 2025
No further comments.

5.4 Area Medical Committee meeting – 12th August 2025

The last approved minute was from the meeting on 12 August. Another meeting had been held in October, the draft minute for that was not yet available. The August minute contained nothing significant to highlight. The Area Medical Committee (AMC) discussed the Director of Public Health's annual report, which was helpful in guiding priorities for the population. There was also useful discussion on secondary care challenges, particularly pressures on vascular services and front-door services such as A&E and acute medicine. No further points were raised.

5.5 Area Optometric Committee meeting – 6th October 2025

C Fraser highlighted that the committee had had discussion around Care Portal and the frustrations that had arisen due to slow progress of the roll out. It was noted that full access was not going to be available for the Optometrists however they did not require full access, they required access to ophthalmology, rheumatology and neurology. There was also a proposed change from using FormStream to SCI Gateway.

It was confirmed that the discussion related only to read-only access to the care portal, not read-and-write access or storing community optometry notes. A Strain noted the disparity with Argyll and Bute colleagues who regularly used Sky Gateway for ophthalmology referrals and expressed frustration that a system available in half of the health board area could not be implemented more widely, while acknowledging the complexity involved.

5.6 Area Nursing, Midwifery and AHP (NMAHP) Advisory Committee meeting – 28th August 2025

H Euson explained that the minutes that were included in the papers were for 28 August as the October meeting had been cancelled. They had agreed to split the committees, so it would be Nursing and Midwifery and AHP Advisory Committees with the Chair and the Vice Chair of NMAHP leading the process. The Chair began arranging meetings for the AHPs, and the Vice Chair had set up a short-life working group (SLWG) with representation from community, acute and midwifery, and had sought input from Argyll and Bute. The focus of the SLWG was on representation and it had reviewed the Constitution and Terms of Reference (ToR), aiming to update these by March2026. Three further meetings had been scheduled between November and January, with plans to confirm Chairs and Vice Chairs and start the new structure in April 2026 in order to align with the financial year. The current Chair would be working to a similar timeline for AHPs.

L Bussell queried whether N Ware and D Watson had been updated in order that a support structure was in place for the splitting of the NMAHP into the two groups. H Eunson confirmed that from an administration perspective, she had had close discussions with N Ware and his team about how the split would work, and agreed that the Short Life Working Group's administration would be managed between the SLWG and the local P.A team to ease pressure on N Ware's team. Moving forward, it had been confirmed that administration support would be put in place. Dates and times were being looked at in order to avoid clashes, as resources were limited.

5.7 Psychological Services Meeting – no meeting held

The Chair explained that there was work ongoing to set up this committee and work was being done. An update would come back to this Forum in due course.

5.8 Area Health Care Sciences meeting – no meeting held

The Forum **noted** the circulated committee minutes, and feedback.

6 Asset Management Group – minute not available.

7 HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE – Minute of meeting held on 3rd September 2025

There were no additional comments.

The Forum **noted** the minutes

8 Argyll and Bute IJB minutes

9 Dates of Future Meetings 2026

15th January
5th March
7th May
2nd July
3rd September
5th November

10 FUTURE AGENDA ITEMS

It was noted that L Cameron-Ross would be presenting on Realistic Medicine. J McBain would also be presenting on data and how this was used in outpatient departments. It was hoped to have a third speaker from within the Psychology Department.

11 ANY OTHER COMPETENT BUSINESS

The Chair asked the forum to reflect on the pace of the agenda for todays meeting. It was highlighted the need to discuss how best to cement the ACF's advisory role. The half-hour conversation with minutes circulated was queried and whether this was enough, or if the forum needed more formal structures. Suggestions included producing reports signed off by the forum to add detail and nuance, time constraints were acknowledged. It was noted that only 30% of the quorum attended, so wider opinions must be reflected, especially given the importance of shaping NHS Highland's 10-year strategy.

12 DATE OF NEXT MEETING

The next meeting will be held on Thursday 15th January 2026 at **1.30pm on Teams.**

The meeting closed at 4.20pm