Agenda Item	6
Report No	JMC/12/26

The Highland Council / NHS Highland

Committee: **Joint Monitoring Committee**

Date: **24 September 2026**

Report Title: **Chief Officer's Report Adult Services**

Report By: **Arlene Johnstone - Chief Officer**

1 Purpose/Executive Summary

1.1 This report provides an overview of the Highland Health and Social Care Partnership's strategic direction and delivery in relation to Adult Services.

The report is presented to support the Joint Monitoring Committee in its role to provide oversight, scrutiny and assurance in relation to the direction of travel and delivery of strategic priorities across Adult Services.

The Partnership's Annual Performance Report 2025/26 was considered by the Health and Social Care Committee in September 2026 and provides a more detailed assessment of performance across Adult Services. The key strategic performance issues requiring Joint Monitoring Committee oversight are summarised within this report.

2 Recommendations

2.1 Members are asked to:

i. **Note** the strategic direction and delivery progress set out in this report; and
ii. **Note** the current performance position and associated system pressures.

3 Implications

3.1 **Resource** - There are no specific resource issues arising from this report, it is expected that the plan will be implemented within existing resource and associated risks and issues escalated to the HSCP and Strategic Planning Group. It is however accepted that in general there are significant resource issues in terms of the delivery of adult social care and those resource issues are governed by the Integration Scheme currently in place, as signed off by the Council and Board in March 2021 and which received Ministerial sign off in February 2022.

3.2 **Legal** - The content of this report is to seek to ensure the Partnership's compliance with The Public Bodies (Joint Working) (Scotland) Act 2014.

3.3 **Risk** - The risks associated with delivery are not new but reflect sustained system pressures, including demand for services, workforce capacity and financial sustainability. These are managed through the Partnership's governance and risk management arrangements.

3.4 **Health and Safety (risks arising from changes to plant, equipment, process, or people)** - There are no Health and Safety implications as a result of this report.

3.5 **Gaelic** - There are no Gaelic implications as a result of this report.

4 Impacts

4.1 In Highland, all policies, strategies or service changes are subject to an integrated screening for impact for Equalities, Poverty and Human Rights, Children's Rights and Wellbeing, Climate Change, Islands and Mainland Rural Communities, and Data Protection. Where identified as required, a full impact assessment will be undertaken.

4.2 Considering impacts is a core part of the decision-making process and needs to inform the decision-making process. When taking any decision, Members must give due regard to the findings of any assessment.

4.3 This is a monitoring and update report and therefore an impact assessment is not required.

5 Background

5.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Partnership to have in place a **Strategic Plan** which sets out the arrangements for the carrying out of the integration functions for the area over the period of the plan and which also sets out how these arrangements are intended to achieve, or contribute to achieving, the national health and wellbeing outcomes.

5.2 This same Act also directs that a Strategic Planning Group requires to be established and in place in to support the development of this Strategic Plan. The Strategic Planning Group continues to oversee the implementation of the Strategic Plan.

5.3 The same Act also directs that Locality Planning Groups require to be established to provide a forum for professionals, communities and individuals to collectively develop and deliver locality plans based on the Joint Strategic Plan and local need. In Highland, these groups are called District Planning Groups.

6 Implementation of the Joint Strategic Plan (2024 – 2027)

6.1 Strategic Planning Group (SPG)

Work has continued to oversee the implementation of the Joint Strategic Plan (2024-2027), now in its final year of delivery, informed by the Joint Strategic Needs Assessment.

Delivery of the Plan continues through a range of associated programmes and strategies, including the Adult Social Care Transformation Programme, the Adult Social Care Commissioning Strategy and supporting implementation plans.

Following agreement by the Strategic Planning Group to undertake an interim refresh of the current Plan, work has progressed to align strategic planning activity with the development of the NHS Highland 10-Year Strategy and ongoing consideration of future Models of Integration.

The Strategic Planning Group continues to support the interim refresh approach, recognising that the current Strategic Plan remains broadly aligned to the needs and priorities identified through the Joint Strategic Needs Assessment, whilst also acknowledging the need to strengthen delivery plans and alignment across supporting strategies.

Alongside oversight of the current Plan, the Strategic Planning Group has begun considering the strategic priorities and themes that will inform development of the next Joint Strategic Plan from 2027 onwards. This work will be informed by the NHS Highland 10-Year Strategy, future integration arrangements, engagement activity, performance information and emerging demographic and service demand trends.

7 Performance

Performance across Adult Services reflects a position of sustained demand exceeding available capacity, particularly across community-based services and discharge pathways.

The Partnership's Annual Performance Report 2025/26 (see **Appendix 1**) was considered by the Health and Social Care Committee in September 2026 and provides a broader assessment of progress against national health and wellbeing outcomes. Whilst the report highlights the significant pressures facing the system, including increasing demand, workforce challenges and delayed discharge, it also demonstrates a number of areas of positive performance and improvement.

Key areas of positive performance include:

- 75.7% of adults receiving care or support rated that support as good or excellent, compared to a Scottish average of 70.0%.
- 65.9% of adults supported at home reported that their health and social care services were well coordinated, compared to 61.4% nationally.
- 80.4% of people reported a positive experience of care provided by their GP practice, compared with the Scottish average of 68.5%.
- Progress continues to be made in shifting towards more personalised models of support, with the number of people receiving SDS Option 1 (Direct Payments) increasing from 800 to 936 and SDS Option 2 (Individual Service Funds) increasing from 299 to 353 during the reporting period.
- Highland continues to perform strongly in relation to falls prevention, with a falls rate of 14.2 per 1,000 population aged 65 and over, compared to a Scottish average of 22.5.
- 90.1% of people's last six months of life were spent at home or in a community setting, supporting the Partnership's ambition to provide care as close to home as possible.

The Annual Performance Report highlights both the progress made and the significant challenges that remain. The key performance issues requiring ongoing Joint Monitoring Committee oversight are summarised below.

7.1 Care at Home

The Partnership's aim remains to reduce unmet assessed critical care needs to zero.

The most recent data shows that 21 people with a critical care need are waiting for a Care at Home service, including 6 people who are delayed in hospital. This represents an improvement from earlier reporting periods, although the Partnership's aim remains to reduce unmet assessed critical care need to zero.

The following graph shows the number of people delayed in hospital and in the community who have been assessed with a critical care need, and also the hours of care per week required.

The majority of those waiting have moderate to substantial needs, reflecting sustained demand for support within the community and the ongoing gap between demand and available capacity.

While there has been some improvement from earlier peaks, the position continues to represent a significant system pressure. This contributes to wider system flow challenges, including delayed discharge, alongside other factors across the system.

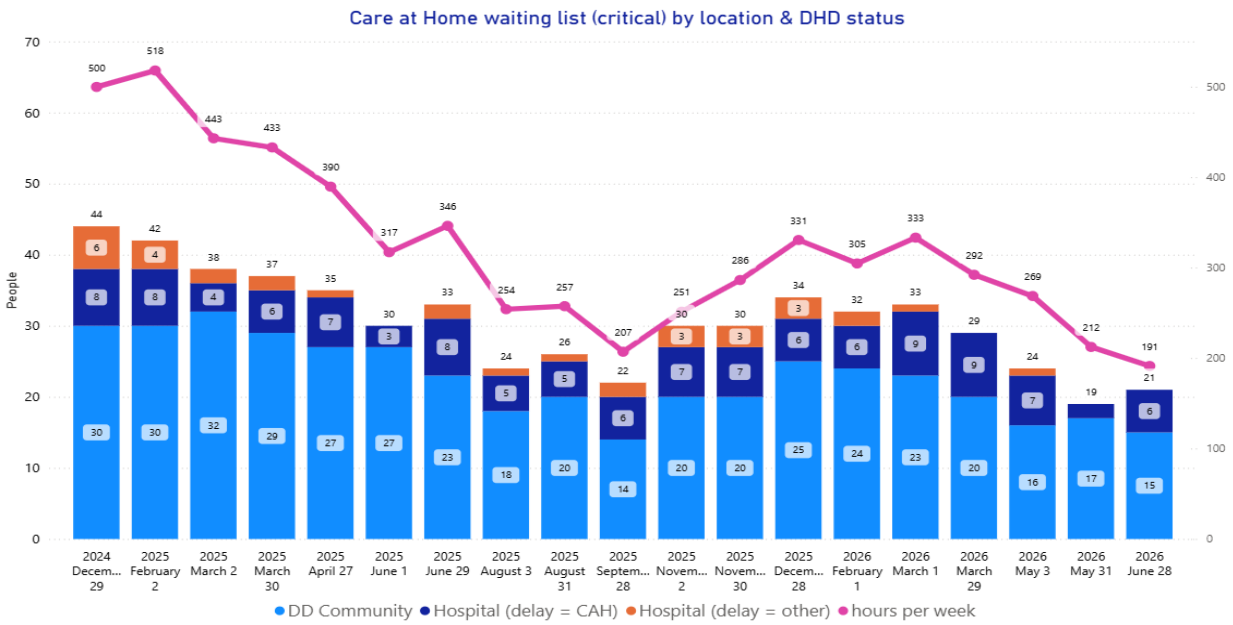


Figure 1: Care at Home Waiting List and Unmet Need

7.2 Care Homes

The Partnership's aim is to maintain an appropriate level of long stay care home placements for older adults.

We aim to maintain the number of new long stay care home placements made per month for older adults at 50 placements per month.

The graph below shows the long stay care home admissions for older adults, by age and care home type.

The data shows that the average age at admission has generally increased. The

reduction in older adult care-home admissions during May and June coincided with an increase in delayed hospital discharges over the same period, reflecting the relationship between placement availability and system flow.

Highland care home providers continue to face significant operational challenges, including workforce recruitment and retention, financial sustainability and the viability of smaller services. These pressures affect the availability of local placements and contribute to delayed discharge where an appropriate placement cannot be secured.

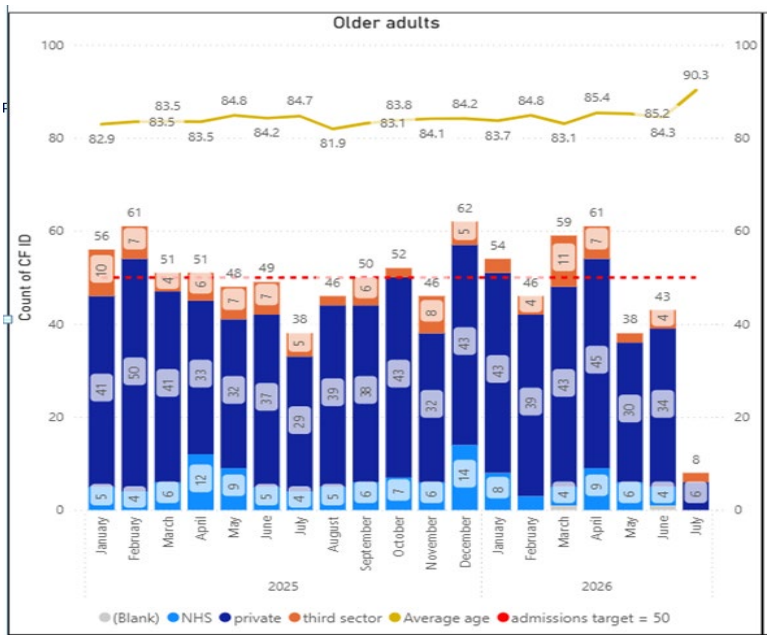


Figure 2: Number of Older Adult Placements per month

7.3 Delayed Hospital Discharges

Delayed discharge remains a significant and sustained system challenge, reflecting pressures across both health and social care services.

Performance continues to be impacted by a combination of factors including increasing complexity of need, workforce availability, care at home capacity, care home capacity and wider community service pressures. Whilst improvement activity is underway, sustained performance improvement remains dependent on increasing community capacity and strengthening pathways of support across the system.

During the reporting period, the Scottish Government published the Health & Care Improving Flow Plan 2026-2031, setting out national expectations to improve flow across health and social care systems. The Highland Discharge Without Delay (DWD) Programme continues to align with these priorities, with a focus on reducing avoidable delays, improving coordination across organisational boundaries and supporting more people to receive care in the right place at the right time.

The Discharge Without Delay (DWD) Programme has refreshed its governance arrangements, workstream leadership and performance framework during 2026/27. A dedicated Interface Manager post is now in place to strengthen programme coordination and leadership oversight of discharge performance, patient flow and delivery of improvement activity. The programme continues to focus on implementation of Integrated Discharge Teams (IDTs), Home First and Discharge to

Assess (D2A) approaches, Planned Date of Discharge (PDD) and improvements to frailty pathways and community hospital flow.

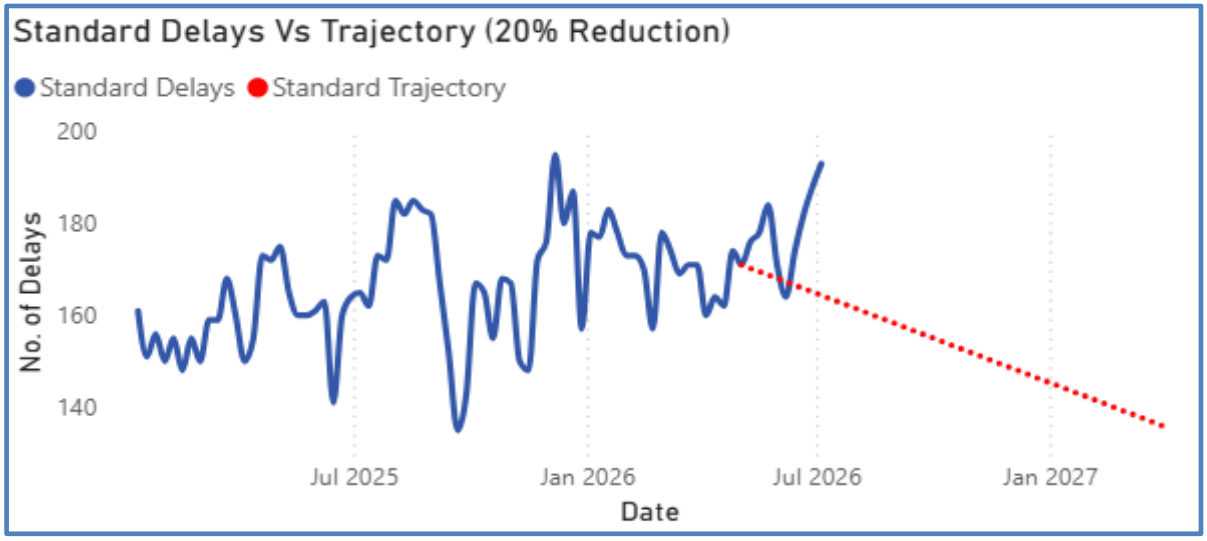


Figure 3: Highland Delayed Discharge Trajectory

Notwithstanding this targeted improvement activity, delayed discharge performance remains off trajectory. Sustained improvement will depend on both more effective discharge pathways and sufficient care at home, care-home and wider community capacity to support people safely following discharge.

7.4 Self-Directed Support (SDS)

The Partnership continues to promote increased uptake of Self-Directed Support (SDS) Options 1 and 2, alongside a reduction in reliance on traditional Option 3 provision.
The current aims are to:

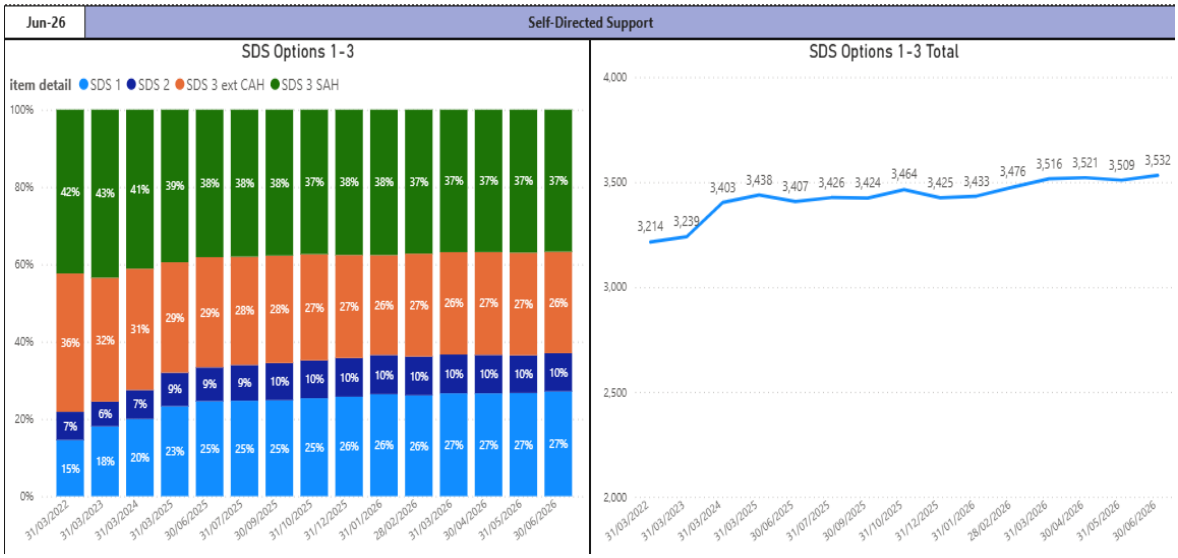
- Increase the proportion of people actively using SDS Option 1 (Direct Payments) to 30%;
- Increase the proportion of people actively using SDS Option 2 (Individual Service Funds) to 11%;
- Reduce the proportion of people supported through SDS Option 3 to 50%; and
- Maintain the overall number of people receiving support through the available SDS options.

Performance data continues to demonstrate a positive trajectory against these objectives. There has been a sustained increase in the number of people supported through both Option 1 and Option 2, with a corresponding reduction in the number of people supported through Option 3. This reflects continued progress towards more personalised and flexible models of support and greater choice and control for people receiving services.

Whilst progress is encouraging, continued growth in the uptake of Options 1 and 2 remains dependent on the availability of market capacity and supporting infrastructure, including brokerage services, personal assistants, community-based support and flexible provider arrangements.

The Adult Social Care Commissioning Strategy and wider transformation programme

place a strong emphasis on developing these enabling arrangements, ensuring that people can access a broader range of support options and exercise greater choice and control over how their support is delivered.



