The Highland Council

Agenda Item	6
Report No	HCW/24/26

Committee: **Health, Social Care and Wellbeing**

Date: **11 November 2026**

Report Title: **Adult Social Care Assurance and Strategic Update**

Report By: **Assistant Chief Executive - People**

1. Purpose/Executive Summary

1.1 This paper is an assurance report setting out the detail of the delivery of Adult Social Care by NHS Highland and is for noting. The report also provides a strategic update in terms of the implementation of the Strategic Plan and is presented with the support and assistance of the Chief Officer of the Partnership from NHS Highland.

The report also provides details on the Transformation Programme which is being taken forward in support of the delivery of the Strategic Plan for the Partnership as well as the Medium-Term Financial Plan developed by the Chief Officer which was developed in recognition of the financial challenge presented in relation to the delivery of Adult Social Care. The report seeks to identify the work that will be required to enable the programme to be delivered and how that work will be resourced. The report also encloses the Strategic Commissioning Plan which has been developed by the Partnership and will support the Transformation Programme

The Report also provides an update on the Transformation Reserve and the uncommitted funding that will be available to support the delivery of the work required in terms of the Transformation Programme.

2. Recommendations

2.1 Members are asked to:

i. **Note** the contents of this report.
ii. **Note** the commitment of the funding to date from the ASC Transformation Reserve

3. Implications

3.1 **Resource -** There are no specific resource issues arising out of the contents of this report. Delivery of Adult Social Care by NHS Highland is governed by the Integration Scheme in place which does itself give rise to resource issues which are not the subject matter of this report. Members are aware in terms of the budget agreed for 2025/2026 that significant reserves have been allocated to the delivery of Adult Social Care which will be monitored via the Council's Delivery Plan and are detailed in **Appendix 1** of this report. Members will also

be aware of ongoing work in terms of the model of integration which may also have resource implications.

3.2 **Legal -** No arising issues. The Committee will be aware that there had been work ongoing with NHS Highland to review the model of integration in place in Highland. At the time of writing, this work has been paused as a consequence of the Programme for Government which has been announced.

3.3 **Risk -** NHS Highland and The Highland Council continue to work collaboratively to address the risks represented in terms of the funding available for the provision of Adult Social Care. That issue is considered more fully in the revenue report which is also before this Committee.

The activity in relation to ongoing service delivery is described later in this report and that risk in relation to care homes is more particularly described in the Council's risk register. The Health & Social Care Partnership, through the Joint Monitoring Committee, have also agreed a risk register.

3.4 **Health and Safety (risks arising from changes to plant, equipment, process, or people) -** There are no such issues arising directly from the contents of this report.

3.5 **Gaelic -** No arising issues.

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 report which provides an update and therefore an impact assessment is not required.

5. Overview and Key Issues Across the Adult Social Care Sector

5.1 By way of an overview this report is intended to provide assurance in relation to the delivery of Adult Social Care by NHS Highland. Members will recall that in terms of the integration scheme those services are delegated to NHS Highland who are the lead agency for the purposes of service delivery but that ultimately the Chief Social Work Officer remains responsible for delivery of those services. The lead agency role is both important and relevant in terms of the monitoring of registered services as detailed in this report.

It is important that this Committee has the appropriate degree of oversight in terms of that commission so that they can be assured in terms of service delivery, including the quality and performance of registered services. NHS Highland's Commissioning Team undertakes oversight of commissioned services and provides regular updates to relevant Council officers.

5.2 Detail will also be provided in terms of the provision of an update in relation to the delivery of adult protection by the partnership. There will also be an update in relation to the ongoing transformation activity and the development of the Highland Care Model.

6. Performance and Associated Challenges

6.1 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 2025/2026 prepared by NHS Highland and attached at **Appendix 2** 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.

Those key service areas reported upon are as follows: -

- Care-at-Home
- Care Homes
- Delayed Hospital Discharges
- Self-Directed Support

6.2 **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.

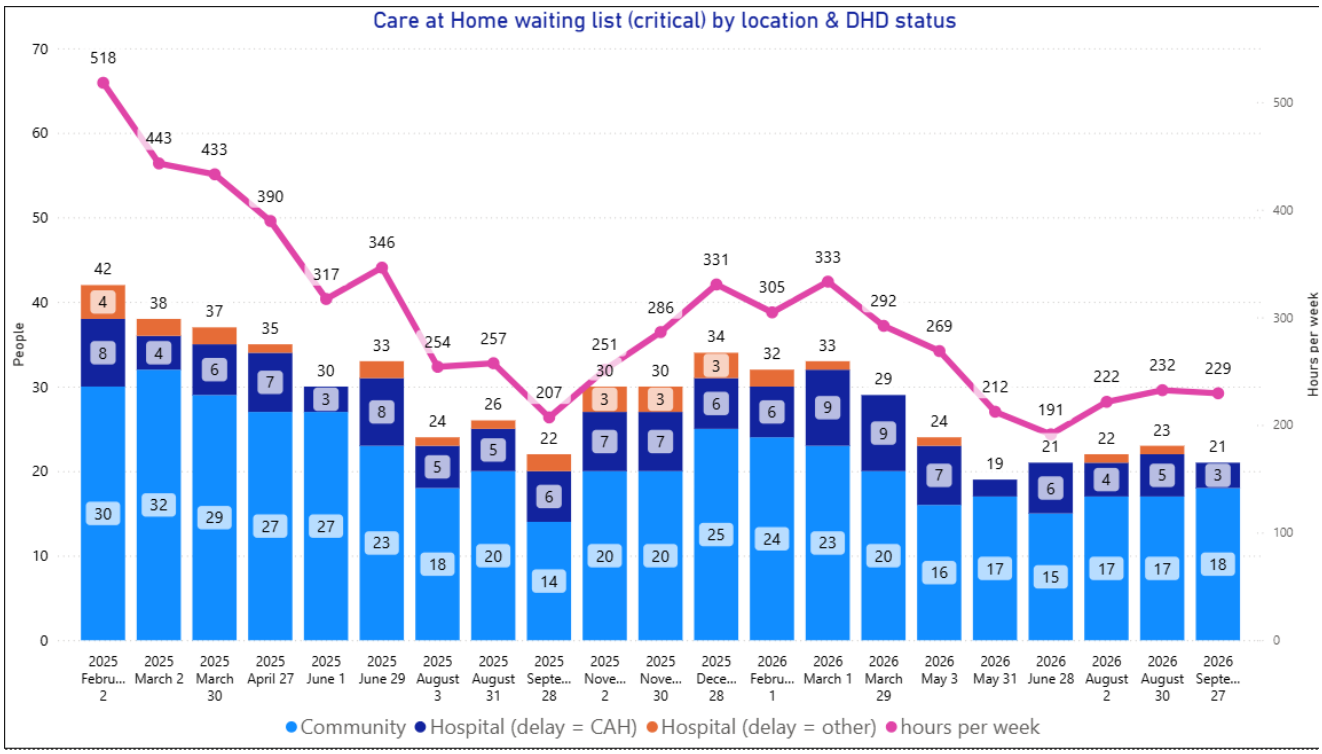


Figure 1: Care at Home Waiting List and Unmet Need

6.3 Care Homes

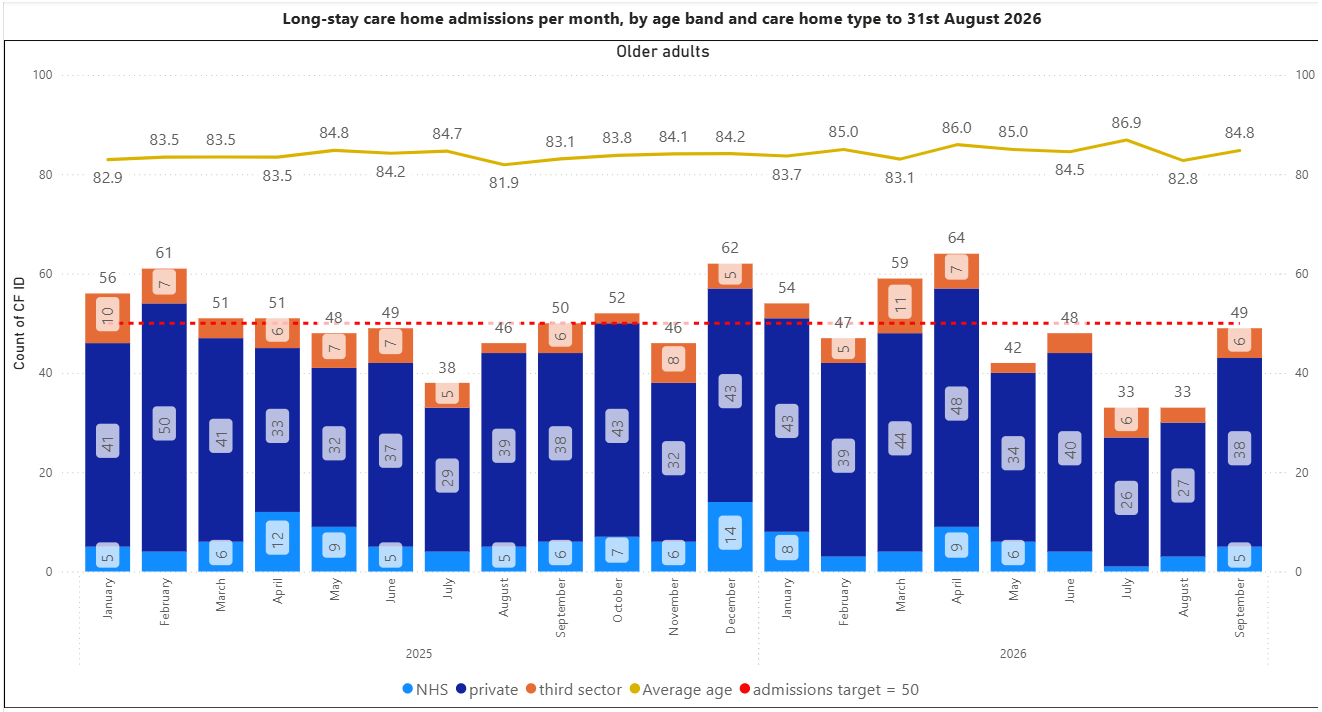
The Partnership's aim is to maintain an appropriate level of long stay care home placements for older adults.

The aim is 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.



Number of Older Adult Placements per month

6.4 Delayed Hospital Discharge

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 2026/2027. 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.

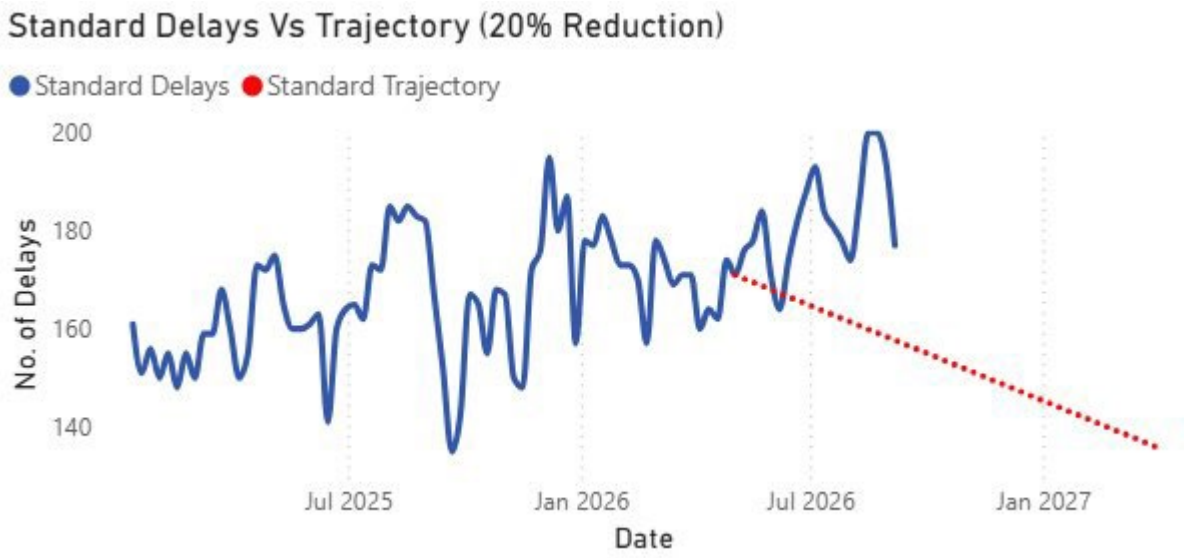


Figure 3:

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.