7.5 Taken together, performance reflects a system operating under sustained pressure, with demand continuing to exceed available capacity in key areas. While there are areas of progress, particularly in the uptake of more personalised care and in targeted flow improvement activity, the scale of challenge in community capacity and delayed discharge remains significant.

These pressures directly inform the Partnership's focus on commissioning, transformation and financial sustainability.

7.6 **Adult Social Care Transformation Activity**

Transformation activity continues to be progressed through the Adult Social Care Transformation Programme, building on the Adult Social Care Finance Plan and being delivered on a whole-system, partnership basis across NHS Highland and The Highland Council. The programme is focused on delivering sustainable redesign of adult social care services in response to increasing demand, workforce challenges, financial pressures and changing patterns of need.

The programme continues to be centred on delivery of the Highland Care Model, which provides the overarching framework for transforming adult social care through a person-centred, preventative and locality-based approach. The model seeks to support more people to live independently within their own communities, reducing reliance on institutional models of care and strengthening community-based support.

During the reporting period, the Adult Social Care Commissioning Strategy 2026–2029 has been completed and is being presented separately to the Committee. It provides the strategic framework for future service development, market facilitation and commissioning activity across Highland.

Key areas of transformation activity include:

- Development of Local Care Models and Community Led Support approaches,

supporting earlier intervention and a stronger focus on community capacity and prevention;
- Expansion of Home First, Discharge to Assess and Integrated Discharge Team models to improve system flow and reduce reliance on hospital-based care;
- Strengthening Self-Directed Support, brokerage arrangements and independent support services to increase choice, control and flexibility for people receiving support;
- Market development activity to improve sustainability of care at home, care home and community support provision;
- Development of place-based approaches through locality planning and engagement activity, ensuring that services reflect local needs and circumstances; and
- Review of Models of Integration to explore whether alternative integration arrangements could further improve outcomes for people and communities across Highland.

A Highland Adult Social Care Conference, *Developing the Highland Care Model: Conversations about the Future of Adult Social Care in Highland*, is planned for November 2026. This will bring together people with lived experience, unpaid carers, staff, providers, communities and partners to help shape future priorities. This will be followed by locality-based engagement events during early 2027, demonstrating the Partnership's commitment to place-based development and co-production.

Alongside service transformation activity, NHS Highland and The Highland Council are reviewing the current Lead Agency arrangements to explore whether alternative models of integration could further improve outcomes for the people of Highland. This work reflects a shared commitment to ensuring that organisational arrangements, frontline practice, governance structures and the use of public resources are aligned to delivering the best possible outcomes for people and communities.

Delivery of the transformation programme remains closely linked to the Partnership's wider strategic planning, commissioning, workforce and financial sustainability agendas. Whilst progress continues to be made, the scale of change required remains significant and sustained partnership working will be essential to achieving the ambitions set out within the Highland Care Model

Designation:	Chief Officer, Highland HSCP
Date:	3 September 2026
Author:	Rhiannon Boydell - Head of Service, Integration, Strategy and Transformation HHSCP Arlene Johnstone, Chief Officer, HHSCP
Background Paper:	None
Appendices:	Appendix 1 – Highland Health and Social Care Partnership Annual Performance Report 2025/26 (for information)

Appendix 1

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**2nd September 2026**
Title:	**Highland Health and Social Care Partnership Annual Performance Report 2025/26**
Responsible Executive/Non-Executive:	**Arlene Johnstone, Chief Officer**
Report Author:	**Rhiannon Boydell, Head of Service, Integration, Planning and Performance HHSCP**

Report Recommendation:
The report is presented as draft ahead of approval being sought from the Joint Monitoring Committee and publication at the end of September 2026 for assurance.

1 Purpose

Please select one item in each section ***and delete the others***.

This is presented to the Board for:

- Assurance

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

This report will align to the following NHSScotland quality ambition(s):

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	

Grow Well		Listen Well		Nurture Well		Plan Well	
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well		Progress well		**All** Well Themes	x		

2 Report summary

2.1 Situation

The Annual Performance Report (APR) assures the progress in meeting the priorities and actions and is required to be updated and submitted annually to the Scottish Government.

The Annual Performance Report 2025/26 is brought to this Health and Social Care Committee for assurance, however is to be approved by the Joint Monitoring Committee.

2.2 Background

The Health, and Social Care Annual Performance Report (APR) for the year 2025/26 follows the requirement by the Public Bodies (Joint Working) Scotland Act, 2014.

The Health and Social Care Partnership (HSCP) is responsible in ensuring that our local communities are clear on how health and social care integration is performing. The HSCP has built upon previous years and demonstrates how services have improved and adapted to complement highland communities Primary, across Community, Mental Health, Acute Care, Children and Adult Social Care.

The Highland Health and Social Care Partnership delivers health and social care services through a lead agency Partnership Agreement. This consists of The Highland Council act as lead agency for delegated functions relating to children and families and NHS Highland who under take delegated functions related to adults.

The strategic framework for planning and delivery of health and social care services consists of 9 Health and Well Being Outcomes and a core suite of integration indicators.

2.3 Assessment

The Annual Report provides an overview of performance at both Health and Social Care Partnership (HSCP) and Scotland level including:

- Assessment of performance in relation to the 9 National Health and Wellbeing Outcomes

- Assessment of performance in relation to integration delivery principles
- Comparison between the reporting year and pervious reporting years, up to a maximum of 5 years. (This does not apply in the first reporting year)
- Financial performance and Best Value

Performance against the national integration indicators is supplemented by data from the Health and Social Care Committee Integrated Quality and Performance Report from the year. The report also includes examples of key achievements and challenges during the year.

Performance against the Integration indicators is strong however key indicators in delay and flow show continuing pressure. Delayed discharges remain persistently high, with reducing delay identified as a key focus for the NHS Highland Unscheduled Care work programme in 2026/27.

2.4 Proposed level of Assurance

Substantial	x	Moderate	
Limited		None	

Comment on the level of assurance

The report has been developed for publication as required and shows strong performance against national integration measures with challenges as reported to Committee through the IPQR regularly.

3 Impact Analysis

3.1 Quality/ Patient Care

Included in the Annual Performance Report

3.2 Workforce

Included in the Annual Performance Report

3.3 Financial

Included within the Annual Performance Report

3.4 Risk Assessment/Management

The work described within the report is risk assessed and managed.

3.5 Data Protection

The work described in this report does not use person identifiable information.

3.6 Equality and Diversity, including health inequalities

Work described with the report includes impact assessment.

3.7 Other impacts

3.8 Communication, involvement, engagement and consultation

The Annual Performance Report has been compiled by senior responsible officers and work stream leads.

3.9 Route to the Meeting

The Annual Performance Report has considered by the following groups who have informed the development of the report:

- Highland HSCP Senior Leadership Team
- Highland HSCP Joint Officer Group
- NHS Highland Executive Directors Group

4.1 List of appendices

The following appendices are included with this report:

- Appendix No. 1, Draft Highland Health and Social Care Partnership Annual Performance Report 2025/26
- Appendix No. 2, performance data appendices to the draft Highland Health and Social care Partnership Annual Performance Report 2025/26

NHS Highland
na Gàidhealtachd

Highland Health and Social Care Partnership

ANNUAL PERFORMANCE REPORT 2025-2026

Contents

Foreword

The past year has been one of sustained effort and continued progress for the Highland Health and Social Care Partnership. Across our services, our focus has remained consistent: to deliver safe, person-centred care, grounded in our shared values of compassion, dignity and respect, and delivered through strong partnership working across health, social care and communities.

At the heart of this work is a commitment to improving outcomes for people across Highland. Throughout 2025/26, we have continued to strengthen how we work together across organisational and professional boundaries, recognising that the best outcomes are achieved when we act as one system. This is reflected in our ongoing focus on integrated governance, collaborative decision-making and the development of community-based models of care that enable people to remain at, or return home, wherever possible.

This has been a year of both progress and learning. We have further developed our approaches to assurance and quality, including embedding more integrated governance arrangements across health and social care. External scrutiny, including the Joint Inspection of Adult Mental Health Services (by Healthcare Improvement Scotland and Care Inspectorate), has provided valuable insight and has supported reflection and improvement. Alongside this, we have prioritised key system challenges such as flow across hospital and community services, with targeted initiatives to support more timely care and reduce delay.

None of this would be possible without the ongoing commitment of our workforce. Staff across Highland continue to demonstrate professionalism, flexibility and a strong commitment to providing high-quality, person-centred care. Supporting staff wellbeing and development remains a central priority, recognising the direct relationship between staff experience, service quality and the safety of people who use our services.

We also continue to work closely with our partners in the independent and third sectors, and with communities themselves, recognising the vital role they play in supporting prevention, early intervention and local solutions. Our approach remains firmly rooted in co-production and in building sustainable models of care that reflect the needs and strengths of our diverse communities.

Looking ahead, the progress made this year provides a strong platform for the year to come. While we remain mindful of ongoing challenges, including financial and workforce pressures, our focus is on sustaining momentum, delivering our strategic priorities and continuing to improve outcomes for the people of Highland through a shared, system-wide approach.

Arlene Johnstone
Chief Officer, Highland Health and Social Care Partnership

Introduction

Welcome to the Highland Health and Social Care Partnership Annual Performance Report. In this report we aim to provide you with our performance, as measured and required by the Scottish Government, against integration measures. The performance of all integration authorities is measured by the National Health and Wellbeing Outcomes and Integration Outcomes. Our performance can be found in the appendices to this report.

We also present local performance data and highlight key challenges and achievements from the past year.

Strategic Integration Context and Overview

Highland Health and Social Care Partnership delivers health and social care services through a lead agency Partnership Agreement. The Highland Council acts as the lead agency for delegated functions relating to children and families, while NHS Highland undertakes delegated functions related to adults.

Both partners report through joint arrangements, with the partnership's governance overseen and managed by the Joint Monitoring Committee. This ensures transparency, accountability, and effective management of the partnership's operations.

The Partnership has been implementing a 3 year Joint Strategic Plan 2024/2027 for adults through ongoing engagement in Strategic and District Planning Groups, and has developed a number of underpinning plans to enable transformation and performance.

Strategic Integration Context and Overview

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The Partnership has been implementing a 3 year Joint Strategic Plan 2024/2027 for adults through ongoing engagement in Strategic and District Planning Groups, and has developed a number of underpinning plans to enable transformation and performance.

The Integrated Children's Services Plan is developed by the Integrated Children's services Planning Board integrated on behalf of Highland Community Planning Partnership. The year 2025/26 has been the final year of the current Children's services plan and the new plan is outlined within this report.

Performance Management and Governance

This report provides an overview of our progress against the delivery of National and Ministerial Integration Indictors and how this activity maps across to the NHS Highland Strategy, Together We Care.

The report additionally provides performance information presented in the NHS Highland Integrated Performance and Quality Report, giving more detail at a service level. The Highland Health and Social Care Partnership IPQR is a set of performance indicators used to monitor progress and evidence the effectiveness of Highland's services aligned with the Annual Delivery Plan. The IPQR is reported to the Health and Social care Committee in NHS Highland and also informs a report from the Chief Officer to the Joint Monitoring Committee.

Key Performance Measures and Highlights

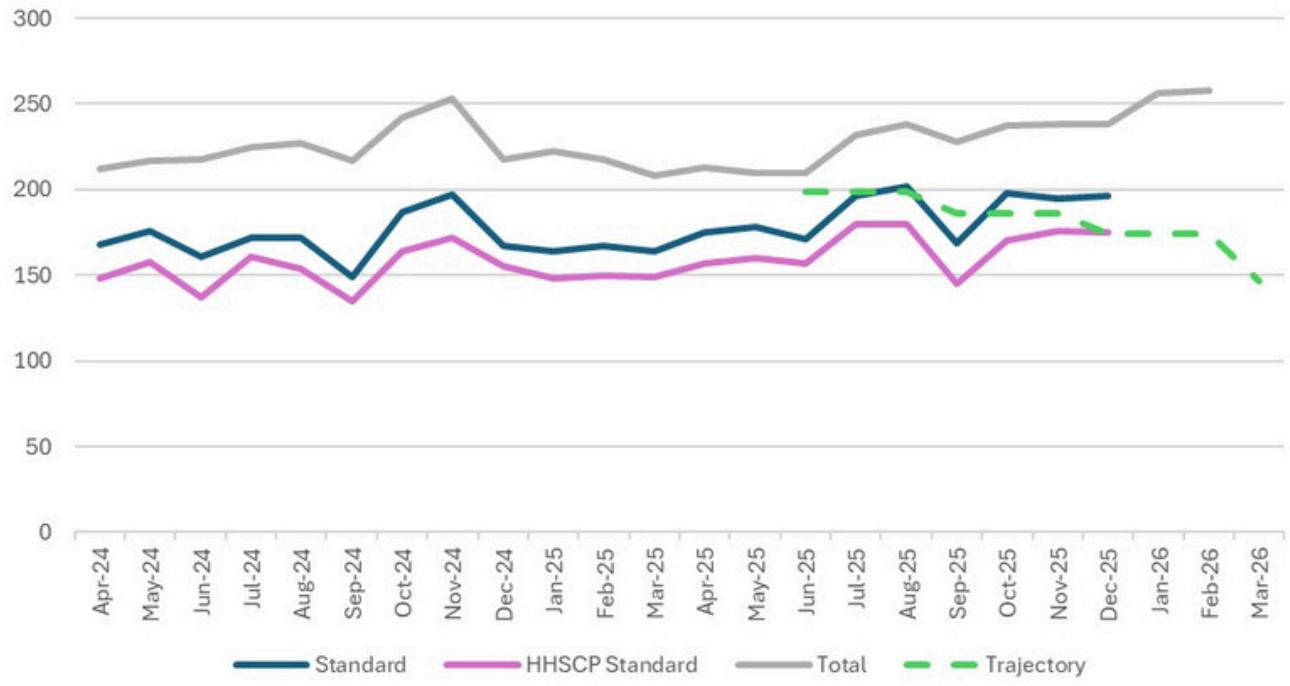
2.1 Integrated Approach to Flow

Throughout the year, there were difficulties in maintaining efficient flow within the health and social care system. Several new service developments were launched to help enhance the patient experience. Key Performance data for measuring flow includes delayed discharges and the wait experienced in Emergency Departments.

Delayed Discharges

Delayed discharge rates have remained persistently high across 2025/26; however, there has not been a further increase compared to previous years. Delays affect people across all hospital settings, including acute, community and mental health sites, and all NHS Highland locations continue to be impacted.

Number of people delayed from hospital discharge at monthly census point

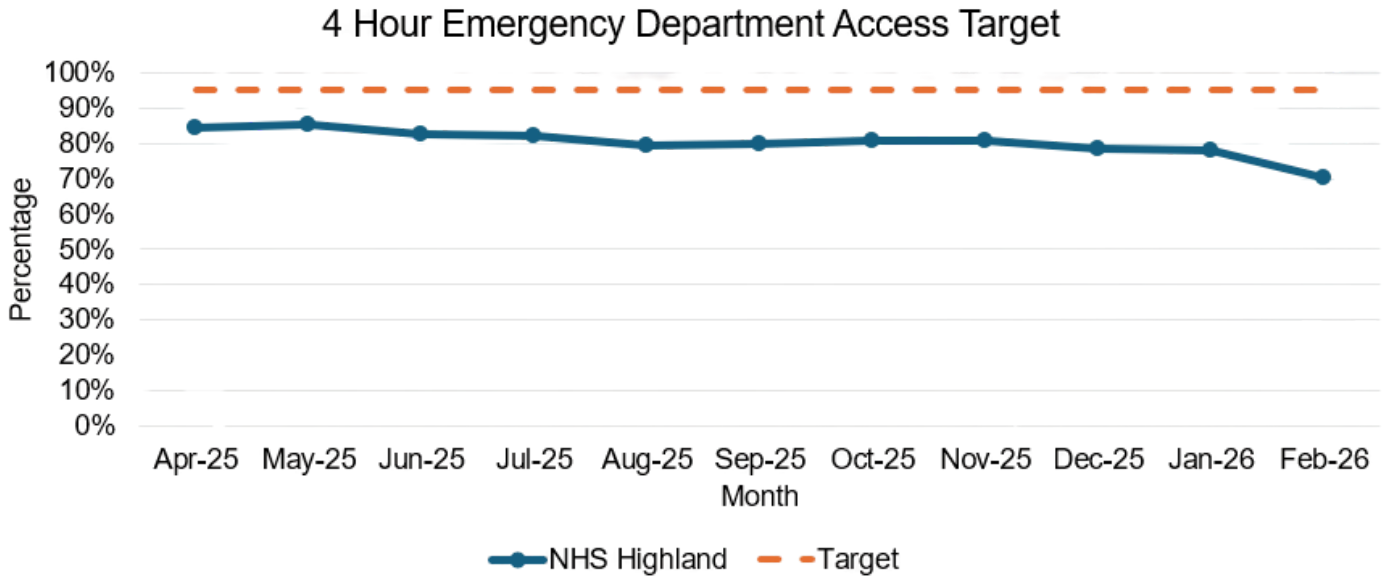


The chart illustrates that there are persistently high levels of people in delay.

Reducing the levels of people in delay in all hospital sites is a key focus on the NHS Highland Unscheduled Care work programme moving into 2026/27.

Emergency Department Performance

The following graph illustrates the performance in achieving the 4 hour emergency department access target for NHS Highland, including Argyll and Bute.



NHS Highland has experienced ongoing difficulties in meeting the national 4-hour emergency department standard. Nevertheless, its performance remains above the national average, which is approximately 60%.

Improving Flow across the System

The Unscheduled Care Programme Board provided oversight for the year's strategic initiatives aimed at supporting individuals to remain at home and minimising hospital delays.

The year saw the appointment of an Interface Manager to oversee and drive whole system approaches to preventing delay. The post is key to spanning the boundary between acute and community integrated teams and to the national Discharge without Delay programme.

The Discharge without Delay (DwD) programme has identified the interdependencies between acute, community, and social care services. This initiative has fostered improved communication and encouraged shared accountability for system flow. As a result, it has supported integrated decision-making and strengthened collective understanding of systemic constraints.