6.5 Self-Directed Support (SDS)

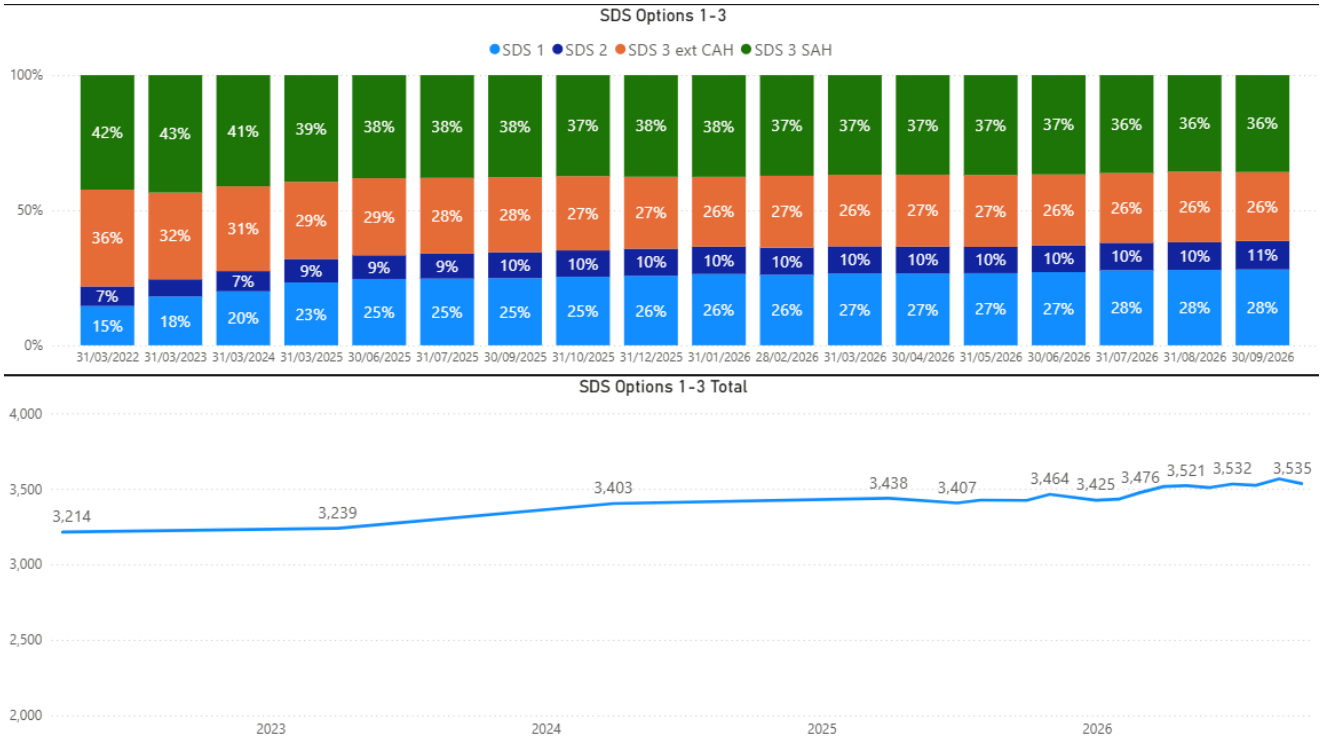
The Partnership continues to promote increased uptake of Self-Directed Support (SDS) Options 1 and 2, alongside a reduction in reliance on traditional Option 3 provision. The current aims are to:

- 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.



6.6 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. Implementation of the Joint Strategic Plan (2024 – 2027) and associated Transformation activity

7.1 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 Committee will recall that a £20m earmarked reserve was first established by the Council in the 29 February 2024. The purpose, intent and process for that reserve was said to be - "Reserves funding to support the Adult Social Care budget on a multi-year basis, and the process of change and transformation."

It has been agreed that there is a need to build upon and develop Strategies on a pan Highland basis which would inform local plans being developed by the District Planning Groups. Those pan Highland Strategies have been previously noted by this Committee and are as follows:

- Self-Directed Support
- Handyperson Scheme
- Care at Home and Care Home future strategy informing a market facilitation plan
- Managing Complex Cases
- Shared Lives
- Workforce Strategy

- Housing Strategy
- Telecare and Digital Strategy.

In terms of those Strategies, a Target Operating Model had been developed, setting out the key pillars for future care delivery. That model has been further developed, and the programme has moved on such that draft Project Mandates have been developed based on the Adult Social Care Finance Plan introduced by the Chief Officer.

The Finance Plan identifies the work required as previously set out in the Target Operating Model in terms of five key workstreams as follows:

- Service Rebalancing - £11.7m savings
- Care Pathway Redesign - £9.3m savings
- Community Led Care Models & Preventative Approaches - £3m savings
- Technology & Workforce Transformation - £3m savings
- Cross cutting projects - £4m savings.

The workstreams referred to above form part of the key workstreams set out in this section with a view to achieving financial balance over a three year period. The savings allocated in terms of the project mandates in development are ambitious but necessary and given the scale of the budget challenge are considered to be appropriate.

In terms of those workstreams the work is broadly defined as follows…

1. Service Rebalancing – Shifting towards more people being supported at home using in house and independent provision effectively.
2. Care Pathway Redesign – Modernising pathways to promote independence and reduce reliance on residential based care prioritising those most in need.
3. Community Led Care Models & Preventative Approaches – Supporting local care models and community innovation promoting Self Directed Support options, reablement and disinvesting in less effective traditional services.
4. Technology and Workforce transformation – Scaling technology-enabled care to improve efficiency and independence. Strategic workforce planning to attract, retain and value carers, improve pay and conditions and support carer development.

Delivery of the transformation needed to meet the ambitious efficiency targets identified is likely to require several key policy changes. Those policy changes will require to consider the allocation of care home beds with a focus on the distinction between nursing home beds and residential beds. It is proposed that initially a Senior Programme Manager will be appointed by NHS Highland to oversee the development and delivery of the programme. They will be responsible for developing the structure and recruiting the Programme Team within the resources available.
In terms of the reserves the latest position of the Transformation Reserve is shown in **Appendix 1**. On 1 April 2026, the Reserve balance was £14,505,872. Commitments for 2026/2027 are £1,969,093 and for 2027/2028 £3,040,404. These commitments include the £1.2m commitment for the Transformation Team as outlined. There is an additional commitment of £378,000 for Shared Lives running through to 31 March 2030. The uncommitted balance of the Reserve is £9,118,375.

7.2 **Commissioning**
Work has continued on the development of the Adult Social Care Commissioning Strategy which has now been completed and has been approved by both NHS Highland and the Joint Monitoring Committee. It is attached as **Appendix 3**. It provides the strategic framework for

how the Highland Health and Social Care Partnership will commission, reshape and deliver adult social care services over the next three years. It builds upon the Joint Strategic Plan for Adult Services 2024-2027 and the Highland Joint Strategic Needs Assessment 2025 and provides a commissioning framework and implementing vehicle to address rising demand, increasing complexity, workforce pressures, provider instability and significant financial challenge. It will be key in terms of the delivery of the transformation agenda.

The commissioning activity described within document ultimately intends to:

- Increase the number of people supported at home.
- Increase uptake of SDS Options 1 and 2.
- Expand prevention and community supports.
- Develop Local Care Models.
- Increase use of technology enabled care.
- Develop the appropriate balance of in-house, independent, third-sector and community provision.
- Focus in-house services on areas of greatest strategic value, including reablement and complex care.

Designation:	Assistant Chief Executive - People
Date:	6 October 2026
Author:	Fiona Malcolm, Chief Officer Integrated People Services Arlene Johnstone Chief Officer, Highland
Background Papers:	N/A
Appendices:	Appendix 1 – Note of reserves Appendix 2 – Annual Performance Report Appendix 3 – Strategic Commissioning Plan

Appendix 1 – Note on Reserves

Programme Summary							
Projects		**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**
Handyperson Scheme		£0	£769,000	£0	£0	£0	£0
Shared Lives		£0	£0	£32,000	£157,000	£223,000	£155,000
Local Care Models		£33,191	£0	£410,000	£706,809	£0	
Invernevis		£213,000	**£256,500**	**£256,500**			
TVI - Vocala		£0	£0	£87,000	£0	£0	£0
		£246,191	**£1,025,500**	**£785,500**	**£863,809**	**£223,000**	**£155,000**
Programme & Project Manager Resources							
Programme & Project Managers - THC		*£95,765*	*£214,268*	*£176,323*	*£165,000*	*£0*	*£0*
Programme Managers - THC	1.2	£52,854	£100,579	£108,599	£111,953	£0	£0
Project Manager - Digital - THC	1	£39,341	£67,134	£19,579	£0	£0	£0
Senior Project Manager - THC	0.6	£3,571	£46,555	£48,145	£49,642	£0	£0
Project Managers - NHSH		£0	£130,204	£165,000	£165,000	£0	£0
SDS Transformation Team		£152,000					
NHSH Transformation Programme Team				£200,000	£1,000,000		
		£247,765	**£344,472**	**£541,323**	**£1,326,595**	**£0**	**£0**
Other Expenditure							
Care Home Sustainability payments (maintenance of provision)		£1,253,578					
Digital Switch Hubs		£509,000					
NDAS				£350,000	£850,000		
Models of Integration (MOI)							
DD Consultancy		£21,622	£46,000	£30,000			
MOI Programme Manager				£86,270			
MOI Engagement Strategy				£176,000			
		£1,784,200	**£46,000**	**£642,270**	**£850,000**	**£0**	**£0**
Year end adjustment to NHSH		**£5,600,000**	**£3,200,000**	**£0**	**£0**	**£0**	**£0**
Total Expenditure		**£7,878,156**	**£4,615,972**	**£1,969,093**	**£3,040,404**	**£223,000**	**£155,000**
ASC RESERVE SUMMARY							
Opening Reserve Balance		20,000,000	£12,121,844	£7,505,872	£12,536,779	£9,496,375	£9,273,375
Additional Funding into Reserve				**£7,000,000**			
Less Expenditure in Year		£7,878,156	£4,615,972	£1,969,093	£3,040,404	£223,000	£155,000
Closing Balance of Reserve		**£12,121,844**	**£7,505,872**	**£12,536,779**	**£9,496,375**	**£9,273,375**	**£9,118,375**
Figures shown in Red are estimates							

NHS
Highland
na Gàidhealtachd



Highland Health and Social Care Partnership

ANNUAL PERFORMANCE REPORT 2025-2026

Contents

Foreword 3

Introduction 5

Key performance measures and highlights 8

2.1 Integrated Approach to Flow 8
2.2 Adult Social Care 14
2.3 Technology Enabled Care 19
2.4 Primary Care 22
2.5 Vaccinations 25
2.6 Primary Care Dental Services 26
2.7 Community Optometry 27
2.8 Prescribing 28
2.9 Mental Health & Learning Disability Services 30
2.10 Psychological Therapies 35
2.11 Children's Services 37
2.12 Neurodevelopmental Assessment Service (NDAS) 40
2.13 Child & Adolescent Mental Health Services (CAMHS) 41
2.14 Quality and Care and Clinical Governance 42

Finance 52

Workforce 58

Integration Performance Overview 60

Performance Appendices 61



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

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.