Specific developments implemented over the year to prevent delay included:

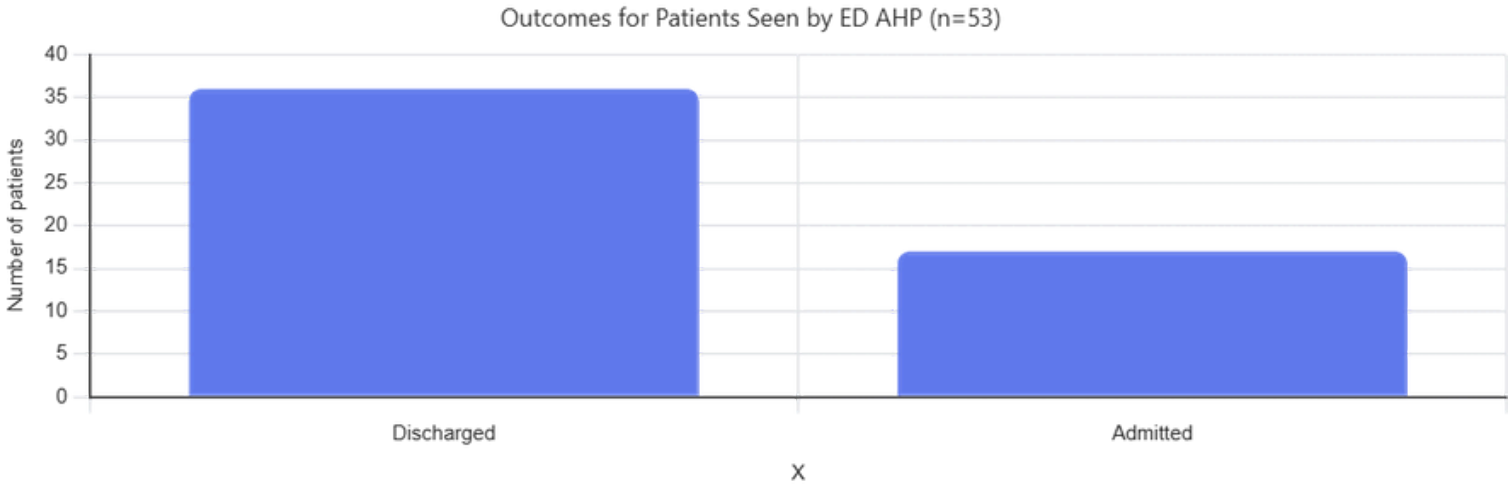
- The use of unscheduled care funds and reconfiguration of care at home capacity in East Ross to develop discharge to assess teams, enabling people's functional abilities to be assessed at home and appropriate care provided to better match their needs
- The Hospital at Home service in Inverness commenced operations, establishing a foundation for future expansion
- The expansion of physiotherapy services, including chronic pain management, in Lochaber
- The ongoing development and expansion of care and support teams across Caithness, East Ross, Inverness, and Lochaber, highlighting their role in community-based support and discharge to assess initiatives
- The development of referral pathways to and from the Flow Navigation Centre directing unscheduled visits to as close as home as possible and to an appropriate practitioner
- Progress in the identification and management of frailty with a frailty programme board now operational, frailty workshops being rolled out across districts, and staff in community hospitals have completed frailty training

As a part of the DwD programme, a specific targeted intervention to improve the outcomes of people with frailty has been the introduction of Allied Health Professionals in the Emergency Department and Frailty Assessment Area. AHPs are providing frailty-focused early assessment in these areas with most patients involved being aged 75 years and over and with complex health and social care needs, including frailty, cognitive impairment and limited support at home.

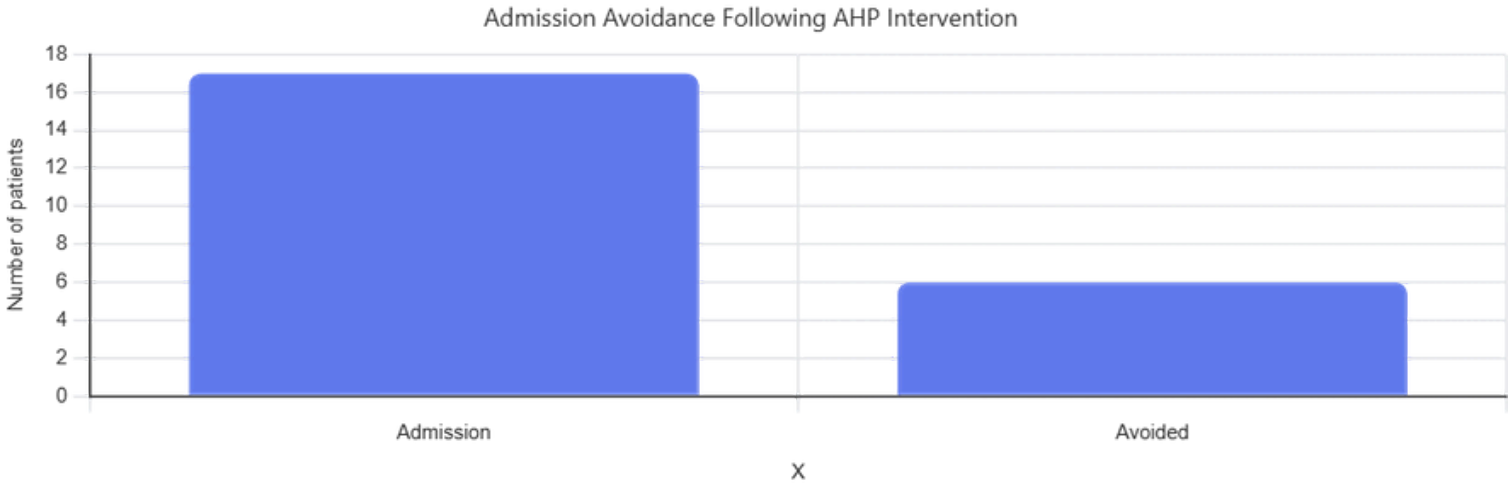
Early AHP involvement supports safe discharge, transition to community services and setting of Functional Criteria Led Discharge for those requiring a medical admission. This contributes to admission avoidance, use of Home First pathways for improved patient flow and better patient outcomes, while maintaining safety.

Front door AHPs also provide frailty assessment and rehabilitation to patients meeting criteria for admission to the Frailty Assessment Area ensuring continuity of assessment and intervention. This supports person-centred outcomes and better alignment between acute and community services.
Demand for AHP at the front door remains consistently high, highlighting the importance of strengthening front door, frailty and rehabilitation pathways.

Over 2/3 of patients seen by AHP were discharged directly from ED.



AHP intervention in ED avoided admission for 1 in 4 patients initially identified for admission.



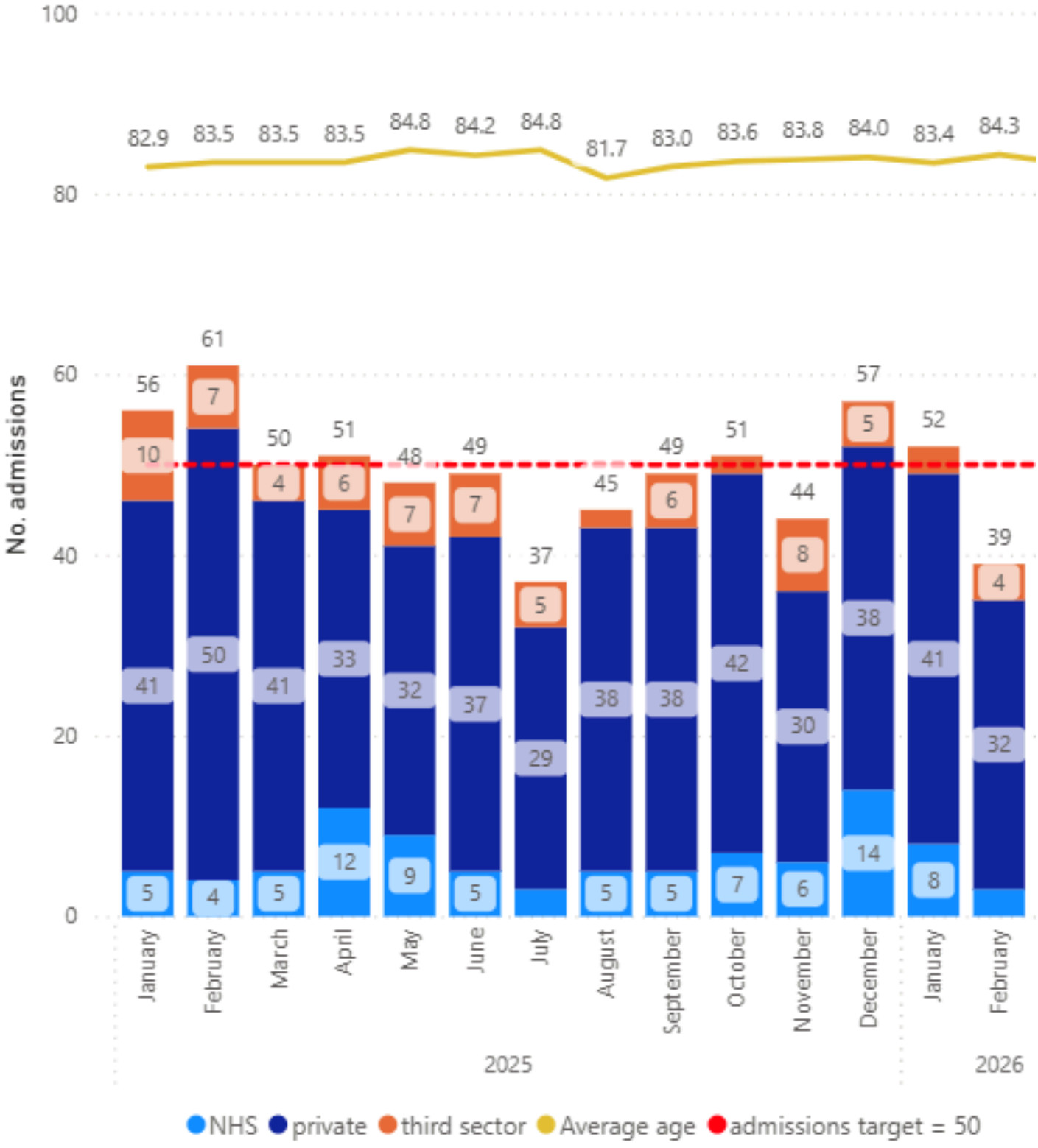
2.2 Adult Social Care

The year has seen challenges in providing care in people's homes. Increasing capacity and sustaining overall market capacity has been a priority.

Care Homes

Demand for placement has been the most common reason for being delayed in hospital over the year. There continues to be turbulence in the market related to operating on a smaller scale, and the challenges with rural operation.

Whilst there have been no care home closures over 2025-2026, this has been a previous pattern of sector instability involving care home acquisition by NHS Highland and The Highland Council. The latest acquisition was on 1st April 2025, whereby NHS Highland became a registered provider at Moss Park in Fort William. The acquisition sought to avoid the loss of nursing home provision from this locality.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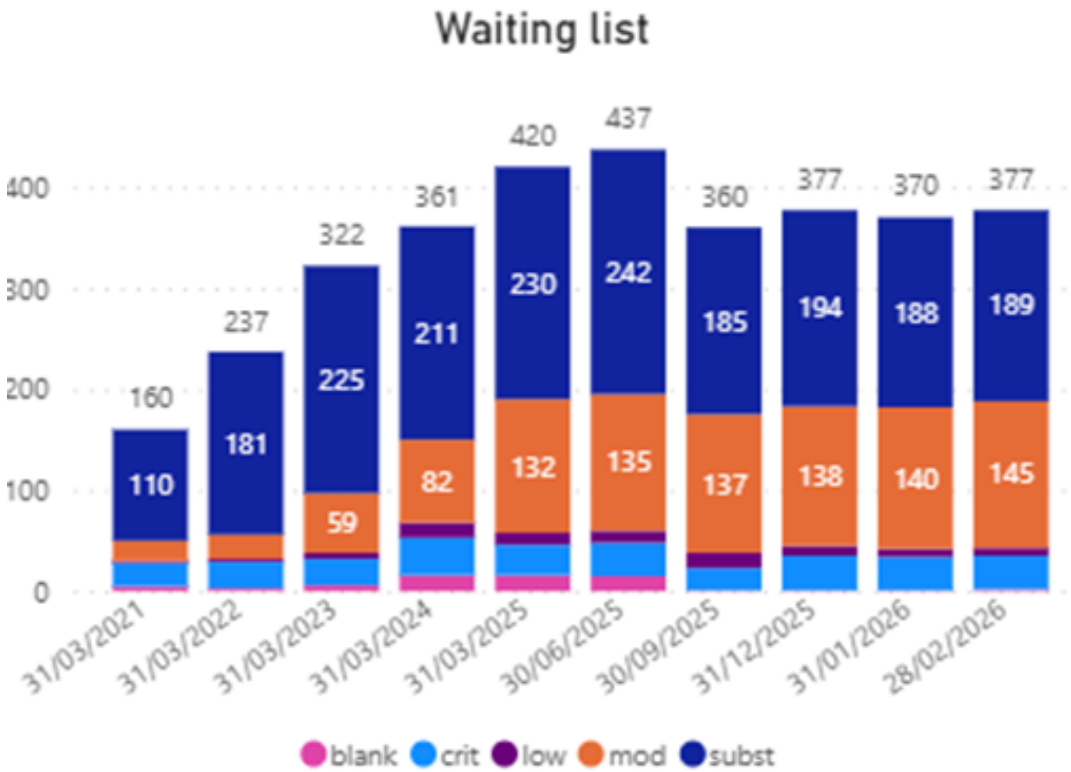
March
April
May
June
July
August
September
October
November
December
January
February
2025
2026
NHS
private
third sector
Average age
admissions target = 50

Care at Home

The care at home market has remained under sustained pressure and demonstrates ongoing volatility, although it continues to operate with capacity largely maintained across the sector. Over the course of the year, six providers exited the market, with activity absorbed by alternative providers.

Operational teams and partner organisations continue to work collaboratively to sustain provision; however, increasing complexity of need, alongside workforce recruitment and retention challenges and competition from other sectors, has constrained overall activity.

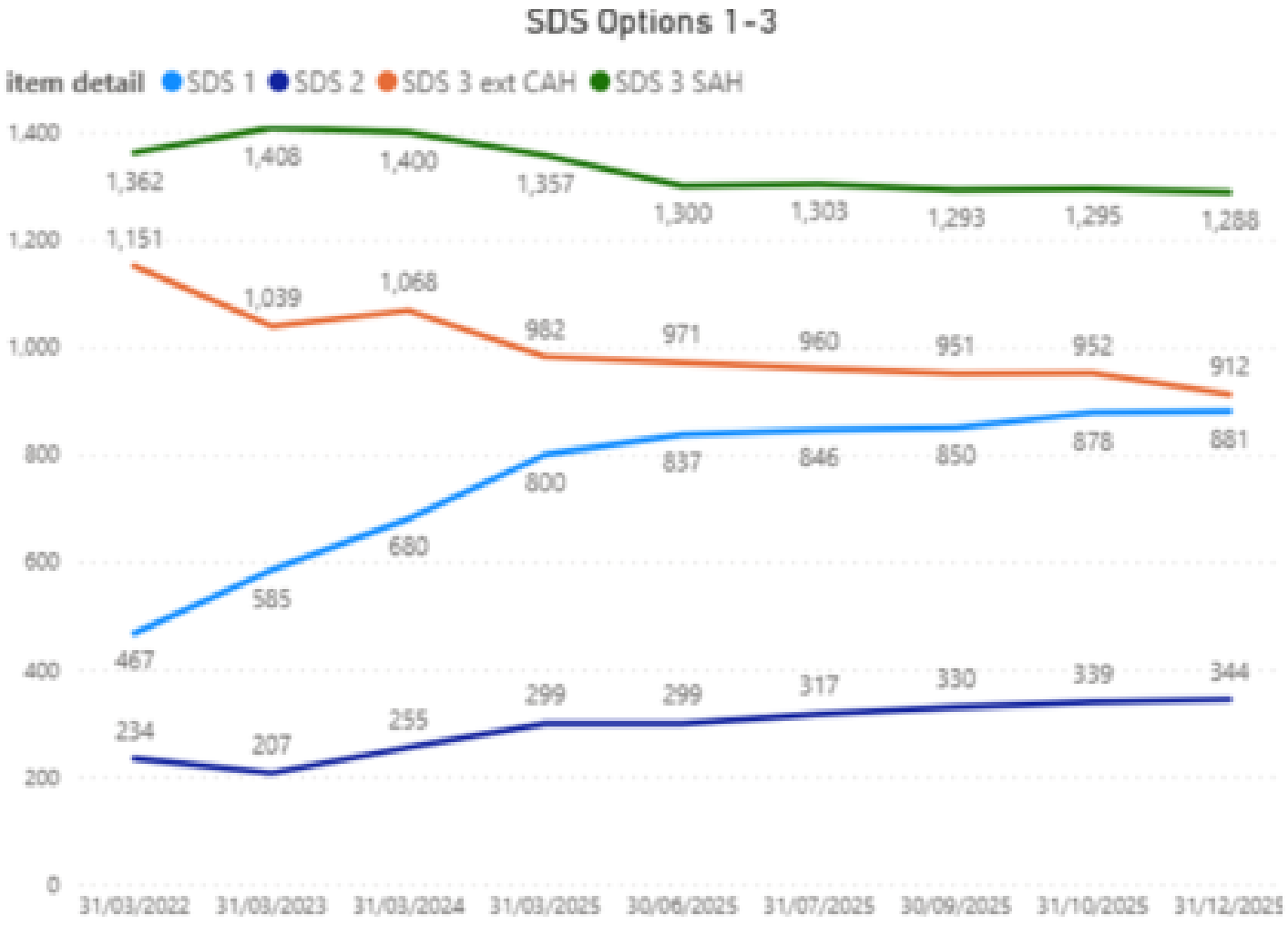
Numbers waiting for Care at Home by Month and Need (critical, substantial, moderate and low)



Self Directed Support (SDS)

Over the year, our aim has been to expand self-directed support, particularly Options 1 and 2. Uptake has continued to grow steadily across both options, supporting greater independence and choice for individuals. We remain committed to further increasing the availability and accessibility of flexible support options.

Numbers of people receiving care through the 4 SDS Options shown 2 monthly.



Work is well underway within identified Highland communities to develop new, local models of care which integrate community and preventative effort with the work of statutory providers.

Local care models seek to be:

- Person-centred and rights-based
- Locality-led and place-based
- Integrated and multidisciplinary
- Preventative and proactive
- Digitally enabled and data-informed
- Co-produced with communities

To create these models we need changes to both our Practice and Service Models and to do this we are working to develop a "Community Led Support" approach, one which seeks to:

- Situate advice and guidance within the heart of our communities
- Links people to the community fabric around them
- Ensure our professionals take an asset and relationship-based approach to their work, and
- Support the development of a spectrum of local supports which underpins the help available to our citizens.

To help us in this we are:

- Providing a fund which co-produced initiatives can access to grow community fabric and try new ways of working
- Commissioning facilitation to support our transition to new "Community Led Support" ways of working.

2.3 Technology enabled care

Technology Enabled Care (TEC) is a core component of transformation in the delivery of social care through the effective use of digital consultation, remote monitoring solutions and telecare.

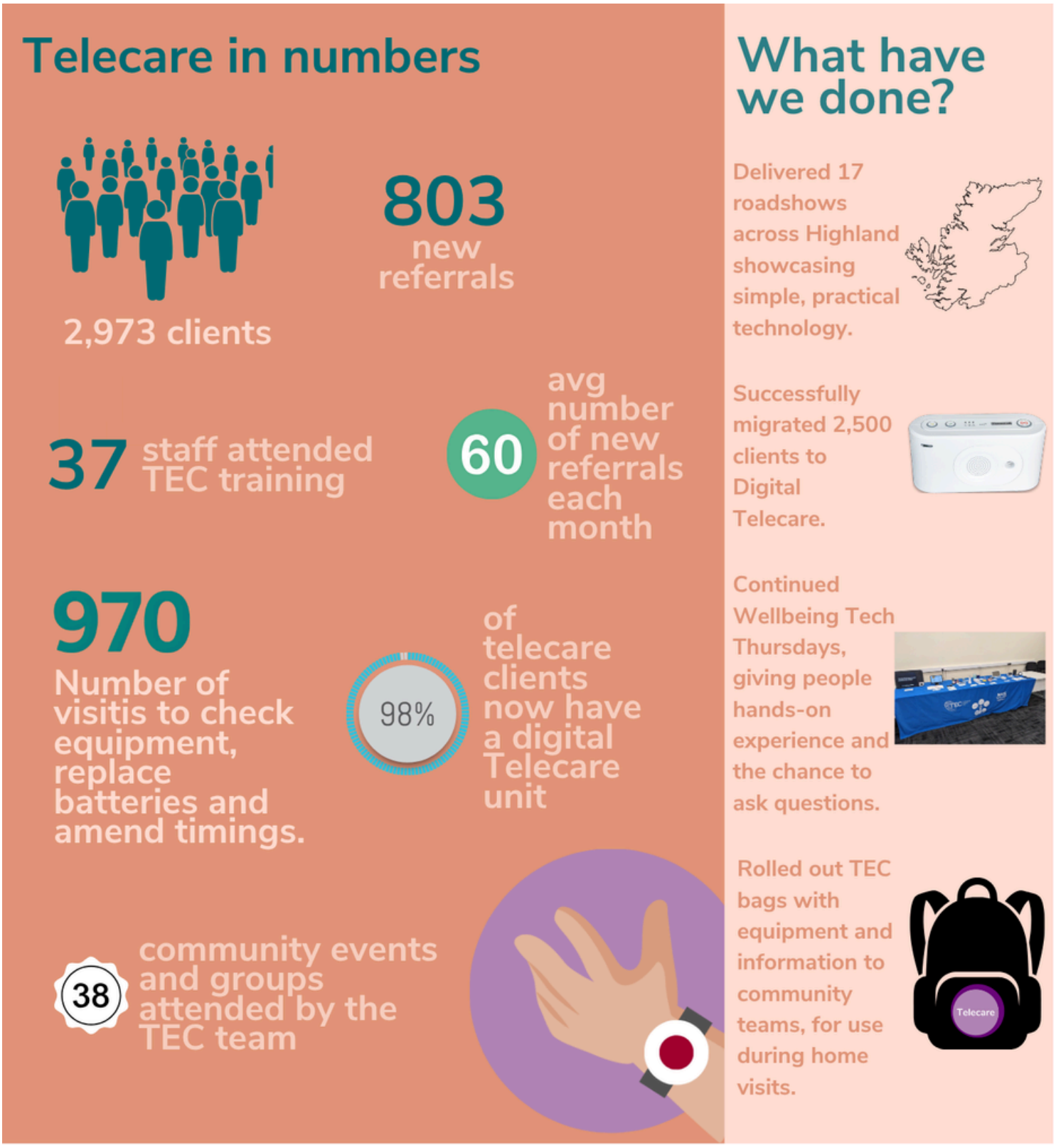
Key areas of focus during the year have included the Digital Telecare Switchover, continued expansion of Near Me video consultations, and sustained use of Connect Me monitoring pathways.

Digital Telecare Service

Digital Telecare Switchover

The major focus of the Telecare Service in 25/26 has been the switch from Analogue to Digital Telecare Devices in people's homes.
Significant progress has been achieved with the Digital Telecare Switchover:

- Approximately 98% of telecare clients have transitioned to digital units.
- The majority of activity was completed after August 2025, following the award of the Digital Telecare contract to the Highland Care and Repair Schemes
- Most equipment swaps were completed by end of February 2026, ahead of the original March deadline.
- The NHS Highland Hub Response Centre was upgraded to a digital call-handling platform.



Near Me Service

Near Me continues to be available across all specialties, with increasing use of group consultations, particularly for:

- Therapy sessions
- Multidisciplinary team (MDT) meetings
- Appointments involving interpreters, carers, or relatives.

To improve accessibility, the number of community-based venues for patient use has expanded across NHS Highland and now includes libraries, community hubs, community centres and GP practices.

Through expanding the venues available, delivering training, introducing a home support service and running engagement and drop in events across Highland, over the year we increased the number of specialties using Near Me video consultations. The number of consultations delivered in this way rose to 29,085.

5.6% of all NHS Highland appointments and 7.4% of Raigmore outpatient appointments are held using Near Me.

Connect Me Service Remote Monitoring Service

The Connect Me Remote Monitoring Service continues to be used across NHS Highland

Current Pathways in Use include Asthma, Blood Pressure, Chronic Pain, Core Home Monitoring, Heart Failure, Lymphoedema, Multiple Long-Term Conditions, and Urogynaecology.

Over the year, there has been a small increase in GP practices using the **blood pressure monitoring pathway**.

- 87 GP practices are signed up to Connect Me Blood Pressure monitoring pathway.
- 51 practices actively monitor patients.
- 2,184 active patients are currently enrolled.

2.4 Primary Care

Enhanced Services

Local Enhanced Services are services that are commissioned from General Practice.They are offered to Practices in addition to the core GP contract and are not mandatory for Practices to deliver.During 2025 a new commissioning framework was introduced for additional services. The underpinning principles of the framework included - item of service fees for activity undertaken with annual uplifts; no caps on activity levels; activity claiming on a real-time monthly basis; and payment made on a monthly basis.

National Primary Care Walk-in Pilot

The Scottish Government has approved the introduction of a seven-day enhanced GP access and walk-in service in Invergordon. The initiative is one of several across Scotland. Working with the registered population of Alness and Invergordon, the pilot aims to improve timely access to urgent primary care, relieve pressure on existing services, and address significant health inequalities within a high-need population.

The service will be delivered from County Community Hospital, Invergordon, maximising the benefits of co-location with the GP practice, Minor Injury Unit (MIU), Out of Hours (OOH) service, diagnostics, and multidisciplinary teams.

Operating 12:00–20:00, Monday to Sunday, the pilot integrates walk-in urgent primary care with telephone, online, and digital eTriage. It establishes two parallel care pathways—urgent same-day care and planned, proactive care—enabling more effective management of demand while improving the overall patient journey.

Primary Care Strategy

NHS Highland has commissioned the development of a Primary Care Strategy to articulate the collective contribution of primary care services to improving population health and wellbeing over the next five years.

A Health Needs Assessment was completed in late 2025, drawing on additional insight from the emerging Pharmacy Strategy. The findings were considered at a multi-professional stakeholder workshop held in August 2025, with representation from Community Pharmacy, General Practice, Dental Services, Ophthalmic Contractors / Community Optometry, and Primary Care Management.

Arrangements are in place to establish a Primary Care Programme Board, providing a single, coherent framework for strategic oversight, assurance, and coordinated delivery across all primary care services. The Board will also oversee the development and delivery of the annual delivery plan.

In parallel, a set of high-level guiding principles has been developed to support future decision-making and inform implementation.

Primary Care Improvement Plan

The Primary Care Improvement Plan has demonstrated ongoing progress in multidisciplinary team delivery, with strong coverage across core services and continued workforce challenges. The plan is supported by significant existing investment and ongoing evaluation.

New GP Funding

In October 2025, The Scottish Government and BMA agreed major national investment (£531m over three years) aimed at improving GP capacity, sustainability, and patient access, aligned to wider service renewal and strategic priorities.

2.5 Vaccinations

During 2025/26 the delivery of vaccinations continued while collaborative work has been underway to implement a new hybrid model of vaccination delivery, a model which will utilise the strengths of various delivery methods to improve vaccination uptake.

For childhood immunisations, between September and December 2025, uptake improved for all immunisations, as illustrated in the following graph:

Level 2 Childhood Immunisations Residence
Health Board/Local Authority of Residence

Date From: Quarter ending Mar 25 | Date To: Quarter ending Dec 25

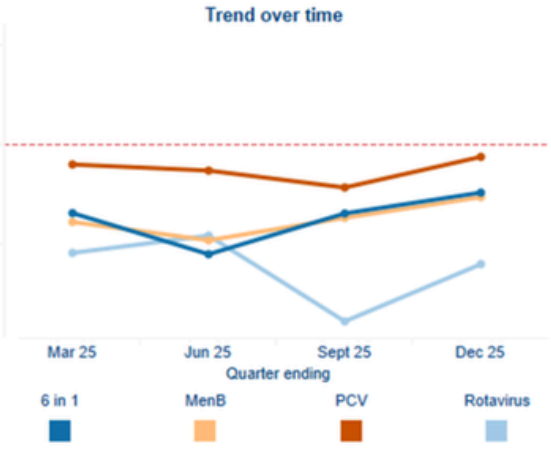
Health Board of Residence data are only available from Quarter ending June 2022.

Board: NHS Highland | Location: Highland | SIMD: All | Age: 12 months

View by: Local Authority / Intermediate Zone

Location: Highland Age: 12 months
SIMD: All

Quarter Ending	Location	Immunisation	Uptake	No. Vaccinated	No. Unvaccinated	Peer Uptake	Peer No. Vaccinated	Peer No. Unvaccinated
		Rotavirus	90.5%	389	41	92.6%	2,837	227
Sept 25	Highland	6 in 1	91.6%	424	39	94.5%	3,070	177
		MenB	91.4%	423	40	94.3%	3,063	184
		PCV	92.9%	430	33	95.7%	3,106	141
		Rotavirus	86.2%	399	64	91.4%	2,968	279
Dec 25	Highland	6 in 1	92.6%	414	33	93.9%	2,695	174
		MenB	92.4%	413	34	93.9%	2,693	176
		PCV	94.4%	422	25	95.0%	2,725	144
		Rotavirus	89.0%	398	49	91.0%	2,612	257



For the winter programme (Covid and Flu immunisations), COVID-19 vaccination percentage uptake performance at 29 March 2026 was 62.3%, with the Scottish average being 65.4%.

2.6 Primary Care Dental Services

Access to Dental Services

Scottish Government Grant Assistance

There are 4 dental practices in the HHSCP area who have within the past 3 years received grant assistance to either set up new or extend their existing dental practices.

These awards of grant have tied the practices into increasing access for patients. Within the Inner Moray Firth, Easter Ross and Skye & Lochalsh areas this has resulted in excess of 7000 patients becoming registered for NHS dental services. There is capacity for a further 1500 patients to have this same access.

2.7 Community Optometry

There are 32 General Ophthalmic Service practice premises in the Highland Health & Social Care Partnership. This is an increase of one practice following a new practice opening in Fort William.

General Ophthalmic Service Specialist Supplementary Service following an interim measure introduced in August 2025 was fully implemented in January 2026. There are currently 18practices delivering the service across NHS Highland, 11 of these practices are across the Highland Health & Social Care Partnership. This service enables patients to receive management of 10 anterior eye conditions in their local communities and therefore reducing the need to travel to an Ophthalmology clinic.

NHS Highland also continues to work to deliver the Community Glaucoma Service across NHS Highland. There are 10 practices in NHS Highland, 7 of which are across the Health and Social Care Partnership, currently accredited to provide this service and the service is anticipated to go live in the financial year 2026/2027.

2.8 Prescribing

Integrated Care

Pharmacy teams work within and across various care settings including general practice, community hospitals, care at home and care home services, prison and police custody. They are contributing to hospital discharge, medicines optimisation and anticipatory care.

In 2025/26 pharmacy services continued to play a role in integrated health and social care across Highland. Pharmacy teams worked across sectors, supporting safer transitions of care, medicines reconciliation at discharge, and optimisation of prescribing for people supported at home and in community settings. This integrated approach helped reduce avoidable medicines-related harm and supported people to remain well and independent in their own communities.

Medicines optimisation and Prescribing Quality

Pharmacy teams led a number of medicines optimisation initiatives during 2025/26, targeting areas of greatest clinical risk and unwarranted variation. Through data-led prescribing reviews, multidisciplinary working and engagement with GP practices and care teams, improvements were delivered in prescribing quality, patient safety and value.

Care Home and Care at Home Pharmacy Support

Pharmacy input to care homes and care at home services continued during 2025/26, with a focus on improving medicines safety for some of the most vulnerable people in our communities and improving the efficiency of systems and processes. Pharmacy teams supported regular medicines reviews, safer administration and medicines management practices and closer collaboration with care providers, contributing to reduced medicines-related risk.

2.9 Mental Health & Learning Disability Services

Adult Mental Health Services Care Inspectorate and Healthcare Improvement Scotland Joint Inspection

This year also brought important challenge and learning through the Care Inspectorate and Healthcare Improvement Scotland Joint Inspection of Adult Mental Health Services. The inspection found that the HHSCP delivered positive outcomes for most people living with mental illness, supported by effective early intervention and prevention initiatives. It recognised the commitment of staff to compassionate, person-centred practice across mental health and learning disability services, while setting out clear recommendations for improvement. These findings are now driving a structured programme of work, reinforcing the importance of learning, reflection and shared accountability.

Mental Health and Learning Disability Strategy

The year 2025/26 saw the development of the Mental Health and Learning Disability Strategy 2025-2028. The strategy articulates the vision for the service, including the vision for digital aspects of care.

Stress and Distress Interventions

This year, Stress and Distress training was extended to health and social care practitioners supporting people living with dementia, promoting a consistent, evidence-informed approach across Highland regardless of care setting or locality. In parallel, opportunities have been embraced to redesign Older Adult Mental Health Services within some localities to strengthen specialist stress and distress capacity. This development is intended to support a more responsive, targeted model of care, enhancing the ability of services to provide timely specialist input and to better support care homes and community settings across Highland. The success of early adopters of this redesign is expected to create further momentum, supporting wider implementation and sustained service improvement.

Digital Tools

Both inpatient and community teams are now using a Discharge App, developed by the Unscheduled Care Programme with benefits being improved communication, patient safety and continuity of care. Additionally, the year saw the planning of the implementation of Vocala devices to support people with learning disabilities to live more independently at home.

Advocacy and Peer Support

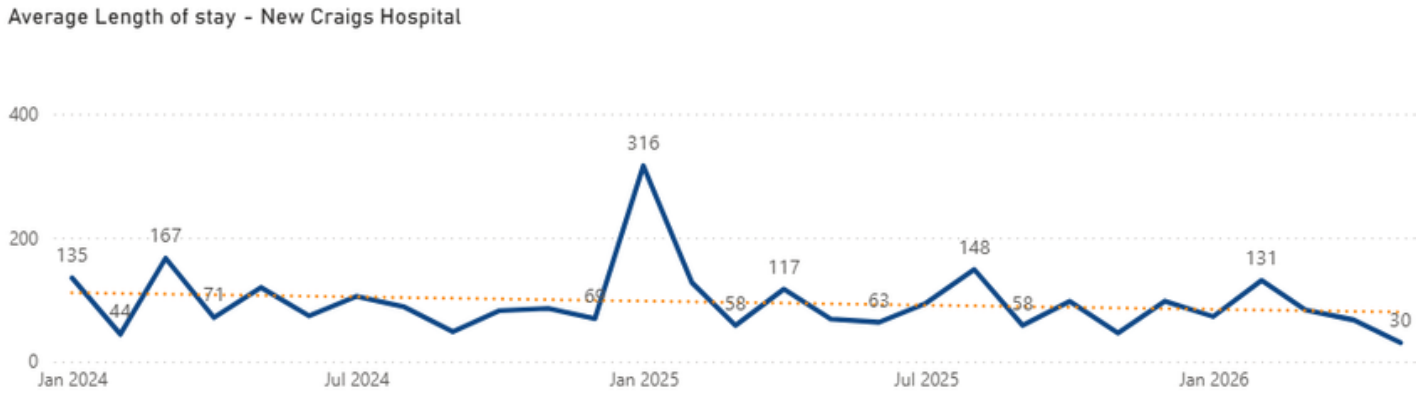
The partnership's engagement with collective advocacy organisations, including Spirit Advocacy, over the year has led to the development of locality-based experience panels, with progress in Caithness, Lochaber, and Badenoch and Strathspey.
A peer support worker within the Perinatal Mental Health Team has been in post over the course of the year and has been extended until March 2027, supported by Scottish Government funding.

Housing and Supported Living

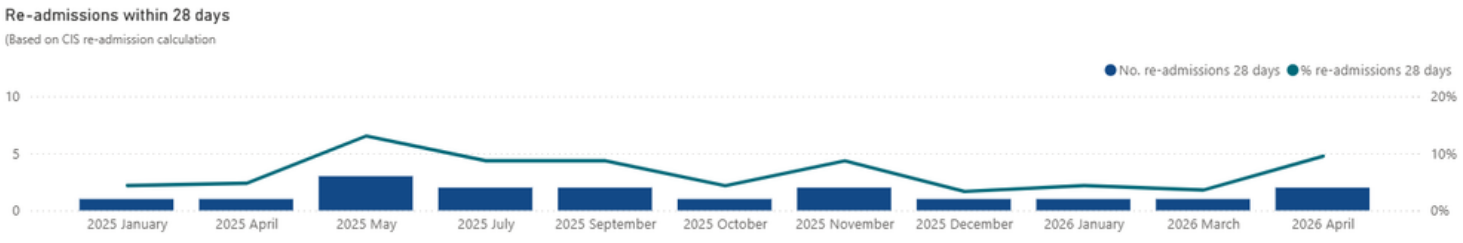
During the year, there was engagement with Highland Council's housing needs assessment, providing information and guidance on future housing requirements for people with mental health needs.