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

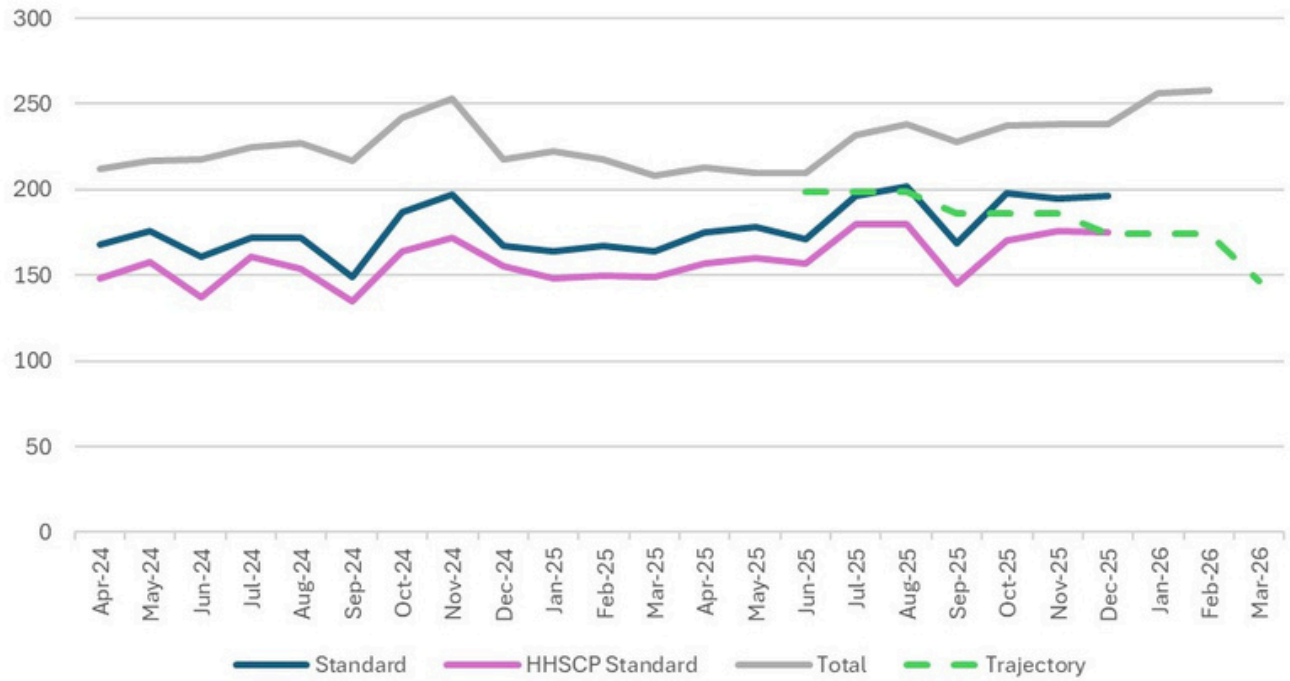
2.1 Integrated Approach to Flow

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

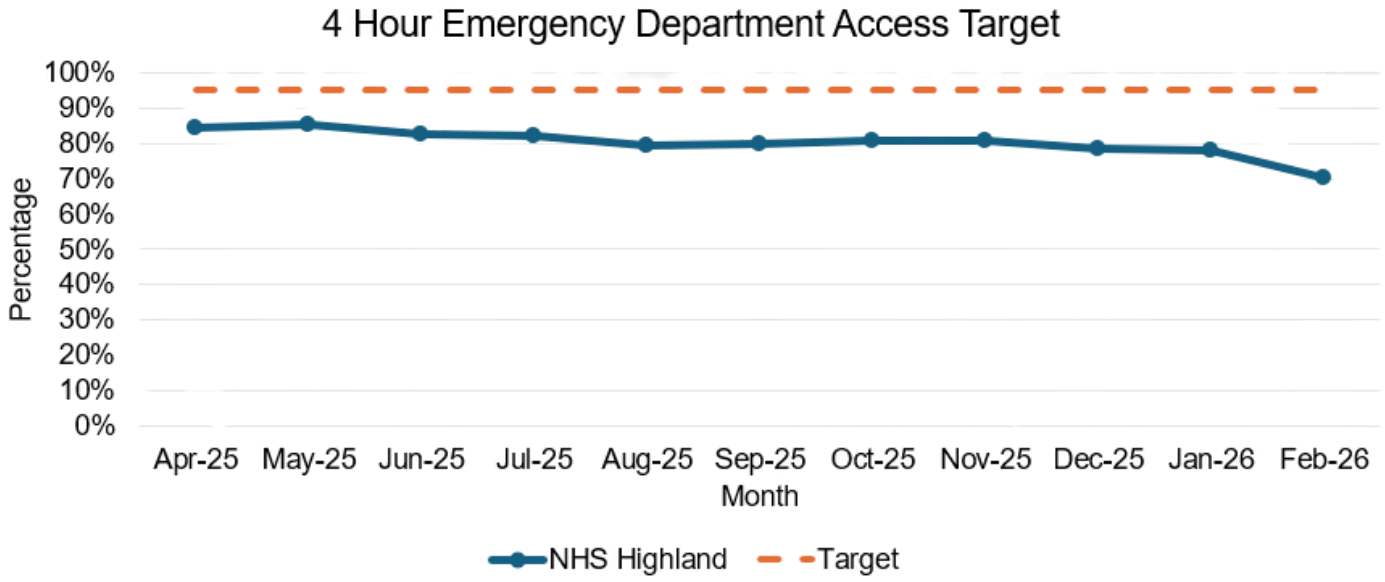


The chart illustrates that there are persistently high levels of people in delay.

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:

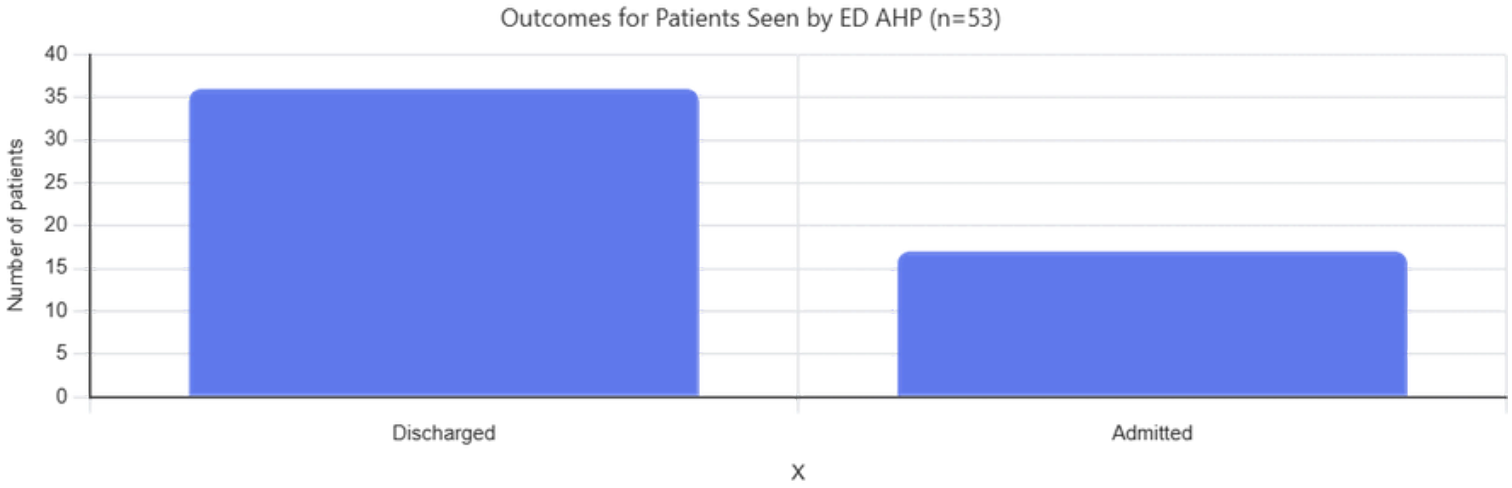
- The use of unscheduled care funds and reconfiguration of care at home capacity in East Ross to develop discharge to assess teams, enabling people's functional abilities to be assessed at home and appropriate care provided to better match their needs
- The Hospital at Home service in Inverness commenced 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.

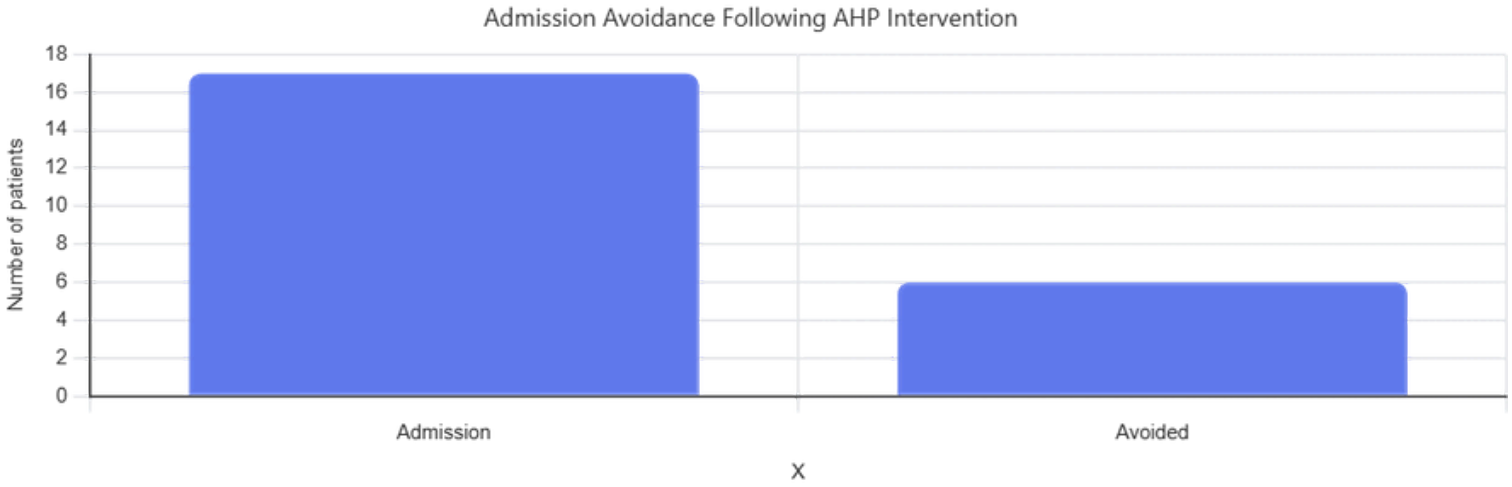
Early AHP involvement supports safe discharge, transition to community services and setting of Functional Criteria Led Discharge for those requiring a medical admission. This contributes to admission avoidance, use of Home First pathways for improved patient flow and better patient outcomes, while maintaining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





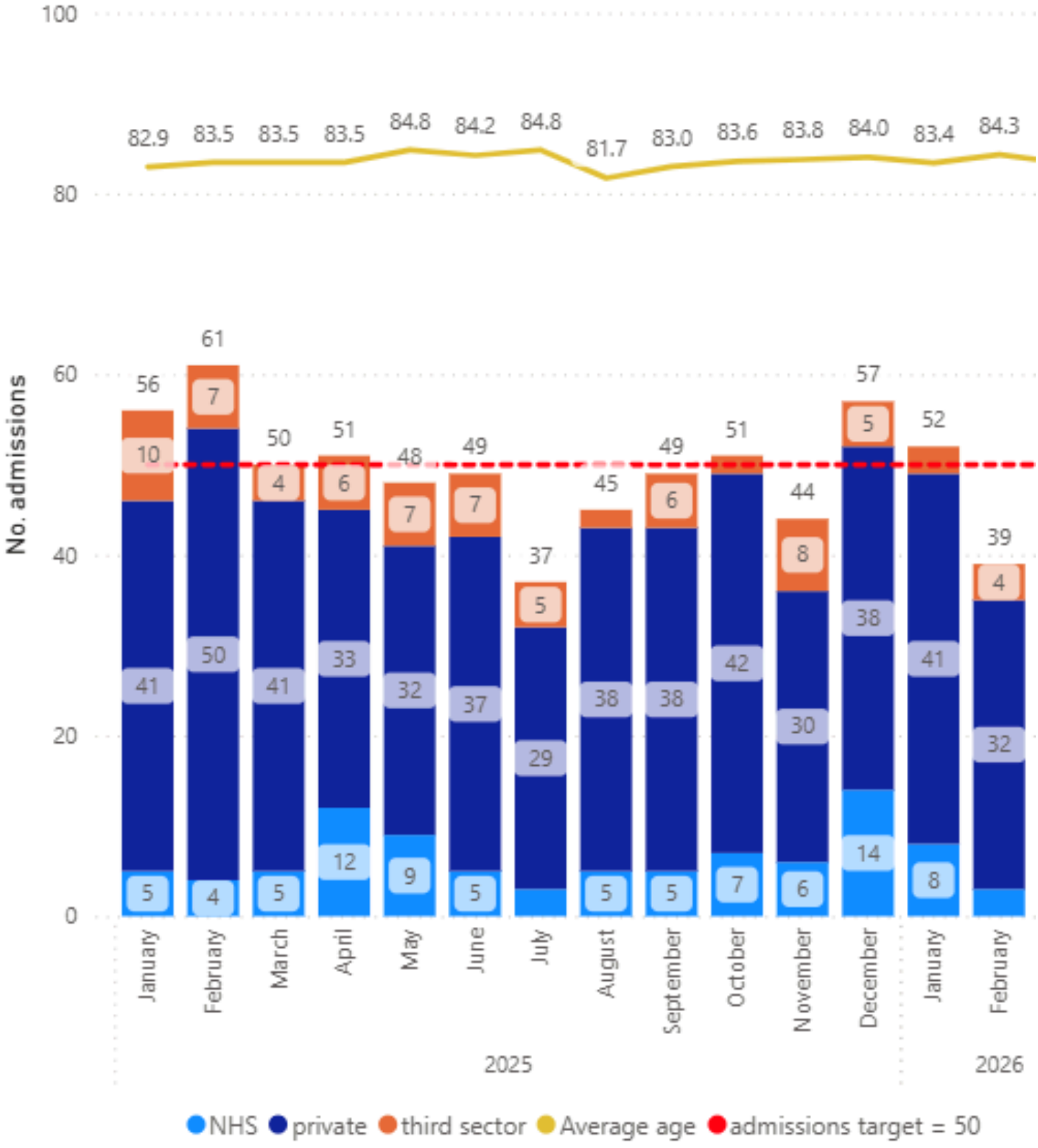
2.2 Adult Social Care

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.

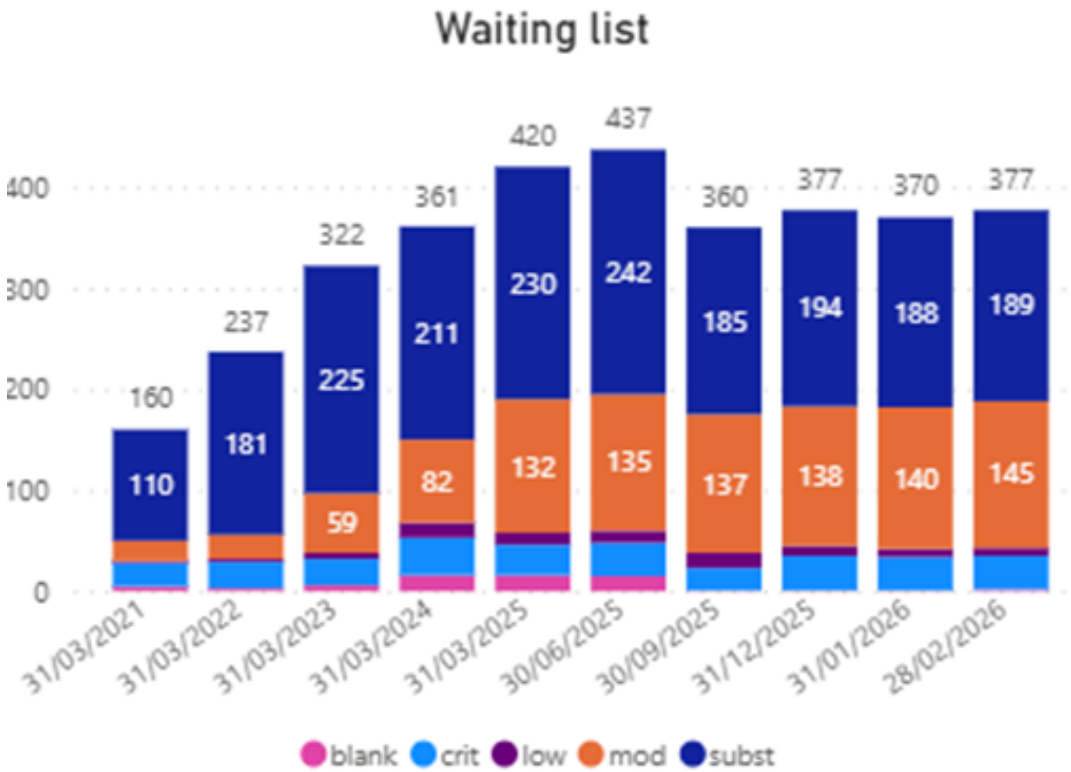

100
80
60
40
20
0
No. admissions
82.9
83.5
83.5
83.5
84.8
84.2
84.8
81.7
83.0
83.6
83.8
84.0
83.4
84.3
56
61
50
51
48
49
37
45
49
51
44
57
52
39
January
February
March
April
May
June
July
August
September
October
November
December
January
February
2025
2026
NHS
private
third sector
Average age
admissions 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.

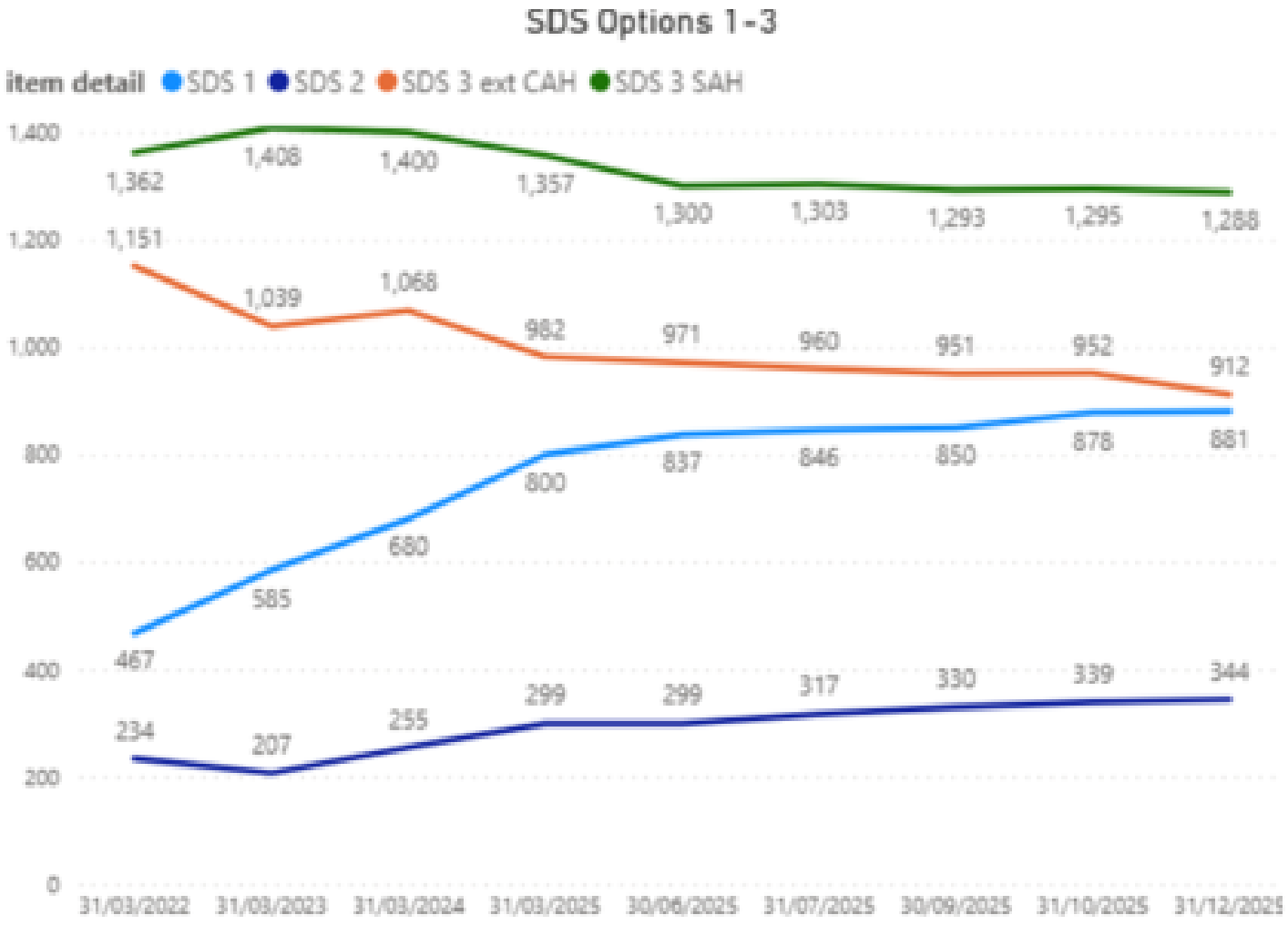
Numbers waiting for Care at Home by Month and Need (critical, substantial, moderate and low)



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.

Telecare in numbers

2,973 clients

803 new referrals

37 staff attended TEC training

60 avg number of new referrals each month

970 Number of visitis to check equipment, replace batteries and amend timings.

98% of telecare clients now have a digital Telecare unit

38 community events and groups attended by the TEC team



What have we done?

Delivered 17 roadshows across Highland showcasing simple, practical technology.



Successfully migrated 2,500 clients to Digital Telecare.



Continued Wellbeing Tech Thursdays, giving people hands-on experience and the chance to ask questions.



Rolled out TEC bags with equipment and information to community teams, for use during home visits.



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

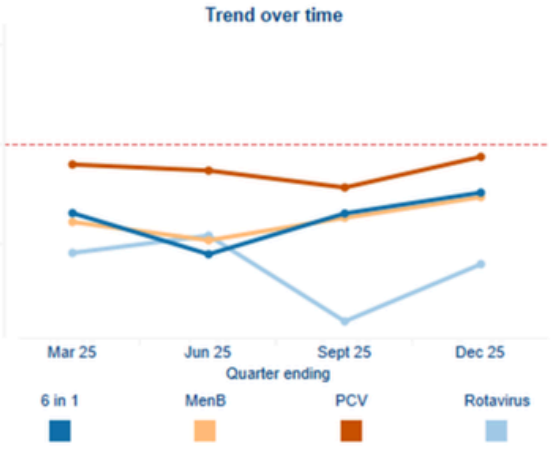
Health Board of Residence data are only available from Quarter ending June 2022.