Acute Mental Health Hospital Performance

Average length of stay performance at New Craigs Hospital shows recent improvement and reduced lengths of stay, with the latest data point significantly below the indicative benchmark. While historical performance has been variable, there is evidence of periods of sustained control and recovery following peaks, suggesting that the redesigned flow and capacity interventions are having a positive impact. Continued focus on flow and discharge pathways is expected to support more consistent performance over time.

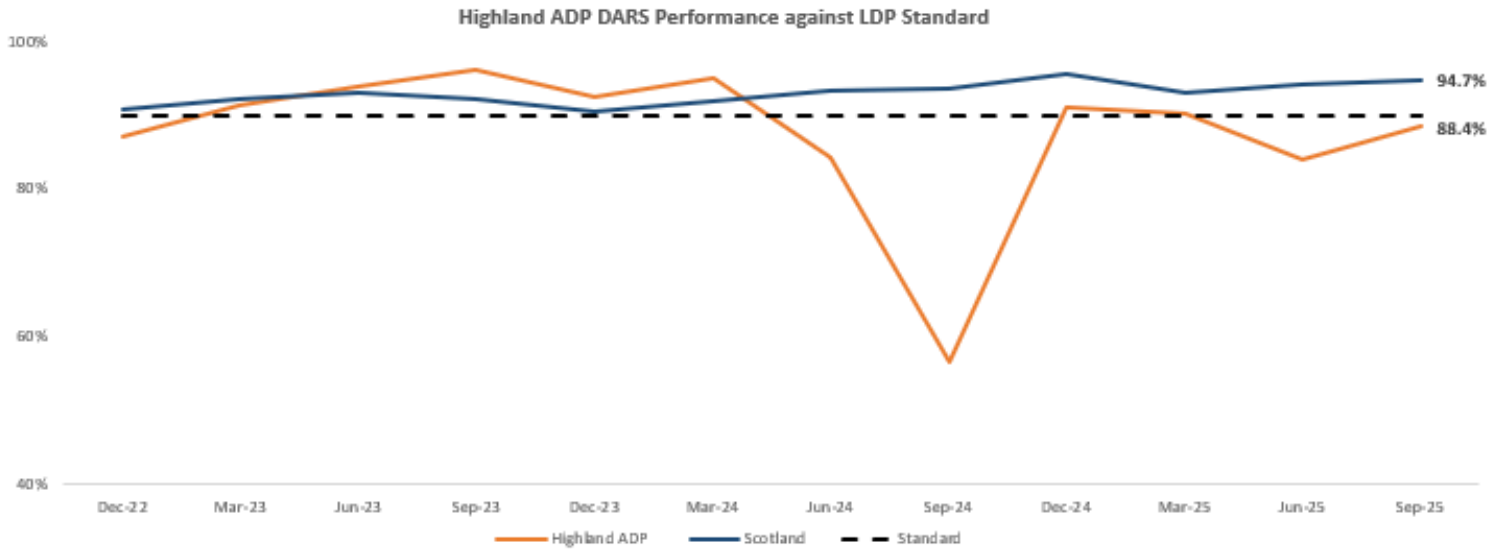


Readmission rates are routinely used as a proxy measure for the quality and safety of discharge planning, as they provide an indication of whether individuals are leaving hospital with the appropriate support, care coordination, and clinical stability in place to sustain recovery within the community. There has been a sustained reduction in readmission rates from 6.1% to 4.4% over the past 12 months, indicating an improvement in the effectiveness of discharge planning and post-discharge support. This trend provides assurance that current approaches to care coordination and community follow-up are contributing positively to safer and more sustainable discharges.



Drug and Alcohol Recovery Services

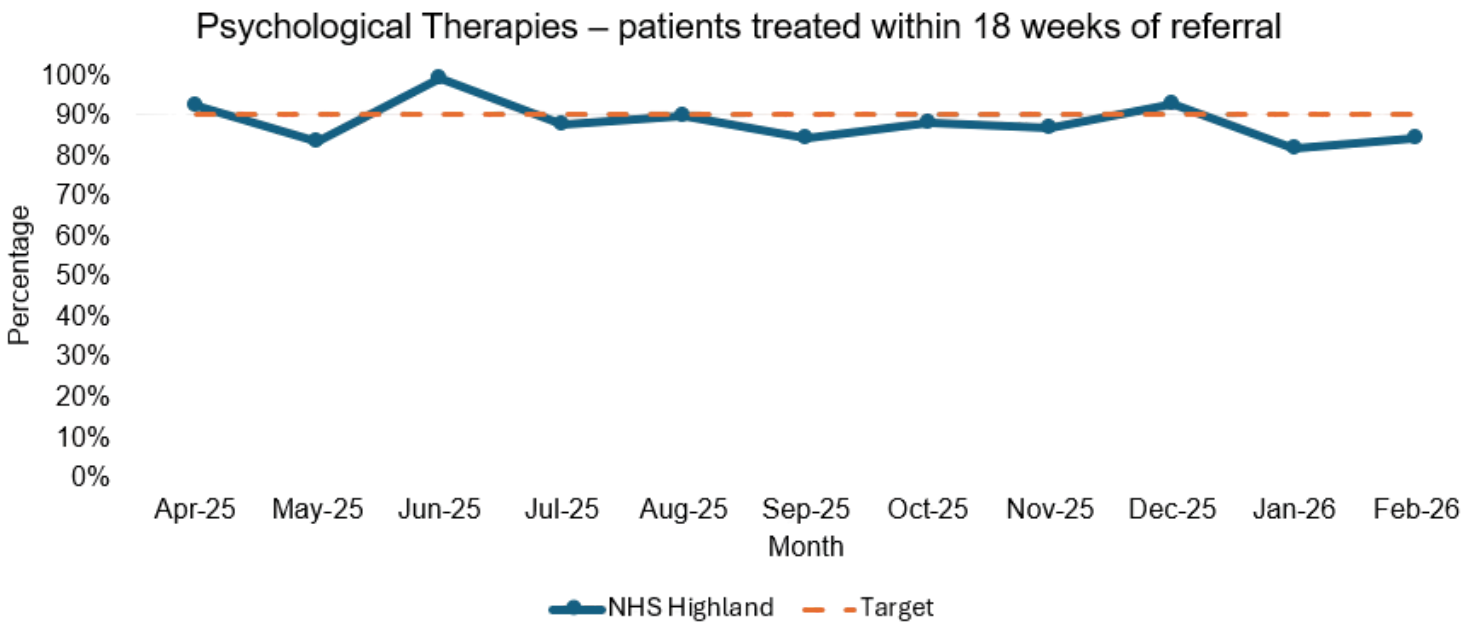
Supporting people presenting with drug and alcohol challenges is a key requirement of health boards. NHS Highland seeks to ensure patients are seen within 3 weeks of referral as an early intervention to support people at risk.



NHS Highland performance continues to be slightly behind the 90% standard and is associated with the overall demand for these services. DARS has successfully mobilised a new digital support service – **withyou** - delivered through strong partnership working with HADP. The model has already begun supporting people across Highland. The contract provides flexibility to scale over time, enabling continued learning and improvement.

2.10 Psychological Therapies

NHS Highland has maintained consistent improved access times to Psychological Therapies services and is continuing to manage waiting lists toensure 90% of people wait no longer than 18 weeks from referral. The following chart illustrates the performance against the target over the year:



To address variance in performance the psychology service is using digital technology and is implementing DCAQ (Demand, Capacity Access and Queue) modelling trajectories to support them with reducing waiting lists.

To further evidence performance and quality the service is working with the NHS Highland eHealth service on data collation solutions.

Safe, Sustainable Services

The psychology Service identified 5 priorities to ensure safe, effective and sustainable services and have made progress over the year in addressing them. The priorities are:

- Senior Leadership Structure for Psychology
- Organisational Position
- Professional Assurance Framework (PAF)
- Governance
- Leadership Development

Research

Plans were made over the year for the launch of our research conference, which is gaining national interest. This showcases the research undertaken within the field of psychology. The Conference took place on 21st April 2026 at UHI House in Inverness and included eminent key note speakers.

Media and Communication

The year 2025/26 saw the launch of the Neuropsychology website and Drug and Alcohol Recovery website, improving access to information and assistance.

2.11 Children's Services

Performance data for Children's services for the year 2025/2026 can be found in the Children's Services Planning Partnership Board Performance Management Framework 2023-2026 in the Appendices.

Children's Services Partnership Plan (2026–29)

Over the year 2025/26 the next Children's Services Partnership Plan 2026-2029 has been in development and was formally approved by the Integrated Children's Services Planning Board (ICSB).

The plan builds directly on the foundations established in the 2023–26 plan. The themes and priorities from the current plan remain highly relevant and have been further developed in response to updated evidence, engagement and system learning.

The new plan continues to strengthen and refine these original themes through the life course approach, ensuring a clearer focus on prevention, early intervention and transitions at key stages of children and young people's lives. This approach supports a more coherent and integrated system, aligning services around the evolving needs of children, young people and families from pre-birth through to adulthood.

This continuity ensures stability in strategic direction while enabling the partnership to respond more effectively to emerging challenges, inequalities and opportunities for improvement.

The plan is underpinned by a strong, evidence-led foundation established through completion of the Highland Children and Young People's Needs Assessment (2026). The needs assessment provides a comprehensive performance update and can be found here.

This quantitative evidence is complemented by a strong Children's Voice evidence base and the plan is built on a robust, rights-based and co-produced foundation, aligned with UNCRC, GIRFEC and The Promise.

The Voice report can be found here.

The synthesis of evidence and engagement has shaped clear strategic direction and priorities for the plan, focused on:

- **Tackling child poverty and inequality** as a central driver of improved outcomes
- **Early intervention and prevention**, with a life-course focus on pregnancy, early years and parenting
- **Whole-system, whole-family support**, including expansion of the Whole Family Wellbeing Programme
- **Addressing rural and access inequalities** through place-based planning
- **Children's rights and participation**, embedding UNCRC and co-production throughout delivery
- **Workforce and system sustainability** to ensure deliverability

Central to the plan is a clear and strengthened delivery architecture, designed to translate strategy into measurable improvement.

The plan will be delivered through the established multi-agency delivery groups, aligned to the plan's priority areas.

These delivery groups will play a critical role in moving the plan from strategy into action, supporting stronger collaboration across services and enabling more joined-up, responsive support for children, young people and families across Highland.

Children and young people's participation is a core pillar of the plan and represents a shift from episodic engagement to continuous participation influencing decision-making and improvement, with a clear emphasis on strengthening feedback loops.

In summary, the Children's Services Plan (2026–29) builds on the established foundations of the 2023–26 plan, strengthening its themes through a life course approach and an enhanced focus on prevention, integration and reducing inequalities.

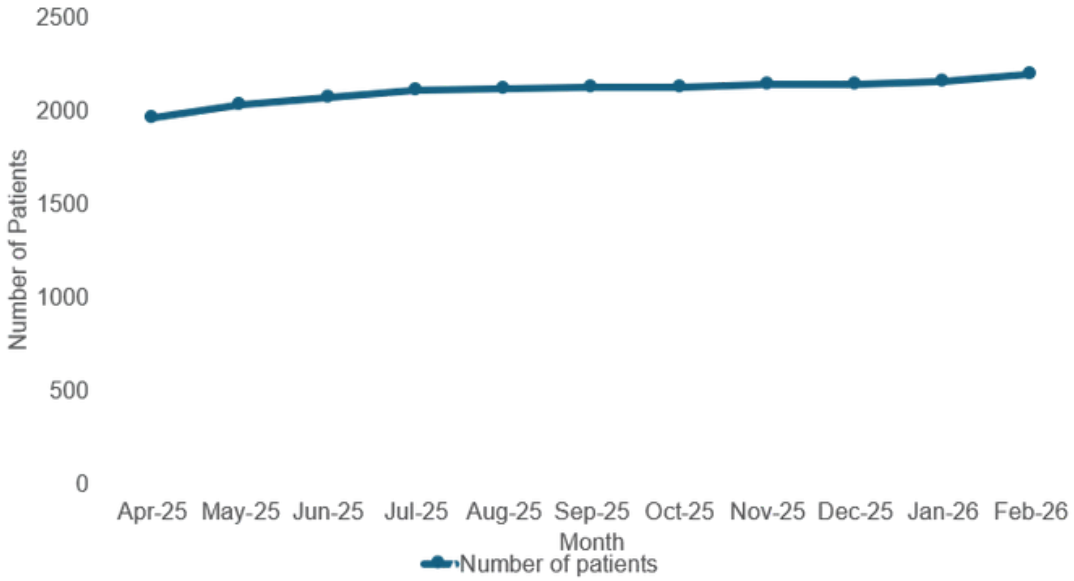
With ICSB approval now secured and final governance underway, the plan is well positioned to move into implementation. A strong evidence base, clear strategic priorities and a defined delivery model provide confidence that the plan will drive measurable improvements in outcomes for children, young people and families across Highland.

2.12 Neurodevelopmental Assessment Service (NDAS)

NHS Highland is actively seeking opportunities alongside partners, such as The Highland Council, to enhance the development of Neurodevelopmental services for individuals referred for assessment.

At present, NHS Highland, in line with other boards, is unable to offer a service for new referrals regarding neurodevelopment assessment. However, a limited number of assessments are being undertaken by the independent sector for those who are clinically prioritised.

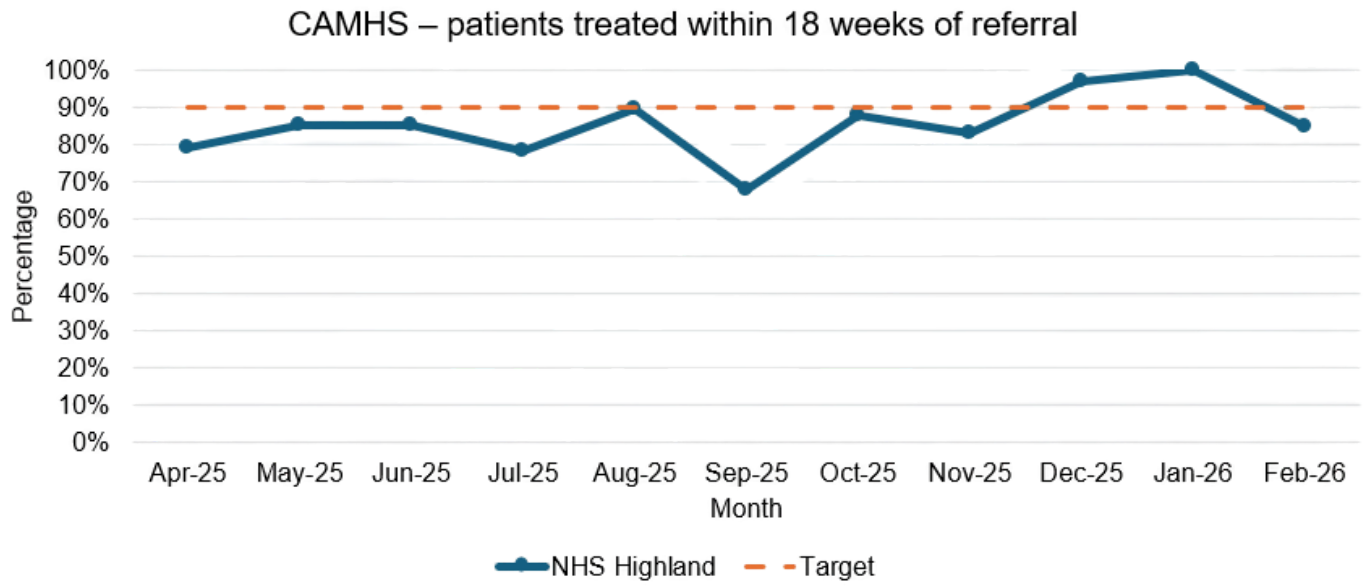
Collaborative efforts with The Highland Council are underway, aiming to create innovative and transformative approaches for supporting individuals referred for neurodevelopment assessment at a more local level. This initiative will necessitate system-wide collaboration, ensuring the presence of skilled professionals at every stage to assist with assessment and address any subsequent needs.



2.13 Child & Adolescent Mental Health Services (CAMHS)

NHS Highland has significant improved access times to CAMHS, moving from one of the worst performing boards to one of the best in Scotland.

During 2025/26, NHS Highland's performance in CAMHS has improved, meeting the Scottish Government's target of 95% in two out of the last three months. This accomplishment reflects the targeted improvements made within these services. Alongside this advancement, there has also been a notable reduction in the waiting list for CAMHS, attributable to service-level actions taken to address the backlog.



2.14 Quality and Care and Clinical Governance

Over the year we made continued progress in embedding the Vincent Framework as a practical way of helping front line teams think about clinical and care governance differently.