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

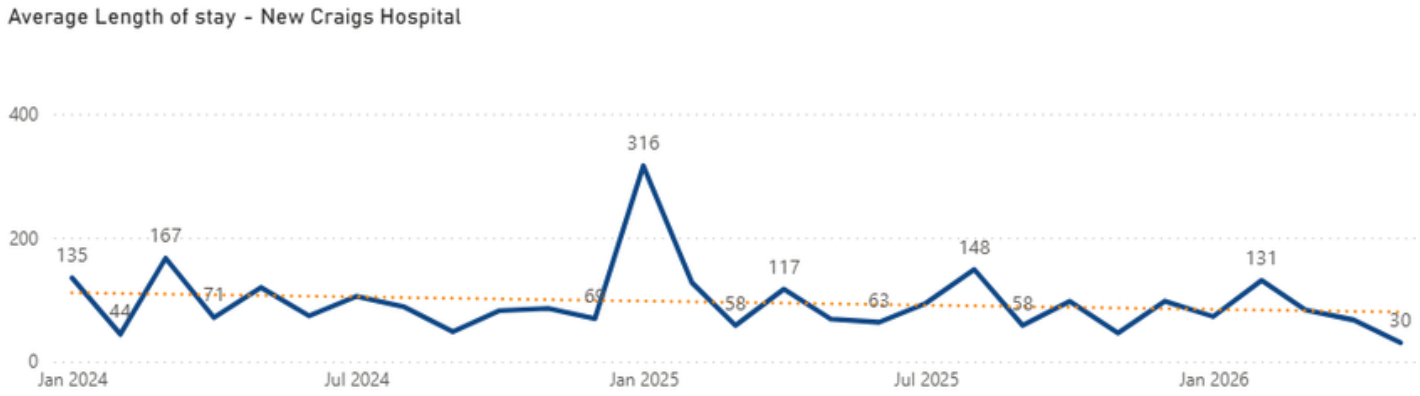
The partnership's engagement with collective advocacy organisations, including Spirit Advocacy, over the year has led to the development of locality-based experience panels, with progress in Caithness, Lochaber, and Badenoch and Strathspey.
A peer support worker within the Perinatal Mental Health Team 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

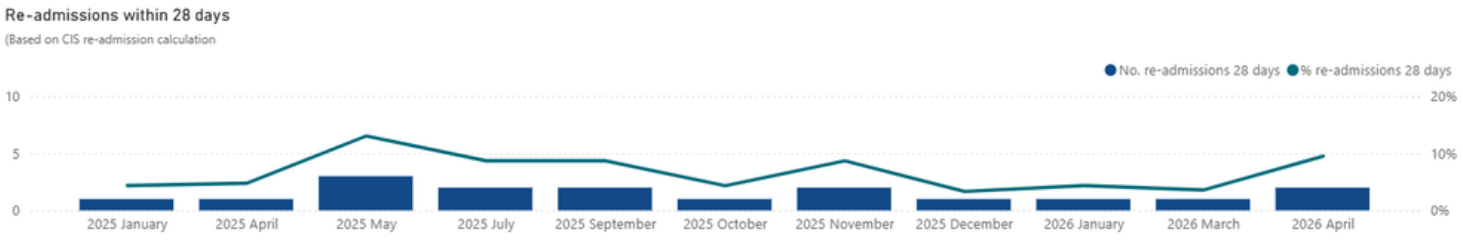
During the year, there was engagement with Highland Council's housing needs assessment, providing information and guidance on future housing requirements for people with mental health needs.

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.

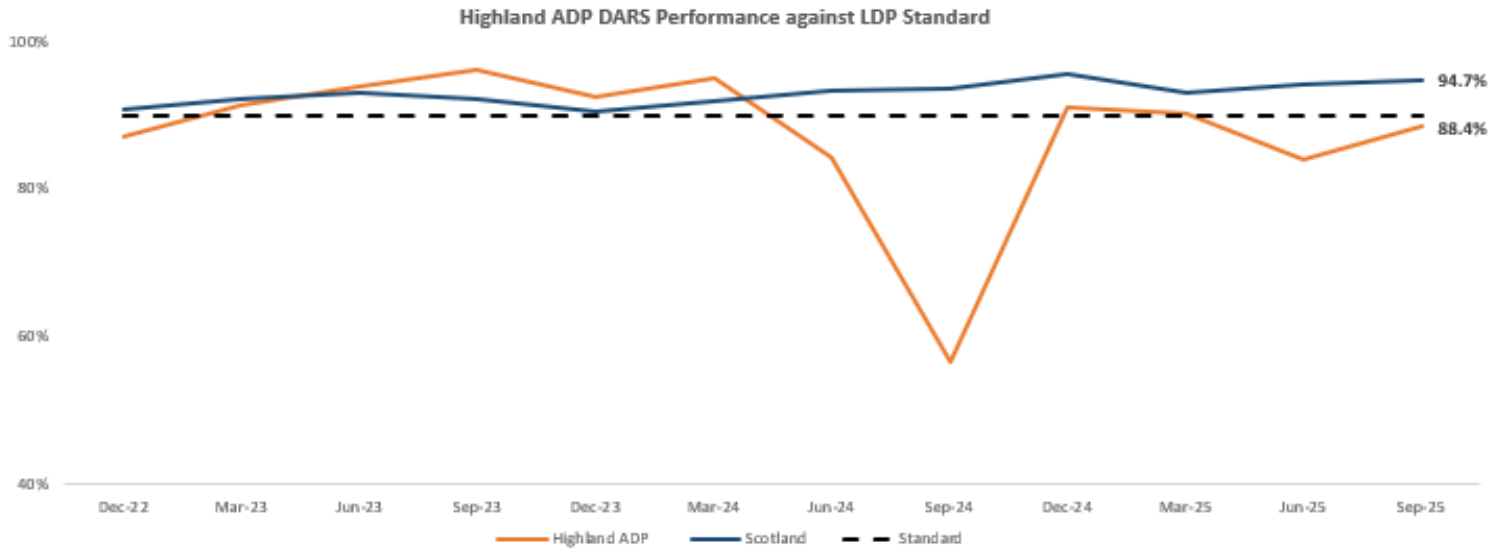


Readmission rates are routinely used as a proxy measure for the quality and safety of discharge planning, as they provide an indication of whether individuals are leaving hospital with the appropriate support, care coordination, and clinical stability in place to sustain recovery within the community. 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

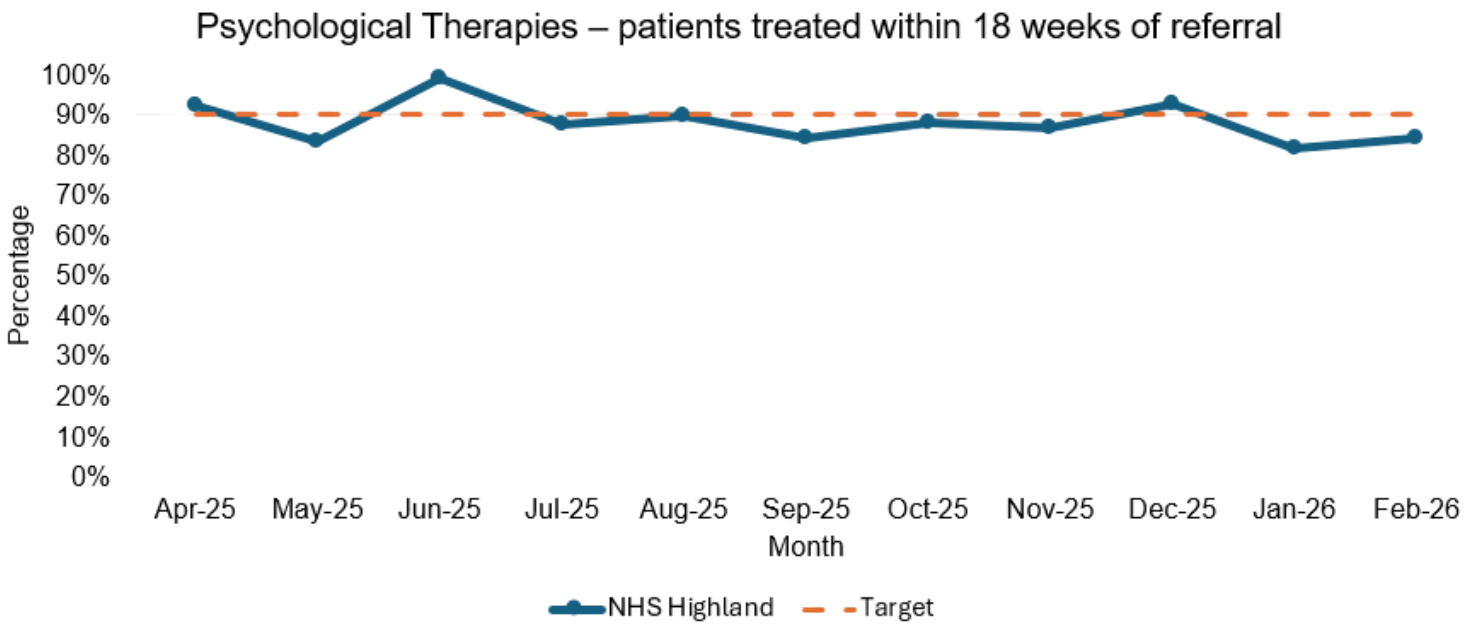
Supporting people presenting with drug and alcohol challenges is a key requirement of health boards. NHS Highland seeks to ensure patients are seen within 3 weeks of referral as an early intervention to support people at risk.



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.

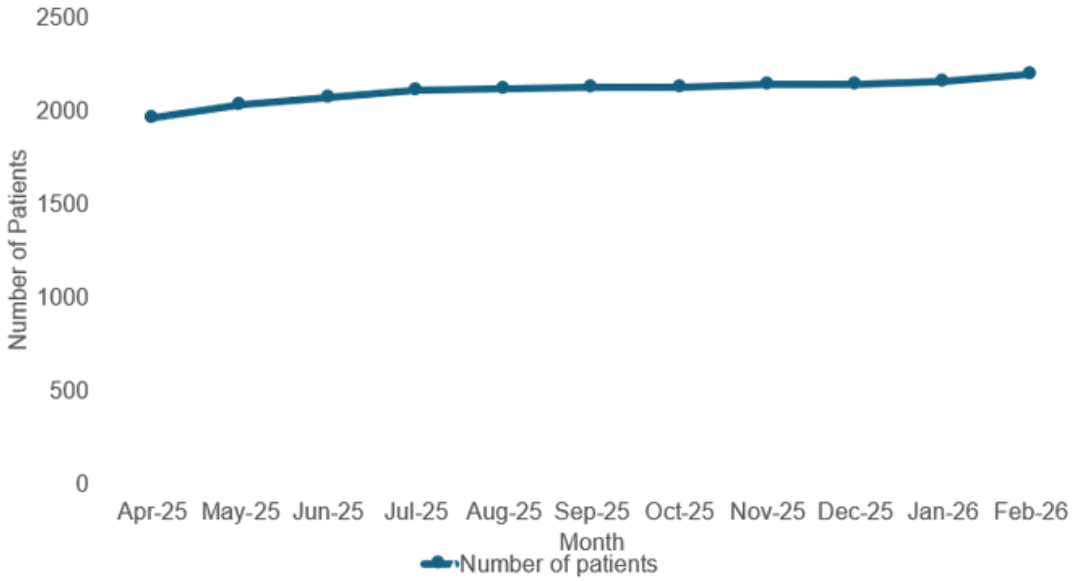
With ICSB approval now secured and final governance underway, the plan is well positioned to move into implementation. A strong evidence base, clear strategic priorities and a defined delivery model provide confidence that the plan will drive measurable improvements in outcomes for children, young people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

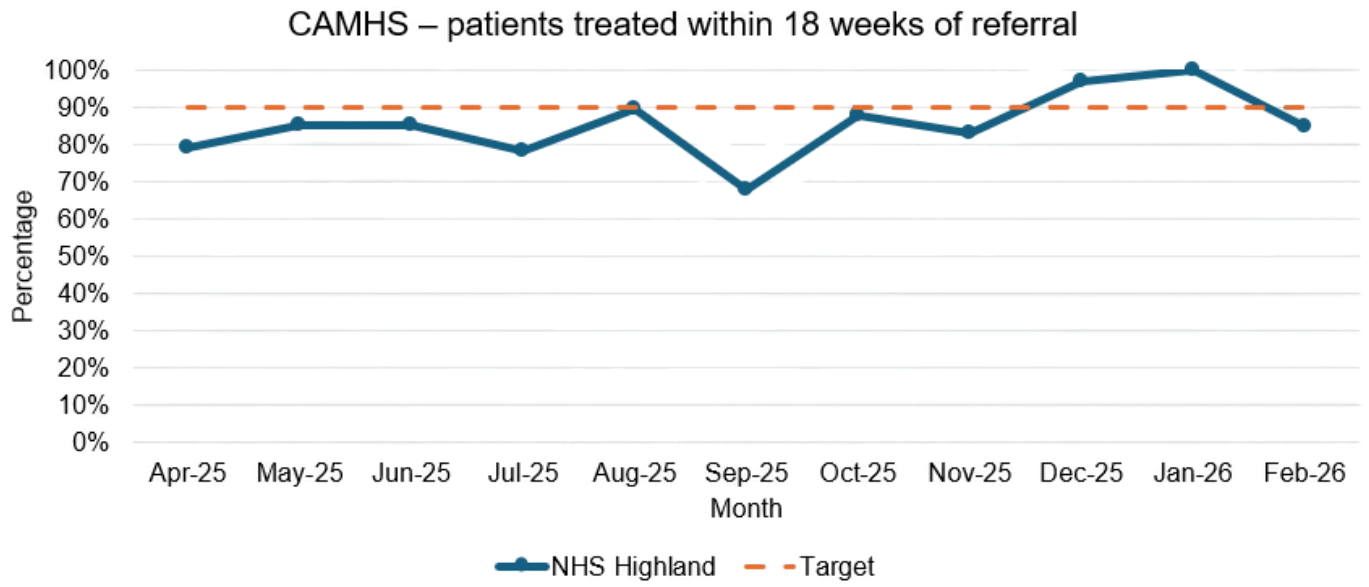
Collaborative efforts with The Highland Council are underway, aiming to create innovative and transformative approaches for supporting individuals referred for neurodevelopment assessment at a more local level. This initiative will necessitate system-wide collaboration, ensuring the presence of skilled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

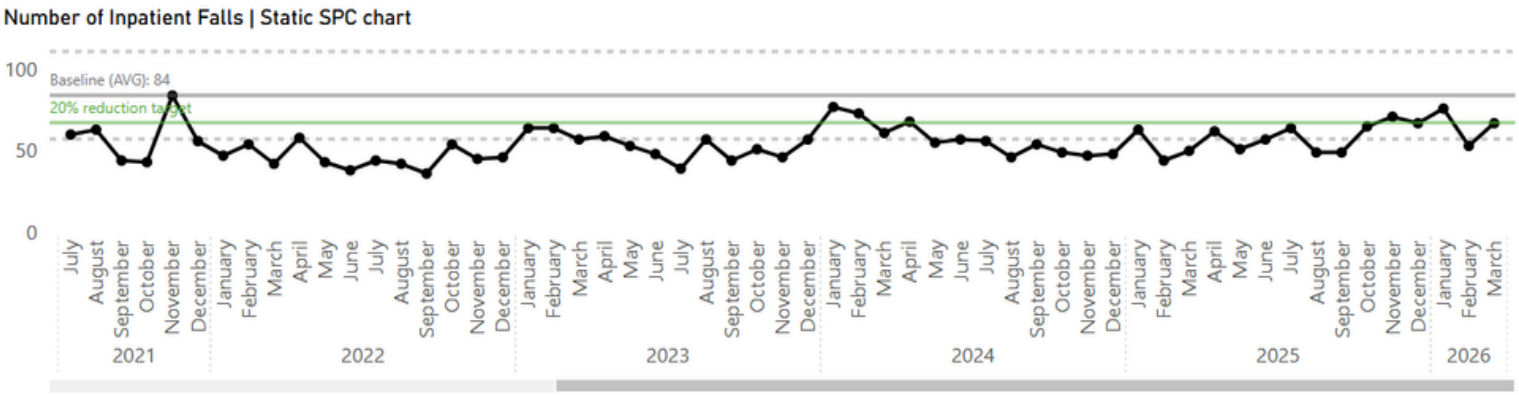
It supports open, learning-focused conversations about what is happening in services, what the risks really are, and what needs to change — with the emphasis on services owning issues and sharing learning. It also helps the HSCP take a more consistent approach across health, social work and adult protection,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

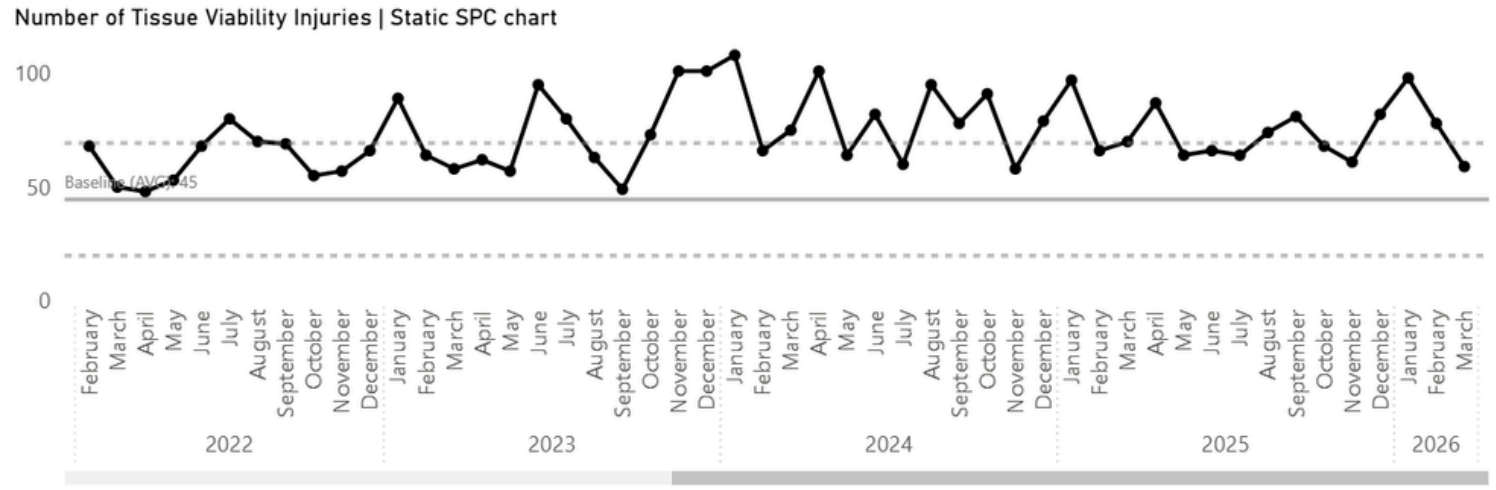
We have also developed prompts for assurance across services and supported more integrated governance with health, social work and adult protection colleagues.



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.

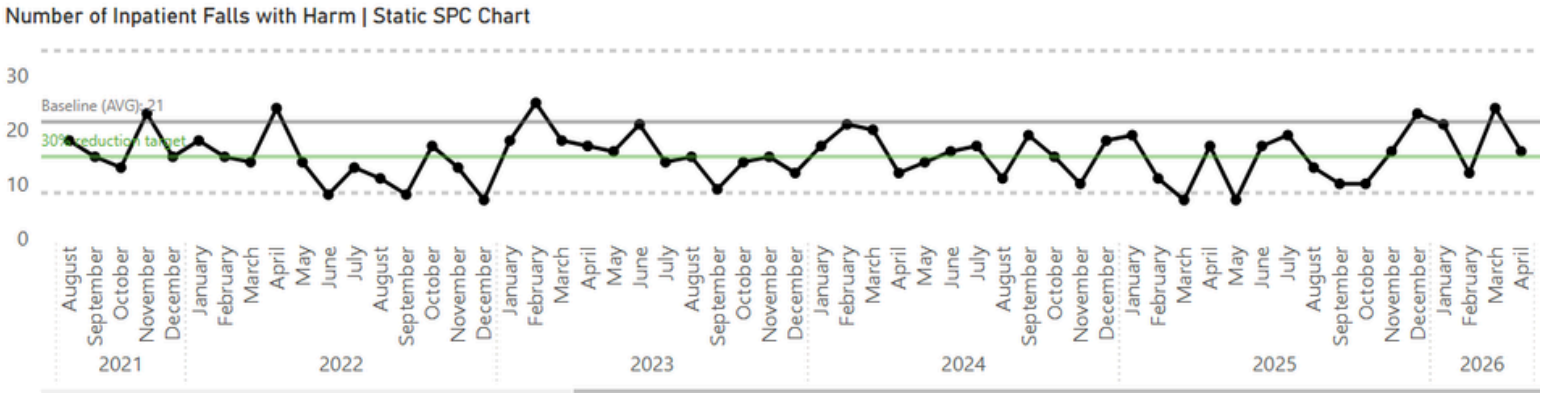
The GEKO device is a new device to improve circulation to heal leg ulcers. A trial was undertaken by community nurses with a number of GP practices in the use of the device. Evidence shows that the use of the GEKO device has either healed leg ulcers that previously have been untreatable for over 12 months,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

Falls

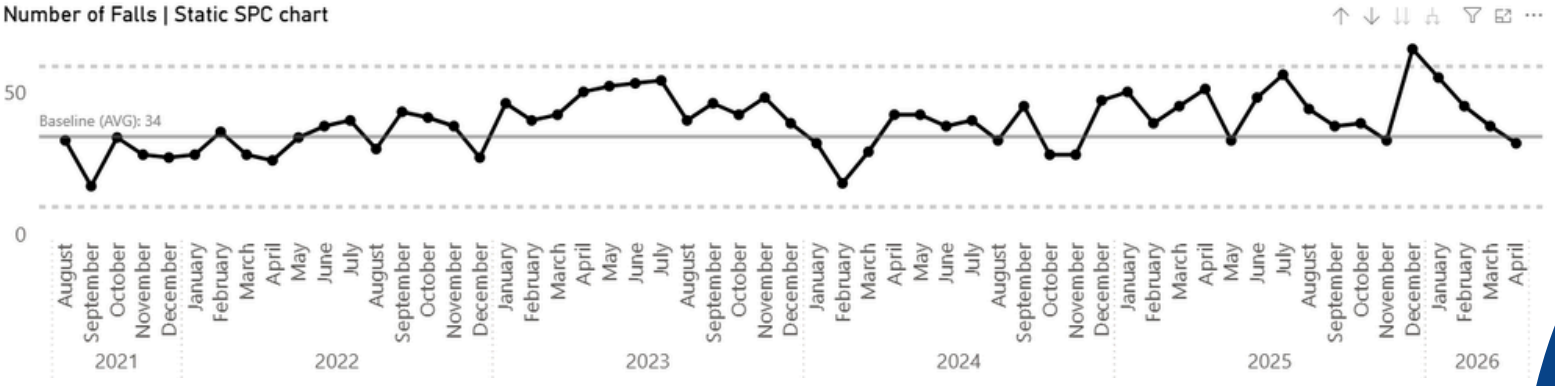
The number of reported incidents of falls within our community hospitals remains consistent over the last 12 months, with a slight rise over the winter period. Despite this, the average number remains on or below the target 20% in falls against the baseline.

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.

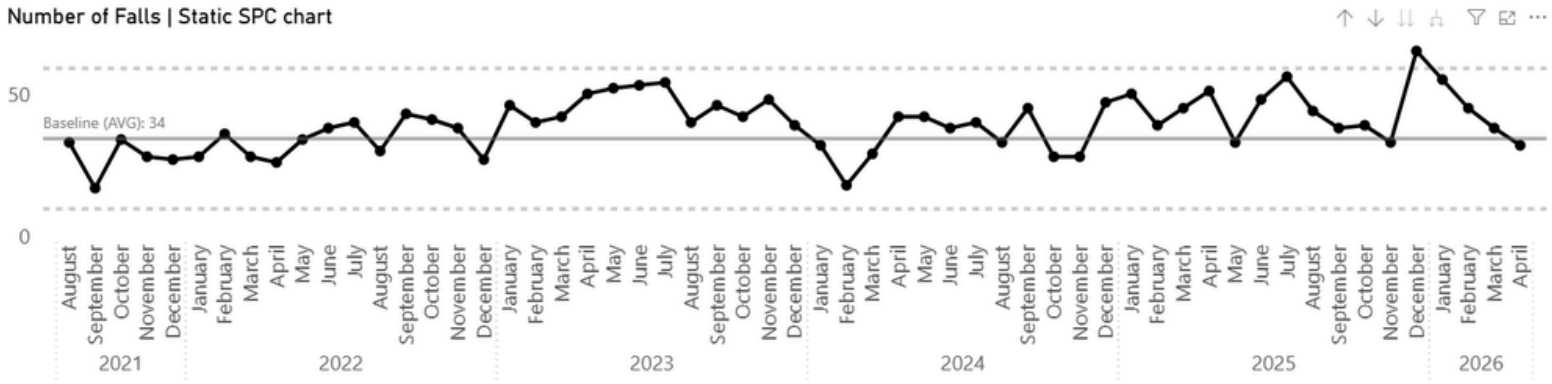
The chart below illustrates the falls with harm (injury) in community hospitals. This area has been less stable as a trend over the last year. The spike in falls with harm over winter is again likely to reflect the acuity and frailty of people in our community hospitals at this time.