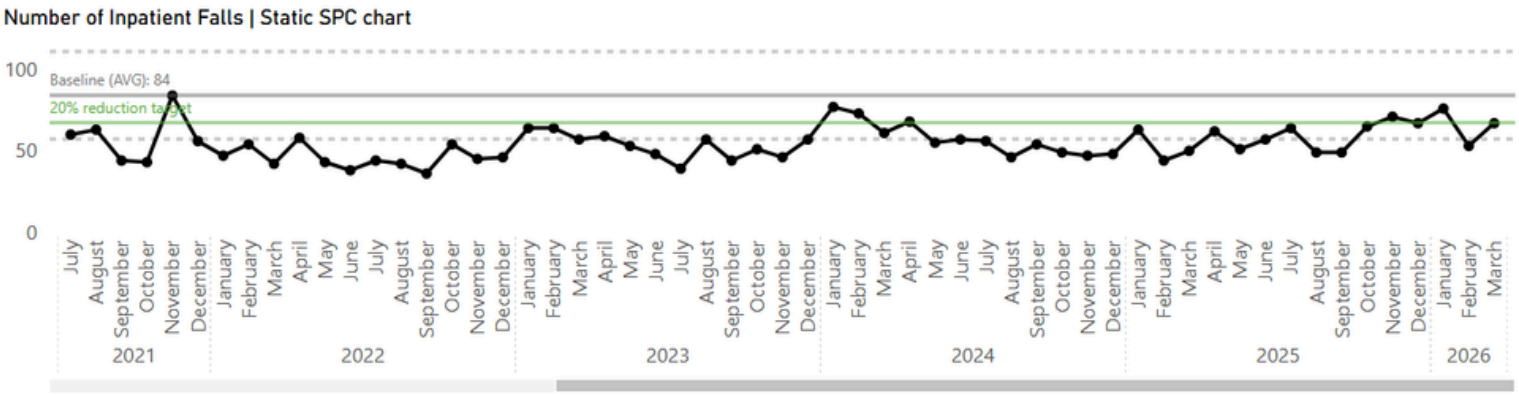
Rather than starting with a long list of metrics, the framework (developed by Charles Vincent and colleagues) uses a small set of prompts to help teams and leaders ask: Was care safe in the past? Is care safe today? Will care be safe in the future? Is our care person-centred? Are we learning and improving?

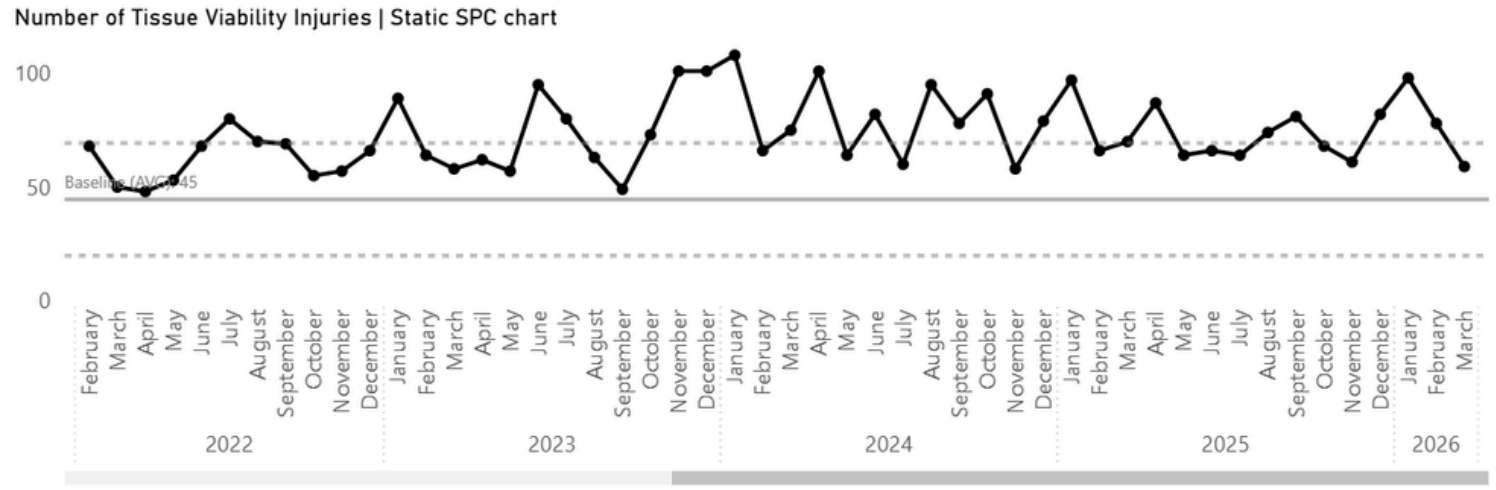
It supports open, learning-focused conversations about what is happening in services, what the risks really are, and what needs to change — with the emphasis on services owning issues and sharing learning. It also helps the HSCP take a more consistent approach across health, social work and adult protection, so that assurance is built from real operational insight and improvement work, not just retrospective reporting.

We have also developed prompts for assurance across services and supported more integrated governance with health, social work and adult protection colleagues.

We have increased emphasis on using performance data through a quality lens and this supported a deeper understanding of care quality beyond headline metrics.

Two performance metrics reported through our Care and Clinical Governance Group are the incidence of falls and the incidence of tissue viability injuries, as illustrated in the following two charts.





Overall, the charts show normal month-to-month variation rather than a single sustained pattern. Where we see spikes, these are used as a prompt to look behind the numbers (for example, whether there were specific care settings, clusters of incidents, or changes in reporting), and to agree targeted improvement actions. Interpreting the data in this way helps us focus on learning and prevention, rather than treating the charts as a simple pass/fail measure of quality.

Tissue Viability

There has been an increase in reporting of developed Tissue Viability wounds. The previous table shows pressure ulcer incidents in the community. This data has been captured through the patients having District Nurse involvement to treat the wound. Work continues by the Tissue Viability team on education in target areas. Collaboration between podiatry and nursing has seen the development of a new assessment tool for care homes to use that will aid early detection of skin damage to feet. This enables the initiation of appropriate early referral and treatment.

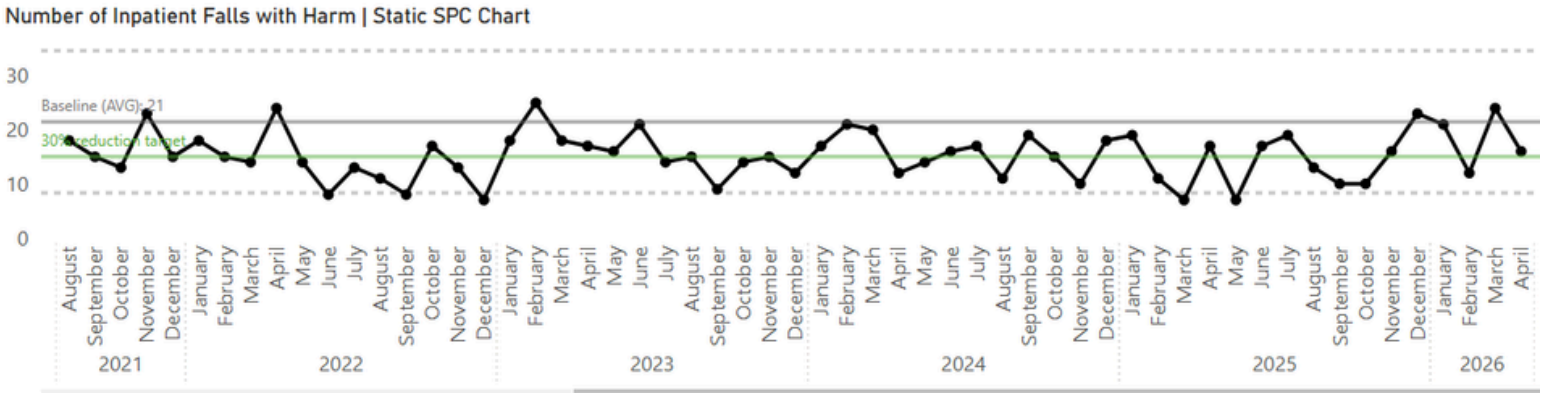
The GEKO device is a new device to improve circulation to heal leg ulcers. A trial was undertaken by community nurses with a number of GP practices in the use of the device. Evidence shows that the use of the GEKO device has either healed leg ulcers that previously have been untreatable for over 12 months, or have significantly reduced pain and exudate.

Falls

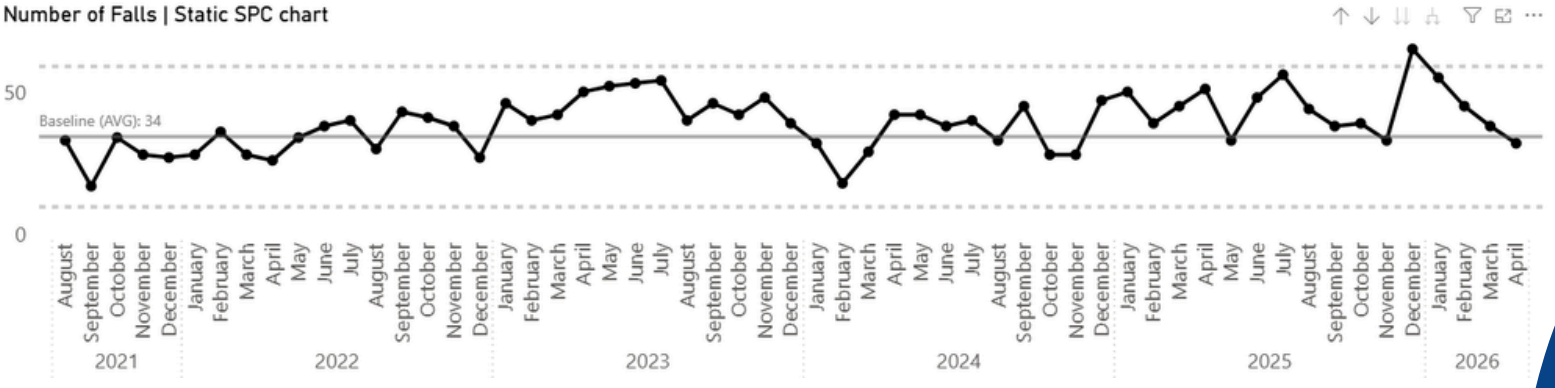
The number of reported incidents of falls within our community hospitals remains consistent over the last 12 months, with a slight rise over the winter period. Despite this, the average number remains on or below the target 20% in falls against the baseline.

Given the system pressures over the last year, on capacity and acuity of people in our community hospital, maintaining this position represents effective assessment and mitigation of risk on the most part. However further mitigating work is ongoing through the embedding of multidisciplinary care plan recording.

The chart below illustrates the falls with harm (injury) in community hospitals. This area has been less stable as a trend over the last year. The spike in falls with harm over winter is again likely to reflect the acuity and frailty of people in our community hospitals at this time.



The next chart illustrates the number of falls in care homes



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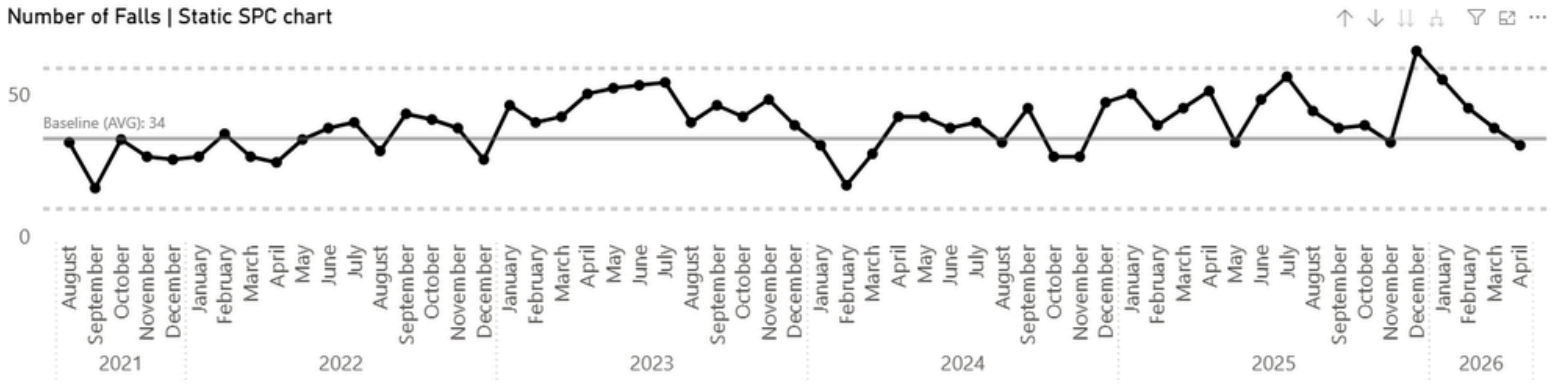


The graph shows a spike in falls over December which is typically a challenging period for staffing in care homes, which may link to the observed increase in falls. Respiratory outbreaks were more prevalent, which would have further stretched staff capacity.

The Care Home Collaborative Team have been reviewing the relationship between falls, malnutrition, medication errors, and stress and distress, noting that rising frailty across these areas often drives the need for additional support.

Other contributing factors were complex resident presentations and admissions for some individuals who experienced a number of falls in succession.

Falls training was delivered in January across several homes and further support is ongoing.

Adult Social care

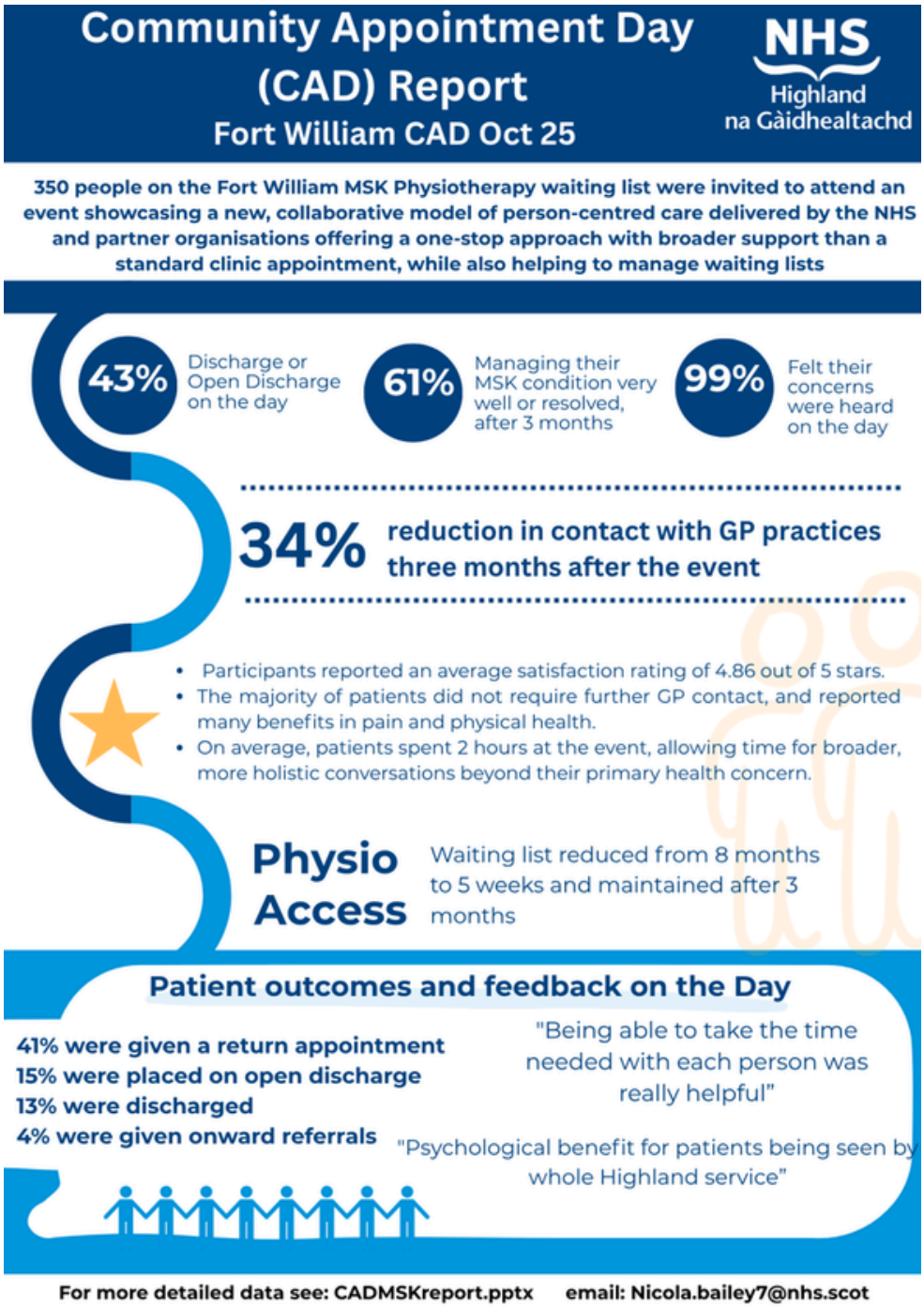
In our adult social care services over the past year, we have strengthened our quality assurance arrangements through additional quality assurance visits. This has enabled us to gather stronger evidence that care is safe, person centred and of a consistently good standard, while also ensuring staff feel supported, listened to and confident in their practice. These visits have improved our oversight, helped identify issues earlier, and supported continuous improvement across services.

The care home collaborative team, supporting care homes across the sector to provide high quality, safe care, has secured permanent funding, providing a stable, long term foundation for their work. This enables a shift from short term planning to sustained improvement, strengthening partnership working, embedding best practice, and supporting consistent, proactive quality improvement across our care homes.

Looking ahead to the next year, we will build on this progress by further strengthening quality assurance, expanding leadership learning and development opportunities, and continuing to support a skilled, compassionate and resilient workforce. Our focus will remain on improving outcomes for people who use services, supporting staff wellbeing, and ensuring safe, high quality care across adult social care services.

Community Appointment Days

Following on from the success of a Community Appointment Day, a one stop approach held with partner services and agencies, in Inverness the previous year, the physiotherapy service has led on further similar events. The following poster illustrates the outcomes from an event in Lochaber.



Specialist Weight and Health Service

The Specialist Weight and Health Service (SWHS) aims to provide a Dietetic-led, trauma informed intervention for around 80 people per year referred with a high BMI and complex medical, psychological, and social circumstances. During 2025/26 the service continued on success measured over the period 2022-2024.

The success of the service is measured in Behavioural and Wellbeing and Clinical outcomes and included improvements in mental wellbeing, diet quality, physical activity levels and reduced food preoccupation and negative thinking for people who received the service. Overall, the behavioural and wellbeing results demonstrate statistically robust and clinically meaningful improvements aligned with the service's emphasis on connected eating, emotional resilience, and self-care behaviours.

Clinically there were improvements demonstrated across all recorded clinical measures reflecting positive trends in cardio metabolic health.

Type 2 Diabetes Prevention and Early intervention; the Live It Highland Approach

The year 2025/26 saw the completion of an evaluation of the Type 2 Diabetes Food and Health service. The service is a Dietetic-led service for people diagnosed with Type 2 diabetes or pre-diabetes across Highland HSCP which began in 2021. The service is based in Primary care and offers holistic one-to-one support focused on food, health and wellbeing, with particular attention to people's life circumstances as well as lifestyle.