The next chart illustrates the number of falls in care homes



The next chart illustrates the number of falls in care homes



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

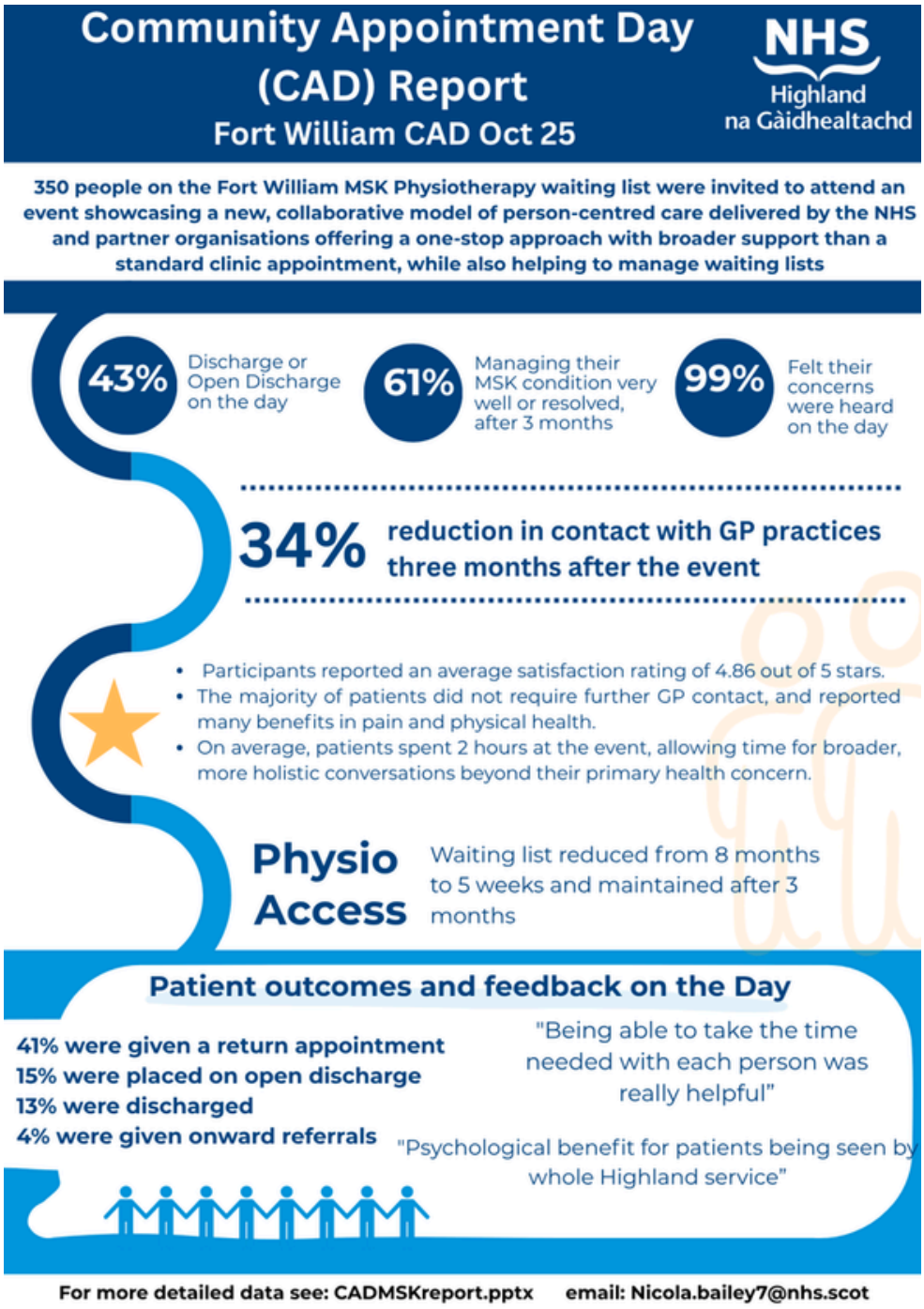
In our adult social care services over the past year, we have strengthened our quality assurance arrangements through additional quality assurance visits. This has enabled us to gather stronger evidence that care is safe, person centred and of a consistently good standard, while also ensuring staff feel 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.

The table below explains the percentage comparison.

Green - Better than average
Amber - Average +/- 5%
Red - Worse than average

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

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 Integrators

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**	92.40%		93.00%			Biennial reporting, latest data = 2023/24
			Scotland	90.90%		90.70%			
			Target						
			Ranking (31)	11		7			
2	n/a	2. Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**Highland**	86.50%		71.90%			Biennial reporting, latest data = 2023/24
			Scotland	78.80%		72.40%			
			Target						
			Ranking (31)	4		20			
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**	72.10%		60.50%			Biennial reporting, latest data = 2023/24
			Scotland	70.60%		59.60%			
			Target						
			Ranking (31)	15		16			
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**	71.90%		65.90%			Biennial reporting, latest data = 2023/24
			Scotland	66.40%		61.40%			
			Target						
			Ranking (31)	4		10			
3	n/a	5. Percentage of adults receiving any care or support who rated it as excellent or good	**Highland**	83.00%		75.70%			Biennial reporting, latest data = 2023/24
			Scotland	75.30%		70.00%			
			Target						
			Ranking (31)	4		8			
3	n/a	6. Percentage of people with positive experience of the care provided by their GP practice	**Highland**	77.20%		80.40%			Biennial reporting, latest data = 2023/24
			Scotland	66.50%		68.50%			
			Target						
			Ranking (31)	6		5			

National Integration Integrators

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**	84.30%		73.60%			Biennial reporting, latest data = 2023/24
			Scotland	78.10%		69.80%			
			Target						
			Ranking (31)	3		12			
6	n/a	8. Percentage of carers who feel supported to continue in their caring role	**Highland**	28.70%		32.00%			Biennial reporting, latest data = 2023/24
			Scotland	29.70%		31.20%			
			Target						
			Ranking (31)	19		13			
7	n/a	9. Percentage of adults supported at home who agreed they felt safe	**Highland**	86.00%		78.20%			Biennial reporting, latest data = 2023/24
			Scotland	79.70%		72.70%			
			Target						
			Ranking (31)	5		9			
1 & 5	n/a	11. Premature mortality rate for people under 75 (per 100,000 population)	**Highland**	405	400	389			Calendar year, latest data = 2023. Rankings based on lowest rate (1) to highest rate (31).
			Scotland	463	441	442			
			Target						
			Ranking (31)	12	11	12			

National Integration Integrators

National Outcome	National Standard	Indicator	Detail	2021/22	2022/23	2023/24	2024/25	2025/26	Comments
1. 2, 4, 5, 7	n/a	12. Emergency admission rate for adults (per 100,000 population)	**Highland**	9,860	9,599	9,549	9,646		latest data = 2024/25 (only covers 2024 calendar year). Rankings based on lowest rate (1) to highest rate (31).
			Scotland	11,645	11,318	11,859	11,559		
			Target						
			Ranking (31)	7	8	6	8		
2, 4, 7	n/a	13. Emergency bed day rate for adults (per 100,000 population)	**Highland**	110,871	119,873	118,628	110,938		latest data = 2024/25 (only covers 2024 calendar year). Rankings based on lowest rate (1) to highest rate (31).
			Scotland	116,389	123,061	120,407	113,627		
			Target						
			Ranking (31)	14	15	15	16		
		* indicator 10 discontinued							

National Integration Integrators

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		latest data = 2024/25 (only covers 2024 calendar year). Rankings based on lowest rate (1) to highest rate
			Scotland	107	102	104	103		
			Target						
			Ranking (31)	23	23	23	23		
2, 3, 9	n/a	15. Proportion of last 6 months of life spent at home or in a community setting	**Highland**	90.70%	89.60%	89.20%	90.10%		latest data = 2024/25 (only covers 2024 calendar year)
			Scotland	89.70%	88.90%	88.90%	89.20%		
			Target						
			Ranking (31)	9	11	14	9		
2, 4, 7, 9	n/a	16. Falls rate per 1,000 population aged 65+	**Highland**	14.2	14.2	14.8	14.2		latest data = 2024/25 (only covers 2024 calendar year). Rankings based on lowest rate (1) to highest rate
			Scotland	22.6	22.1	22.7	22.5		
			Target						
			Ranking (31)	1	1	1	4		
3, 4, 7	n/a	17. Proportion of care services graded “good” (4) or better in Care Inspectorate inspections	**Highland**	80.30%	83.00%	84.80%	81.20%		latest data = 2024/25
			Scotland	75.80%	75.20%	77.00%	81.90%		
			Target						
			Ranking (31)	12	4	7	20		
2	n/a	18. Percentage of adults with intensive care needs receiving care at home	**Highland**	56.80%	58.70%	54.80%	56.50%		Calendar year, latest data = 2024
			Scotland	64.50%	64.70%	64.50%	64.70%		
			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**	1,019	1,213	1,822	2,209		latest data = 2024/25. Rankings based on lowest rate (1) to highest rate (31).
			Scotland	748	883	867	952		
			Target						
			Ranking (31)	27	24	30	31		

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 NeedNo. 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

Together We Care Strategic Outcomes

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

Together We Care Strategic Outcomes

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

Together We Care Strategic Outcomes

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

Together We Care Strategic Outcomes

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.				

Together We Care Strategic Outcomes

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
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

Together We Care Strategic Outcomes

	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
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				

Together We Care Strategic Outcomes

	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.				
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
NHS Highland & The Highland Council

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	90.70%	89.60%	89.10%	89.60%		2024/25 = latest data and is provisional
MSG 5	End of Life, percentage of last six months in hospital / hospice	9.30%	10.40%	10.90%	10.40%		2024/25 = latest data and is provisional
MSG 6	Balance of Care, percentage of population in community settings	99.70%	99.70%	99.70%			2023/24 = latest data. Totals shown for 'Care Home', 'Home (Supported)' and 'Home (Unsupported)'

Highland Health and Social Care Partnership

ADULT SOCIAL CARE

Commissioning Strategy and Intentions

2026 to 2029



NHS Highland

The Highland Council
Comhairle na Gàidhealtachd

Contents

1. **Foreword** 2
2. **Executive summary** 3
3. **Background** 4
4. **Commissioning** 7
5. **Context** 11
6. **Profile** 17
7. **Change and transformation** 25
8. **Commissioning actions and intentions** 29
9. **Governance** 31
10. **Conclusion and next steps** 32

Appendices

Appendix 1: Service area commissioning actions and intentions 35

Appendix 2: Commissioning intentions summary and plan 51

Appendix 3: Key terms 53



1 Foreword

It gives me great pleasure to present the Highland Health and Social Care Partnership's Commissioning Strategy and Intentions 2026–2029, setting out our ambitious approach for the years ahead.

This strategy sets out a clear direction for adult social care across Highland, with a strong commitment to delivering services that are sustainable, person centred, and fully responsive to the changing needs of our communities.

We are operating in a period of rising demand, increasing complexity, financial pressure, and persistent workforce challenges. These realities make it more important than ever that our commissioning approach is ambitious, transparent, and shaped through meaningful collaboration with partners, providers, and communities.

Over the next three years, we will drive forward our Highland Care Model by expanding community-based options, strengthening reablement and early intervention, and ensuring our commissioning decisions are grounded in robust data, clear evidence, and meaningful engagement.

Delivering within a balanced budget will demand tough choices, honest conversations, and a collective determination to do what is right for the people of Highland.

Together, I am confident that we can build a stronger, more resilient and more sustainable system of care - one that reflects our values, delivers real impact, and meets the needs of Highland's communities now and for the future. I look forward to working with you to turn this ambition into action.