Paired questionnaire analysis was undertaken to evaluate Type 2 Diabetes prevention-relevant outcomes for people completing the Live it Highland 1-1 intervention at 12 months, using matched baseline and final questionnaires completed between April 2021 and March 2026.

Statistically significant and sustained improvements were observed across all key behavioural and psychosocial domains associated with diabetes risk reduction. The sustained improvements at the 12 month period align with Scottish Government priorities on Type 2 Diabetes prevention and reducing health inequalities, as set out in the Diabetes Improvement Plan 2021–2026 and the Framework for the Prevention, Early Detection and Early Intervention of Type 2 Diabetes. National policy emphasises person-centred, preventative approaches that build individuals' capacity to reduce future diabetes risk, particularly in communities experiencing greater socioeconomic disadvantage.

Shockwave Therapy

In May 2025 Podiatry, in collaboration with Orthopaedics, set up a Shockwave Therapy clinic based at Abban Street in Inverness.
The treatment is suitable for people who have a musculoskeletal condition suitable for shockwave therapy (primarily plantar heel pain, fibromas & Achilles tendinopathy) who have exhausted all conventional treatments over a 9 month time period with no improvement.

Shockwave therapy provides an evidence based alternative more invasive treatments such as steroid injection or surgery.

Over 50 courses (4 week blocks) of treatment were completed over the year and results so far are promising showing on average around 50% reduction in symptoms at 8 weeks post treatment. For this patient group who are experiencing chronic pain with few other treatment options this is really encouraging.

Finance

Financial Performance

The HHSCP is committed to the highest standards of financial management and governance, and this report is presented to enable discussion on the financial position at Month 13 (March) 2025/2026 (subject to final amendments and Audit).

Background

NHS Highland submitted a financial plan to Scottish Government for the 2025/2026 financial year in March 2025. This plan presented an initial budget gap of £115.596m. When cost reductions/ improvements were factored in the net position there was a gap of £55.723m. The Board received feedback on the draft Financial Plan which requested submission of a revised plan with a net deficit of no more that £40m. A revised plan was submitted in line with this request in June 2025 and this revised plan was accepted by Scottish Government.

The Board continues to be escalated at level 3 within the NHS Scotland Escalation Framework. Work continues internally and with the support of SG to improve the financial position by identifying opportunities and implementing new ways of working which will support a move to financial balance.

Assessment

At the end of March 2026 (Month 13) the draft year end out-turn is a deficit of £0.147m being reported for the Board. This assumes deficit support funding of £40.000m. The final out-turn is dependent on final allocations from the Scottish Government and any Audit amendments.

The table below summarises the position as at 31st March 2026.

Current Plan £m	Summary Funding & Expenditure	Plan to Date £m	Actual to Date £m	Variance to Date £m
1,407.749	**Total Funding**	1,407.749	1,407.749	-
	Expenditure			
515.106	HHSCP	515.106	539.015	(23.910)
	Support to Bring ASC Position to Breakeven			
515.106	Revised HHSCP	515.106	539.015	(23.910)
348.158	Acute Services	348.158	372.974	(24.815)
248.787	Support Services	248.787	199.915	48.872
1,112.051	**Sub Total**	**1,112.051**	**1,111.904**	**0.147**
295.698	Argyll & Bute	295.698	295.698	0.000
1,407.749	**Total Expenditure**	**1,407.749**	**1,407.602**	**0.147**

Red = overspends black = underspends

The recurrent deficit brought forward from previous years, net of non-recurrent benefits, is the major driver of the year-to-date position. There have also been new pressures in year, particularly in relation to digital priorities and further pressure in Adult Social Care.

The financial position includes delivery of £41.549m of budget savings and cost reductions.

HHSCP Position

The HHSCP year-end out-turn is a deficit of £23.910m. Health accounted for £2.066m of this overspend; with Adult Social Care being £21.844m.

The tables below summarises the HHSCP position as at 31st March 2026, as well as supplementary spend to 31st March 2026.

Current Plan £m's	Detail	Plan to Date £m's	Actual to Date £m's	Variance to Date £m's
301.067	NH Communities	301.067	315.099	(14.032)
62.738	Mental Health Services	62.738	64.961	(2.223)
171.093	Primary Care	171.093	171.618	(0.525)
(19.792)	ASC Other	(19.792)	(12.662)	(7.130)
515.106	**Total HHSCP**	**515.106**	**539.015**	**(23.910)**
328.169	Health	328.169	330.235	(2.066)
186.936	Social Work	186.936	208.780	(21.844)
	0	0.000	0.000	0.000
515.106	Total HHSCP	515.106	539.015	(23.910)

Red = overspends black = underspends

Locum/ Agency & Bank Spend	In Month £'000	YTD £'000
Locum	288	4,762
Agency (Nursing)	262	3,154
Bank	883	10,976
Agency (Non Med)	223	2,699
Total	1,656	21,592

The overspend in health included pressures in prescribing, and locums and agency nursing staff particularly in mental health and 2C practices, with supplementary staffing costs of £21.592m in the position as shown in the above table.High cost out of area placements have also contributed to the overspend within Mental Health.

A high number of vacancies across all specialities in the services have been the major factor in the use of supplementary staffing, however this has also mitigated the pressure within pays. Non Pay continues to experience pressures in mainly in clinical supplies with the driving factor being increased acuity in both community hospitals and community settings.

The Adult Social Care gap includes the deficit brought forward, plus additional pressures in 25-26, including supplementary staffing costs in in-house care homes, slippage on the value and efficiency plan, and additional cost of transitions as clients move from Children's Services, where THC is the lead agency, to Adult Social Care.

In March 2026 Highland Council agreed to provide £5.000m additional non recurrent funding reducing the impact of ASC to 60% of the NHSH deficit. The Board also received additional financial support from the SG to offset in part the pressure within ASC; this is being reported within the health position to provide clarity on the size of the Adult Social care gap.

Value and Efficiency

The financial plan submitted to the Scottish Government includes a target of achieving 3% efficiency savings across both North Highland and Argyll and Bute.

This equates to a total Value and Efficiency savings goal of £36.335m for the financial year 2025/2026. At the end of the financial year there is a shortfall of £9.699m between the savings target and savings delivered.

For the HHSCP (Health), a savings target of £7.007m was assigned and delivery as at 31st March 2026 was £7.133m, an over achievement of £0.125m.

For ASC £2.607m was achieved against the efficiency target of £6.192m.

Financial Outlook, Risks and Plans for the Future

The coming year remains challenging both for the Board and the HHSCP with an opening gap of £123.177m. Non-recurring sustainability funding will be required to reduce pressures and the reported deficit. An overall 3% efficiency target of £30.601m will be supported by a refreshed 15 box grid offers that offers opportunities to deliver recurring savings in both Health and ASC. Delivery of savings as well as working within the agreed limit is essential to avoid overspends being reflected in the Annual Accounts.

For ASC, £167m will be transferred nationally to Local Government to support commitment to the Real Living Wage and Free Personal Nursing Care Rates, for the HHSCP this will 'pass through' the Quantum via the Highland Council. ASC 3% efficiency target of £6.581m will be supported by Track 1 and 2 of the Cost Containment Plan.

Workforce

During 2025/26 our workforce remained a top priority and efforts have been focussed on recruitment, investment in leadership roles, listening to staff, creating career opportunities and providing training. Services provided education, training and development opportunities, ensuring both leadership and professional development. These actions helped maintain service resilience while supporting staff wellbeing and career progression.

Some specific examples include:

- In integrated teams, District staff engagement and wellbeing visits were conducted by management, human resources colleagues and the NHS Highland whistleblowing champion.
- In Adult Social care enhanced end of life training for staff was introduced, with a clear focus on dignity, compassion and high quality care at the most sensitive times. This has supported staff to feel more confident and skilled when caring for people at the end of life, and has strengthened our commitment to compassionate, values based care for individuals and their families.
- We also enhanced support for SVQ qualifications, improving access to learning and providing clearer guidance and encouragement for staff to progress their professional development. This has contributed to improved skills, confidence and retention within the workforce.
- Additionally, we implemented a specific adult social care induction programme and will increase availability next year. This has helped new staff to better understand their role, responsibilities and the values underpinning adult social care, supporting a safer, more confident transition into practice.

- In Primary Care, there was success in recruiting to a full medical leadership team of Clinical Director and Clinical Leads. Since 2023 there has been an improvement in the vacancy rate of GP posts from 35% in 2023 to 31% in 2025.During this period the headcount (number of GPs in post) has increased from 34 to 38.

- Recruitment has been successful in Carbost, Tongue and Armadale moving from full locum provision to salaried GPs.

- A further success has been recruitment to salaried GP posts within Alness & Invergordon with a headcount increase from 3 at 2023 to 11 at 2025.

- In pharmacy, despite ongoing workforce pressures, pharmacy services focused on developing roles and ways of working in 2025/26. This included supporting the development of clinical roles, expanding the contribution of pharmacy technicians and pharmacy support workers.

- Agency staff usage within Mental Health has reduced, supported by the appointment of over 20 Bank Band 3 Healthcare Support Workers to the short notice team at New Craigs Hospital, improving stability within inpatient services. As part of the redesign of the short notice team, 8.7 whole time equivalent (WTE) Band 3 posts and 4.35 WTE Band 5 posts are progressing through the permanent vacancy process and will be advertised shortly. This approach is intended to enhance workforce stability for mental health practitioners, while also creating opportunities for staff to gain experience across a range of clinical areas within a more flexible and responsive staffing model.

- Psychology was successful in recruiting to interim Directors of psychology, enabling them to take forward their priorities for the service. They were able to increase the training opportunities for clinicians and business support staff. This training included specific clinical training, CPD, and leadership development.

- Psychology also utilised degree apprenticeship opportunities with the University of the Highland and Islands

Integration Performance Overview

The key performance overview appendices demonstrate the financial year (April 2025 – March 2026). The Latest performance against the National Integration indicators and Ministerial Indicators is detailed in the appendix and is shown with previous year's performance.

Benchmarking

The benchmark for the National Integration Indicators, comparing it with the Scottish average, has been incorporated into the appendix. This allows a performance comparison as there are no national standards or targets in place.

Performance Appendices

1. Scottish National Integration Indicators
2. “Together We Care” NHS Highland Strategic Outcomes
3. Integrated Children’s Services Planning Board Performance, The Highland Council
4. Ministerial Strategic Indicator Summary

Annual Performance Report Appendix 2

Highland Health and Social Care Partnership

NHS Highland & The Highland Council

1. Scottish National Integration Indicators
2. “Together We Care” NHS Highland Strategic Outcomes
3. Integrated Children’s Services Planning Board Performance, The Highland Council
4. Ministerial Strategic Indicator Summary

Key to Tables			
performance status		benchmarking	
Improving Performance			Better than average plus 5%
Static performance			Average +/- 5%
Declining performance			worse than average plus 5%
Pending Publication			PHS data

National Integration Indicators

National Outcome	National Standard	Indicator	Detail	2021/22	2022/23	2023/24	2024/25	2025/26	Comments
1	n/a	1. Percentage of adults able to look after their health very well or quite well	**Highland**	92.4%		93.0%		92.1%	Biennial reporting, latest data = 2025/26
			Scotland	90.9%		90.7%		90.6%	
			Target						
			Ranking (31)	11		7		12	
2	n/a	2. Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**Highland**	86.5%		71.9%		78.6%	Biennial reporting, latest data = 2025/26
			Scotland	78.8%		72.4%		73.6%	
			Target						
			Ranking (31)	4		20		12	
2 & 3	n/a	3. Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	**Highland**	72.1%		60.5%		71.1%	Biennial reporting, latest data = 2025/26
			Scotland	70.6%		59.6%		63.9%	
			Target						
			Ranking (31)	15		16		4	
3 & 9	n/a	4. Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	**Highland**	71.9%		65.9%		68.6%	Biennial reporting, latest data = 2025/26
			Scotland	66.4%		61.4%		65.0%	
			Target						
			Ranking (31)	4		10		8	
3	n/a	5. Percentage of adults receiving any care or support who rated it as excellent or good	**Highland**	83.0%		75.7%		80.3%	Biennial reporting, latest data = 2025/26
			Scotland	75.3%		70.0%		72.1%	
			Target						
			Ranking (31)	4		8		4	
3	n/a	6. Percentage of people with positive experience of the care provided by their GP practice	**Highland**	77.2%		80.4%		79.9%	Biennial reporting, latest data = 2025/26
			Scotland	66.5%		68.5%		70.7%	
			Target						
			Ranking (31)	6		5		6	

National Integration Indicators

National Outcome	National Standard	Indicator	Detail	2021/22	2022/23	2023/24	2024/25	2025/26	Comments
4	n/a	7. Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**Highland**	84.3%		73.6%		77.2%	Biennial reporting, latest data = 2025/26
			Scotland	78.1%		69.8%		71.7%	
			Target						
			Ranking (31)	3		12		8	
6	n/a	8. Percentage of carers who feel supported to continue in their caring role	**Highland**	28.7%		32.0%		33.4%	Biennial reporting, latest data = 2025/26
			Scotland	29.7%		31.2%		31.9%	
			Target						
			Ranking (31)	19		13		8	
7	n/a	9. Percentage of adults supported at home who agreed they felt safe	**Highland**	86.0%		78.2%		81.0%	Biennial reporting, latest data = 2025/26
			Scotland	79.7%		72.7%		74.7%	
			Target						
			Ranking (31)	5		9		6	
1 & 5	n/a	11. Premature mortality rate for people under 75 (per 100,000 population)	**Highland**	405	400	389	382		Calendar year, latest data = 2024. Rankings based on lowest rate (1) to highest rate (31).
			Scotland	463	441	440	426		
			Target						
			Ranking (31)	12	11	12	11		
1. 2, 4, 5, 7	n/a	12. Emergency admission rate for adults (per 100,000 population)	**Highland**	9,929	9,603	9,525	9,871	9,719	latest data = 2025/26 (only covers 2025 calendar year). Rankings based on lowest rate (1) to highest rate (31).
			Scotland	11,777	11,327	11,764	11,333	11,470	
			Target						
			Ranking (31)	6	8	7	10	9	
2, 4, 7	n/a	13. Emergency bed day rate for adults (per 100,000 population)	**Highland**	113,388	122,802	124,439	123,563	110,597	latest data = 2025/26 (only covers 2025 calendar year). Rankings based on lowest rate (1) to highest rate (31).
			Scotland	118,395	124,329	121,590	116,715	108,988	
			Target						
			Ranking (31)	14	16	19	21	17	
		* indicator 10 discontinued							

National Integration Indicators

National Outcome	National Standard	Indicator	Detail	2021/22	2022/23	2023/24	2024/25	2025/26	Comments
2, 3, 7, 9	n/a	14. Emergency re-admissions to hospital within 28 days of discharge (per 1,000 discharges)	**Highland**	114	116	116	117	112	latest data = 2025/26 (only covers 2025 calendar year). Rankings based on lowest rate (1) to highest rate (31).
			Scotland	107	102	105	103	104	
			Target						
			Ranking (31)	23	23	23	24	22	
2, 3, 9	n/a	15. Proportion of last 6 months of life spent at home or in a community setting	**Highland**	90.7%	89.6%	89.1%	89.5%	88.7%	latest data = 2025/26 (only covers 2025 calendar year)
			Scotland	89.6%	88.8%	88.8%	89.0%	89.3%	
			Target						
			Ranking (31)	9	11	14	12	21	
2, 4, 7, 9	n/a	16. Falls rate per 1,000 population aged 65+	**Highland**	14.2	14.2	14.6	14.2	14.3	latest data = 2025/26 (only covers 2025 calendar year). Rankings based on lowest rate (1) to highest rate (31).
			Scotland	22.5	22.1	22.5	21.9	22.2	
			Target						
			Ranking (31)	1	1	1	4	4	
3, 4, 7	n/a	17. Proportion of care services graded “good” (4) or better in Care Inspectorate inspections	**Highland**	80.3%	83.0%	84.8%	81.2%	82.9%	latest data = 2025/26
			Scotland	75.8%	75.2%	77.0%	81.9%	83.1%	
			Target						
			Ranking (31)	12	4	7	20	17	
2	n/a	18. Percentage of adults with intensive care needs receiving care at home	**Highland**	56.8%	58.7%	54.8%	56.5%		Calendar year, latest data = 2024
			Scotland	64.5%	64.7%	64.5%	64.7%		
			Target						
			Ranking (31)	29	30	30	29		
2, 3, 4, 9	n/a	19. No. of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	**Highland**	1,035	1,213	1,752	2,051	2,147	latest data = 2025/26. Rankings based on lowest rate (1) to highest rate (31).
			Scotland	750	883	842	899	873	
			Target						
			Ranking (31)	27	24	30	31	30	

Together We Care Strategic Outcomes

Strategic Outcome	Priority	Measure	2021/22	2022/23	2023/24	2024/25	2025/26	Comments
3 (outcome 9)	2 (9a-c)	Care at Home - Unmet Need No. of clients assessed and awaiting a service (waiting list includes DHD patients)	241	329	371	446	408	number of clients per week, as at year end position, assessed for care at home and awaiting a package of care
3 (outcome 9)	2 (9a-c)	Care at Home - Unmet Need No. of hours required - assessed and awaiting a service (includes DHD patients)	1,455	2,659	2,660	2,942	2,754	number of scheduled hours per week required, including new clients and those already in receipt of a service requiring additional hours
3 (outcome 9)	2 (9a-c)	Care at Home - current clients in receipt of a service	1,895	1,770	1,776	1,644	1,566	number of clients per week in receipt of a care at home package, including internal and external provision as at year end
3 (outcome 9)	2 (9a-c)	Care at Home - hours per week current clients in receipt of a service	14,905	13,303	13,413	12,962	12,688	number of clients per week in receipt of a care at home package, including internal and external provision as at year end
3 (outcome 9)	2 (9a-c)	Care at Home - new clients in receipt of a service	1,091	1,086	1,130	1,005	974	all clients (internal and external provision) recorded as “new” or “short service” during year
3 (outcome 9)	2 (9a-c)	Care Homes - current long-stay residential & nursing placements	1,695	1,712	1,658	1,626	1618	number of placements as at March year end (excludes intermediate)

Together We Care Strategic Outcomes

Strategic Outcome	Priority	Measure	2021/22	2022/23	2023/24	2024/25	2025/26	Comments
3 (outcome 9)	2 (9a-c)	Care Homes - new long-stay residential & nursing placements	724	718	590	644	634	admissions during year (excludes intermediate)
3 (outcome 9)	2 (9a-c)	Care Homes - long-stay residential & nursing placements (closed)	707	697	641	675	618	discharges during year (excludes intermediate)
3 (outcome 9)	2 (9a-c)	Carer Breaks - Number of people who were approved funding	381	536	533	517	127	Scheme commenced September 2021
3 (outcome 9)	2 (9a-c)	Carer Breaks - Total funding approved (£k)	£1,000k	£1,228k	£1,015k	£643k	£177k	Scheme commenced September 2021
3 (outcome 9)	2 (9a-c)	SDS Option 1 - Current number of clients in receipt of a direct payment	467	585	680	800	936	number of people in receipt of a direct payment as at March year end
3 (outcome 9)	2 (9a-c)	SDS Option 2 - Current number of clients in receipt of an ISF	234	207	255	299	353	number of people in receipt of an ISF as at March year end

Annual Performance Report Appendix 2

Highland Health and Social Care Partnership

NHS Highland & The Highland Council

No	Together we care outcome	Description	Main Service	Link to National & Ministerial outcomes and indicators
1	Start well	Give every child the opportunity to start well in life by empowering parents and families through information sharing, education, and support before and during pregnancy	Maternity & Neonatal Services PNIMH	
2	Thrive Well	Work together with our families, communities and partners by building joined up services that support our children and young people to thrive	CAMHS / NDAS / Corporate Parenting / Integrated Children's Services / Paediatrics	
3	Stay Well	Work alongside our partners by developing sustainable and accessible health and care focused on prevention and early intervention	Public Health / Sexual Health / Gender Identity / Women's Services	National outcome 1
4	Anchor Well	Be an anchor and work as equal partners within our communities by designing and delivering health and care that has our population and where they live as the focus	Public Health / Comms & Engagement	
5	Grow Well	Ensure that all colleagues are supported to be successful in their role and are valued and respected for the work they do. Everyone will be clear on their objectives, receive regular feedback and have a personal development plan	People & Culture / All services	
6	Listen Well	Work in partnership with colleagues to shape our future and make decisions. Our leaders will be visible and engage with the wider organisation, listening to, hearing, and learning from experiences and views shared	People & Culture / All services	National Outcome 8
7	Nurture Well	Support colleagues' physical and mental health and wellbeing through all the stages of their life and career with us. We foster an inclusive and kind culture where difference is valued and respected	People & Culture / All services	
8	Plan Well	Create a sustainable pipeline of talent for all roles, and excel in our recruitment and onboarding, making us an employer of choice both locally and nationally	People & Culture / All services	
9	Care Well	Work together with health and social care partners by delivering care and support together that puts our population, fami- lies, and carers experience at the heart	Adult Social Care	National Outcome 2, 3, 4, 6, 7, 9 Ministerial Strategic Indicator 6
10	Live Well	Ensure that both physical and mental health are on an equal footing, to reduce stigma by improving access and enabling all our staff in all services to speak about mental health and wellbeing	Mental Health Services	National Outcome 2, 3, 4, 7, 9 Ministerial Strategic Indicator 2c

NHS Highland & The Highland Council

Outcome 1 Highland's Children will be safe, healthy, achieving, loved, nurtured, active, included, respected and responsible				
	target	baseline	current	data source
Indicator 1 The number of young carers identified on SEEMiS will increase	improve from baseline	68		Education & Learning
analysis				
Indicator 2 the number of households with children in temporary accommodation will reduce	95	100		Education & Learning
analysis				
Indicator 3 Percentage of children reaching their developmental milestones at their 27 – 30 month health review will increase	85%	75%	82%	Child Health
analysis: Data from NHS, last updated Jan - Mar 23. Note in the data file that this is incomplete. Data shows a slightly deceasing number of children achieving their developmental milestones at the 27-30 month Child Health Surveillance review. This is correlated to the number of assessments being undertaken and the targeted approach which is part of the mitigation plan to improve outcomes. (note Indicator #6)				
Indicator 4 Percentage of children in P1 with their body mass index measured	95%	75%	82%	Child Health
analysis: data last updated in 2021-22 by NHS Highland				
Indicator 5 The rate of LBW babies born to the most deprived compared to those born in the least deprived parts of Highland.	improve from baseline	1%		Population Health

NHS Highland & The Highland Council

Outcome 1 Highland's Children will be safe, healthy, achieving, loved, nurtured, active, included, respected and responsible				
	target	baseline	current	data source
analysis: A number of key professionals, including midwives, health visitors, Community Early Years Practitioners (CEYP) and specialist breast feeding support workers support women to exclusively breastfeed their baby in Highland. Breastfeeding rates have been consistently good in Highland. The performance has dipped slightly in the past quarter, however an improvement plan has been put in place to address this, particularly to a partnership approach, between NHSH and THC, is being tested to improve support for breast feeding in remote and rural Highland. This involves better use of core support worker roles (CEYP) through enhanced additional infant feeding support. It is hoped this approach will provide a more effective and equitable service for families across Highland. This will be evaluated to support the scale and spread of a more universal approach to infant feeding support across other rural locations in Highland				
Indicator 10 Maintain 95% Allocation of Health Plan indicator at 6-8 weeks from birth (annual cumulative)	95%	97%	NK	Child Health
analysis: not updated in NHSH file				
Indicator 11 Maintain 95% uptake rate of MMR1 (% of 5 year olds)	95%	95%	95%	Child Health
analysis: latest data from NHSH to Dec 22				
Indicator 12 90% CAMHS referrals are seen within 18 weeks	90%	80%	100%	CAMHS, Education & Learning
analysis: Considerable progress has been made in clinical modelling, performance and governance. Progress has been made despite a lack of appropriate supports and improvements in e – health with much of the work of business analyst colleagues having to be completed manually due to limitations of current systems. The service has halved the number of patients waiting since the peak of May 2022 and reduced longest waits from over 4 years just over 2 years projected clearing of cases over 2 years by April 2023. This progress has been achieved with a workforce funded establishment at the second lowest of mainland boards with a current vacancy rate of 48% with ongoing national workforce shortages and additional recruitment challenges of remote and rural services. We are diversifying our staff profile and adopting a grow our own strategy which is showing promise but will be a medium-term approach to increasing capacity.				
Indicator 16 Percentage of children and young people referred to AHP Service OCCUPATIONAL THERAPY, waiting less than 18 weeks from date referral received to census date (Interim Measure) - NOT 18RTT METHODOLOGY	90%	85%	51%	Health & Social Care

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Outcome 1 Highland's Children will be safe, healthy, achieving, loved, nurtured, active, included, respected and responsible				
	target	baseline	current	data source
Analysis: There are a number of contributory factors to the increase in waiting times for OT over the last year, including an increase in need/number of request, limited resilience due to staff sickness/availability of staffing within the small paediatric OT service in Highland, increase in the urgent area of work, hospital discharges from out of authority and acute complex cases in more rural areas and increased surgeries for CYP post covid. A particular pressure has arisen since 2020 since the removal of a number significant portion of ASN support in schools. A mitigation plan is in place which includes: A Central approach to managing waiting times for cross team overview and prioritisation, revisiting geographical boundaries to enable longer waits to be actioned, consideration of alternative ways of interventions (telephone, telehealth, face to face), pre request discussions are being carried out and increasing to manage where possible advice / support and intervention and building capacity through reduction of time on Just Ask helpline. Clinic-based services have been tried with limited success as many CYP need school / home visits as well. Some aspects of the service have been redesigned to ensure upfront intervention and support and reduce the need for Requests in some areas (e.g. Sensory , Post diagnostic support). Further data cleansing is planned to ensure figures are correct. OT have recently redesigned some aspects of their service to ensure upfront intervention and support, aiming to reduce the need for Requests in some areas. A steady staffing flow over the coming months is required to begin to improve the 18 week RTT target				
Indicator 17 Percentage of children and young people referred to AHP Service DIETETICS, waiting less than 18 weeks from date referral received to census date (Interim Measure) - NOT 18RTT METHODOLOGY	90%	88%	66%	Health & Social Care
Analysis: Paediatric dietetics consists of a small specialist team. The increase in waiting times has been a direct result of an increase in need/referrals (from 71 requests in 2022 to 86 per month in 2023) to the service and a decrease in staffing availability, with an average of 28% reduction across dieticians and support staff as a result of long term sickness, carers leave etc. A review of the service was undertaken in 2022 with mitigating action plan which included further prioritisation. This includes a greater focus on early prevention and intervention and working with schools and families, addressing emerging issues at an earlier stage working and through the implementation of new focussed pathways around particular areas of increased need. (eg: selective eating). The plan also is driving forward change to the approach addressing infant allergy which aims to provide early support for parents of infants with feeding difficulties and a reduction in the misdiagnosis of cow's milk protein allergy as well as contributing to service development for the increased number of CYP who have diabetes including supporting access to technology for more vulnerable CYPs, to support self management A period of full staffing may be possible in coming months, and this should improve waiting times to within target by the autumn as long as demand does not continue to significantly increase. The mitigation plan will be adapted according to presenting need with risks escalated as necessary.				
Indicator 18 Increase the uptake of specialist child protection advice and guidance to health staff supporting children and families at risk	90%		46%	Health & Social Care
Analysis:				
Indicator 23 Increase the uptake of specialist child protection advice and guidance to health staff supporting children and families at risk	improve from baseline	59%	100%	Health & Social Care

Analysis:
IRDs are the interagency tripartite (health, social work and police Scotland) discussions which form part of the risk assessment and planning for children at risk of harm. Child Protection Advisors, are accountable for co-ordinating, representing and analysing all information from across the health systems as part of the IRD process. There has been a 48% increase in the Interagency Referral
Discussions (IRDs) between 20/21 and 22/23. This created significant pressure to the service including risks to the delivery of stat/man Child Protection training across the partnership and for providing supervision to staff to universal and targeted health services. An action plan was implemented to ensure the tripartite process was secured. These actions included upskilling from the general workforce to be trained in being the agency decision maker at IRD. Notwithstanding this, the service, and ability to retain the national tripartite approach to child protection risk management, continues to be at risk.
The risk is likely to increase in the incoming months as a result of implementation of the new Child Protection Guidance and an increase in the number of IRDs

Outcome 2 The voice and rights of Highland's children will be central to the improvement of services and support				
	target	baseline	current	data source
Indicator 24 The number of children reporting that they feel safe in their community increases	improve from baseline	85%	88%	Education & Learning
Analysis: Most recent data from the 2021 lifestyle survey with over participants from P7, S2 and S4 pupils. Baseline for the data was established in 2011 – the survey is undertaken every two years across Highland schools Large improvement in the value for the most recent survey, with an increase from 55.41% in 2019 and 58.98% in 2017.				
Indicator 25 Self-reported incidence of smoking will decrease	improve from baseline	13%	3%	Education & Learning
Analysis: Most recent data from the 2021 lifestyle survey with over participants from P7, S2 and S4 pupils Baseline for the data was established in 2011 – the survey is undertaken every two years across Highland schools Mean of 3.28% (P7: 0.44%, S2: 2.71% and S4: 6.70%) is a decrease from 5.32% in 2019. This downward trend has been seen for a number of years.				
Indicator 26 The number of children who report that they drink alcoholat least once per week	improve from baseline	20%	6%	Education & Learning
Analysis: Most recent data from the 2021 lifestyle survey with over participants from P7, S2 and S4 pupils. Baseline for the data was established in 2011 – the survey is undertaken every two years across Highland schools Mean of 5.56% (P7: 0.43%, S2: 1.37% and S4: 14.90%) is a decrease from 8.79% in 2019. This downward trend has been seen for a number of years.				
Indicator 33 The number of children entering P1 who demonstrate anability to develop positive relationships increases	improve from baseline	91%		Health & Social Care
Analysis:				
Indicator 34 The delay in the time taken between a child being accommodated and permanency decision will decrease (Target in Months)	15	55	21	Health & Social Care

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Analysis: This data is reported quarterly on PRMS under the title "Average months between child accommodated to permanence decision at CPM Qtr". The latest update was for Q4 21/22 and the baseline was established in 2016.				
Indicator 35 The number of care experienced children or young people placed out with Highland will decrease (spot purchase placements)	3	8	3	Health & Social Care
Analysis: This data is reported monthly. The baseline was established in 2016.				
Indicator 36 The number of care experienced children or young people in secure care will decrease	3	8	3	Health & Social Care

	target	baseline	current	data source
Analysis: This data is reported monthly. The baseline was established in 2016.				
Indicator 37 There will be a shift in the balance of spend from out of area placement to local intensive support, to reduce the number of children being placed out with Highland through the Home to Highland programme	50%	10%	38%	Health & Social Care
Analysis: This data is collected monthly. The baseline was established in 2018.				
Indicator 38 All children returning "Home to Highland" will have a bespoke education/positive destination plan in place	100%	22%	15%	
Analysis: This data is collected annually. The baseline was established in academic year 2018/19				
Indicator 44 Number of concerns recorded for children placed on the child protection register at a pre-birth or initial conference		58	90	HHSCP minimum data set
Analysis: This data is collected quarterly and reported in the Child Protection Minimum Dataset. Latest data from Q3 2022/23.In Q3 2022/23, there were 90 concerns recorded and showed an increase from the low value in the prior quarter. Emotional Abuse was the most common concern recorded across Highland in the Quarter, but there was also a notable increase in Physical Abuse in the quarter.				
Indicator 45 Number of children and young people referred to the Children's Reporter	reduce	8	1	HHSCP minimum data set

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Analysis: This data is collected quarterly and reported in the Child Protection Minimum Dataset. Latest data from Q3 2022/23. There tended to be little variation in the figures until last quarter, where the number of children referred on Non-Offence Grounds has increased significantly and remained at this high level. In particular, there have been sharp rises in the reason for referral being: "Child's Conduct Harmful to Self or Others", rising from 49 in Q1 2022/23 to 94 in Q2 and 130 in Q3, and "Lack of Parental Care", rising from 93 in Q1 to 125 in Q2 and 180 in Q3.The current figure is much higher than the baseline figure				
Indicator 47 The number of non-offence referrals taken to a hearing by the Reporter	reduce	218	417	HHSCP SCRA quarterly report
Analysis: Data reported quarterly from SCRA, last update for Q3 22/23 (April 23).There has been a sharp and significant increase in recent updates in the total number of non-offence referrals				
Indicator 48 Number of Children's Hearings held		263	202	HHSCP SCRA quarterly report
Analysis: Data reported quarterly from SCRA, last update for Q3 22/23 (April 23). The number of Children's Hearings has remained relatively steady in recent quarters, with the most recent update being the lowest level since Q4 21/22				

	target	baseline	current	data source
Indicator 54 Number of looked after children and young people with prospective adopters	increase from baseline	12	16	HHSCP SG annual return
Analysis: This data is collected and quality-assured annually as part of the statutory returns to Scottish Government. The snapshot for the data is 31 July. Number of looked after children and young people with prospective adopters has decreased in the year from 22 to 16. This decrease is in line with the decreases seen above (-28%). It is, however, above the baseline figure.				
Indicator 55 Number of looked after children and young people within a local authority provided house	reduce from baseline	81	65	HHSCP SG annual return
Analysis: This data is collected and quality-assured annually as part of the statutory returns to Scottish Government. The snapshot for the data is 31 July. While the number of looked after children within a local authority provided house has decreased from 70 in 2021 to a provisional figure of 65, this represents a greater %age of overall LAC. The number of LAC has reduced by -17% but those LAC within a local authority provided house has only decreased 7%.				
Indicator 56 The number of LAC accommodated outwith Highland will decrease	30	44	17	Health & Social Care
Analysis: This data is reported quarterly on PRMS, with the baseline being established in 2016. The last update was in April 2023. The indicator on PRMS is titled: The average no. of LAC accommodated outwith Highland - Quarterly. The current value of 17 is a continued decrease since Q3 22/23, and represents the lowest value since the baseline was established.				

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Indicator 57 The percentage of children needing to live away from the family home but supported in kinship care increases	20%	19%	18%	Health & Social Care
Analysis: This data is reported monthly on PRMS, with the baseline being established in 2016. The last update was in April 2023. There has been a slight decrease in the monthly figure for the last three months, with the current figure sitting below both the target and baseline figure				
Indicator 58 The number of children where permanence is achieved via a Residence order increases	82	72	120	Health & Social Care
Analysis: This data is reported monthly on PRMS, with the baseline being established in 2016.The last update was in April 2023.There has been an overall steady increase in the value in recent months, and a significant increase in both the target and baseline figure.				

Annual Performance Report Appendix 4 Ministerial Strategic Indicators

Highland Health and Social Care Partnership

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MSG No.	Measure	2021/22	2022/23	2023/24	2024/25	2025/26	Comments
MSG 1A	Number of emergency admissions - North Highland	20,855	20,896	21,166	22,482	20,229	12-month total Apr-Mar, except 2025/26 which is Jan-Dec
MSG 2A	Unplanned bed days (Acute Services)	183,291	202,456	206,055	206,897	161,229	12-month total Apr-Mar, except 2025/26 which is Jan-Dec
MSG 2C	Unplanned bed days (Mental Health)	31,243	30,991	32,745	32,705	30,800	12-month total Apr-Mar, except 2025/26 which is Jan-Dec
MSG 3A	ED Attendances	28,213	40,804	42,170	42,971	43,710	12-month total Apr-Mar, except 2025/26 which is Jan-Dec
MSG 4A	Delayed Discharges, bed days all reasons	34,673	44,897	64,269	75,093	75,059	12-month total Apr-Mar, except 2025/26 which is Jan-Dec
MSG 4C	Delayed Discharges, bed days H&SC reasons	24,482	31,998	43,864	51,121	54,686	12-month total Apr-Mar, except 2025/26 which is Jan-Dec
MSG 5	End of life care, percentage of last 6 months in the community	90.7%	89.6%	89.1%	89.6%		2024/25 = latest data and is provisional
MSG 5	End of Life, percentage of last six months in hospital / hospice	9.3%	10.4%	10.9%	10.4%		2024/25 = latest data and is provisional
MSG 6	Balance of Care, percentage of population in community settings	99.7%	99.7%	99.7%			2023/24 = latest data. Totals shown for 'Care Home', 'Home (Supported)' and 'Home (Unsupported)'