Arlene Johnstone
Chief Officer

Highland Health and Social Care Partnership

2 Executive Summary

- Our Adult Social Care Commissioning Strategy and Intentions 2026–2029 sets out a bold programme of change for Highland, building on the Joint Strategic Plan (JSP) published in 2024 and the Joint Strategic Needs Assessment (JSNA) updated in 2025.
- This strategy is a clear call to action. It translates vision into delivery and sets out how the Highland Health and Social Care Partnership will reshape adult social care in the face of rising demand, increasing complexity, and significant financial challenge.
- Highland is facing a powerful combination of demographic change, growing complexity of need, workforce fragility and financial pressure. Demand is rising across both older adult and younger adult services, with particular urgency around complex support, reablement, and sustainable alternatives to high cost models of care.
- At its heart, this strategy is about shifting the balance of care. Our ambition is to support far more people to live independently and well at home, reduce reliance on residential provision, and ensure that specialist and complex services are available for those who need them most.
- The strategy is firmly grounded in national and local policy, but its focus is practical and transformative: building stronger locality led care, expanding choice and flexibility through Self Directed Support, and creating services that are more person centred, preventative, and community based.
- The case for change is immediate and unavoidable. With a significant overspend, unmet need, and growing service pressure, incremental change will not be enough. We need decisive action to rebalance investment, modernise delivery models, and secure a sustainable future for adult social care in Highland.
- Our Highland Care Model will drive this transformation by putting reablement, early intervention, local care models, and flexible community support at the forefront. It will also sharpen our focus on younger adults with complex needs, strengthen alternatives to residential care, and direct resources towards the most effective forms of support.
- This strategy is the starting point for delivery. It will now be taken forward through detailed implementation, market facilitation, workforce planning and service redesign - turning strategic intent into visible, measurable change across Highland over the next three years.

3 Background

- This Adult Social Care Commissioning and Intentions document follows on from the Highland Adult Services Joint Strategic Plan 2024-2027 (Joint Strategic Plan), which was agreed in December 2023 following extensive consultation.
- The previously prepared Joint Strategic Plan (JSP) is a requirement of the Public Bodies (Joint Working) (Scotland) Act 2014. It's purpose is to:
  - set out the arrangements for the carrying out of the integration functions for the area of the local authority over the period of the plan,
  - set out how those arrangements are intended to achieve, or contribute to achieving, the national health and wellbeing outcomes, and
  - include such other material as the integration authority thinks fit.

  The provision to be included in a strategic plan by virtue of subsection (2) (a) requires:
  - dividing the area of the local authority into two or more localities, and
  - setting out separately arrangements for the carrying out of the integration functions in relation to each such locality.
- The JSP therefore is to describe the arrangements for carrying out integrated functions and to outline how these will achieve, or contribute to achieving, the national health and wellbeing outcomes, including how the Partnership will commission and deliver services for its area over the medium term.

  The term "Strategic Plan" was previously referred to as "Strategic Commissioning Plan" in earlier Scottish Government statutory guidance.
- Alongside the Strategic Plan, there are requirements to:
  - Publish the **strategic plan**, consultation actions, financial statement, equality impact assessment (and any other relevant impact assessments).
  - Produce an **implementation plan**, (or set of implementation plans), outlining how the strategic plan will be delivered. This is to include a **procurement plan** providing specific detail to direct those responsible for contracting services.
  - Prepare a **market facilitation plan** to complement the strategic plan and support its delivery.
  - Consider how workforce planning will enable delivery of the strategic plan (**workforce plan**).
  - Publish an **annual financial statement** to set out in relation to the strategic plan to which it relates, the amount that the integration authority intends to spend in implementation of the plan.
  - Produce an **annual performance report** that sets out an assessment of performance in planning and carrying out integration functions for the reporting year.
  - Review and prepare a **replacement plan** prior to expiry.

- The JSP was prepared in 2023 in the absence of a Joint Strategic Needs Assessment (JSNA), which was unavailable at the time. The content of the prepared document set out a high level vision and future direction of travel for the provision of adult social care services in Highland but did not draw from a JSNA nor include commissioning intentions.
- The JSNA is now available (March 2025, revised June 2025) and there is an opportunity to reflect on this document and prepare this more specific Commissioning Strategy and Intentions document, of what services we need across all client groups and geographies, in order to deliver on the requirements of the JSP within the budget set for Adult Social Care.
- This commissioning strategy and intentions document will therefore support the high level vision and direction set out within the JSP and will support the development of a number of enabling supporting plans, which describe the detailed actions for supporting delivery of the JSP and this commissioning strategy and intentions:
  - **Market facilitation plan**
    Actions and timescales for how we intend to stimulate a diverse, vibrant and sustainable market, so there are different types of support and provider organisations for supported people to choose from.
  - **Procurement plan**
    Actions and timescales for how we intend to progress the identified procurement activity and delivery.
  - **Workforce plan**
    Actions and timescales for how we intend to create and support the future workforce needed to deliver the required services in Highland.
- This document is prepared for the purpose of directing the Partnership's activity in delivering on its JSP and also for other stakeholders, particularly those who use the services and also those who currently or may deliver services in the future, for awareness of these intentions.
- Our scope, as articulated within this document, relates only to the commissioning of services for people across the following noted priority areas:

Care homes
- Complexity
- Nursing

Supported living at home
- Care at home
- Support services
- Day care

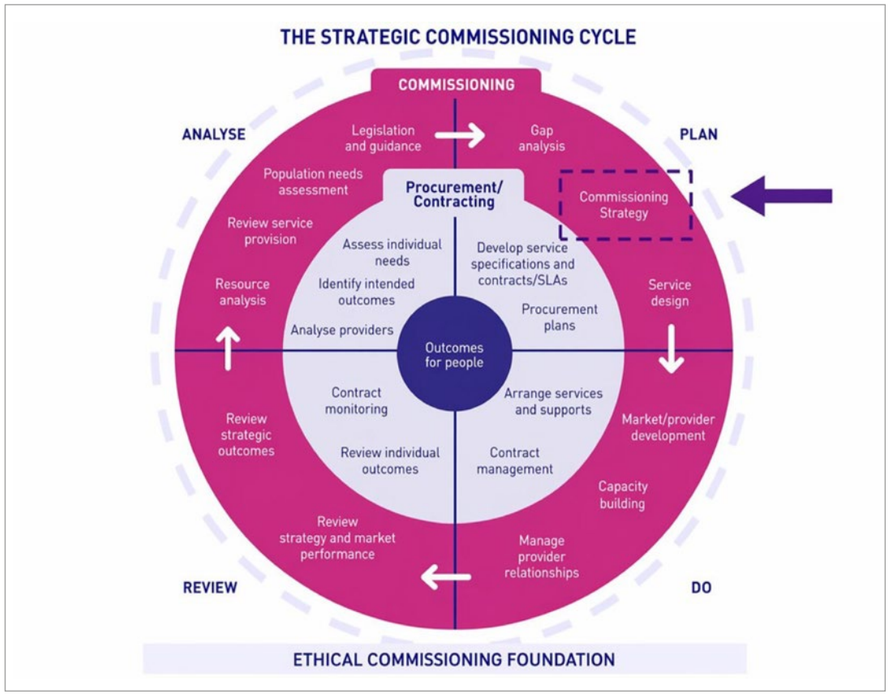
Community based supports
- Local care model
- Personal assistants
- Unpaid carers
- Technology
- Third sector / prevention promotion

Document Development

- As legislatively required by the Public Bodies (Joint Working) (Scotland) Act 2014, there was full consultation and engagement in the development of the JSP, aligned with the prescribed steps of the Act.
- This document does not require such a process, however we have sought to ensure a collaborative and co-productive approach in its preparation.
- The initial document was developed by a joint NHS Highland and The Highland Council Reference Group, and its further development has been informed and shaped by discussion at the Strategic Planning Group, Health and Social Care Committee, individual provider inputs, and through further internal feedback.
- It is intended that our commissioning strategy and intentions will be a collaborative working document, reviewed on an annual basis and aligned to the periods of the overarching JSP.
- The Joint Monitoring Committee, as owners of the JSP, will approve this commissioning strategy and intentions document and will oversee its implementation.

4 Commissioning

- The JSP explains what the Partnership's priorities are, why and how we decided upon them, and how we intend to make a difference by working closely with partners.
- Strategic commissioning is the process for how we intend to take this high level vision to a practical reality.
- Commissioning therefore involves the strategic, whole system process of understanding needs, planning services, shaping the market, and ensuring services deliver good outcomes.
- It refers to all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range, and quality of future services, and working in partnership to put these in place.
- The commissioning process comprises a range of activities, including:
  - Assessing needs
  - Setting priorities
  - Planning services
  - Procuring services
  - Monitoring quality
- The commissioning stages are cyclical, and each part is of equal importance.
- The process is often depicted as the cycle noted below.



- This commissioning cycle provides the Partnership with a foundational framework for all of our commissioning activity.[1]
- This commissioning strategy and intentions document represents the "commissioning strategy" step of the cycle, bringing together the relevant information to determine what services are needed in order to meet the vision and aim of the JSP.
- A key principle of the commissioning process is that it should be equitable and transparent, and therefore open to influence from all stakeholders via an ongoing dialogue with people who use services, unpaid carers, and providers.
- The Partnership's commissioning approach to date has been a focus on collaboration and engagement and this is intended to continue and to further develop.
- We will build on our current approaches to actively engage with our current providers, potential providers, and community representatives and create the conditions where Self Directed Support Options 1 and 2 can both grow and be supported.
- In our actions to date, we have instinctively been operating from a premise of ethical commissioning in our sector interactions and procurement activity – working alongside some sectors in co-producing commissioning principles and strategic action plans.
- We recognise we need to build on, formalise, and consistently apply, an ethical commissioning foundational approach across all areas of activity and intend to do so.
- Our intent aligns with the Scottish Government's ethical commissioning and procurement direction and policy advice[2]. Further, it aligns with the requirement that social care procurements should be based on ethical commissioning and procurement principles and that ethical commissioning and procurement approaches should ensure full engagement with those who access social care support, those who support people to access social care support, families and friends, unpaid carers, the workforce and providers.
- Our intent also aligns with the Independent Review of Adult Social Care recommendations[3] and its call for:

  "An end to this emphasis on price and competition and to see the establishment of a more collaborative, participative and ethical commissioning framework for adult social care services and supports, squarely focused on achieving better outcomes for people using these services and improving the experience of the staff delivering them".
- This independent review helpfully summarises a suite of new ways of thinking to focus a preferred direction of travel.

[1] Source: Independent Review of Adult Care in Scotland, adapted to reflect ethical commissioning foundation.
[2] Procurement Policy Manual - June 2025
[3] Adult Social Care: independent review - gov.scot

Old Thinking	New Thinking
Social care support is a burden on society	Social care support is an investment
Managing need	Enabling rights and capabilities
Available in a crisis	Preventative and anticipatory
Competition and markets	Collaboration
Transactions	Relationships
A place for services (e.g. a care home)	A vehicle for supporting independent living
Variable	Consistent and fair

- We fully endorse the "new thinking" direction and have sought to underpin this approach within this commissioning strategy and intentions document.
- This approach will be more explicitly articulated with the Market Facilitation Plan which is being developed to complement this strategy.



5 Context

Lead Agency Arrangements

- The Highland Health and Social Care Partnership has operated under a lead agency model since 2012.
- These arrangements are currently under active review, and it is acknowledged there is a likelihood of significant organisational change over the lifetime of this plan.
- Notwithstanding this anticipated key change, it is important that the necessary strategy and planning around the commissioning of services continues to be progressed.

Joint Strategic Plan

- The primary context for this commissioning strategy and intentions document is the Partnership's Joint Strategic Plan.
- This is where we have articulated our vision of:

working together to support our communities in Highland to live healthy lives and to achieve their potential and choice to live independently where possible

- We have also confirmed our commitment to:
  - enable people to be as independent as possible, supported by their family, friends, and local community before formal paid support is discussed; and
  - work with unpaid carers to ensure their health and wellbeing is looked after and we will encourage and enable community organisations to thrive.
- The services we need to commission require to support this vision.
- The scope of this document will align with the JSP and focus on adult social care services across all older and younger adults, although it is recognised that there is a connection across the wider health and social care system.
- Our focus will therefore be on prioritising those services which will support people to remain at home, and on those services which require to be available for people whose level of need is unable to be provided in their home environment.
- This commissioning strategy and intentions extends beyond the end of the current JSP, however we anticipate the direction of travel for commissioned services to continue to align with supporting people to remain well and independently at home.

Legislative and Policy Landscape

- In addition to the JSP as the key driver for this document, it is relevant to reference the extensive national and local policy landscape that the Partnership operates within in delivering adult social care services.
- These national policies set the direction which the Partnership requires to follow and the local strategies describe how the Partnership intends to translate and implement these across the Highland area.
- The national and local policy landscape underpin the JSP and in turn, our commissioning strategy and intentions.

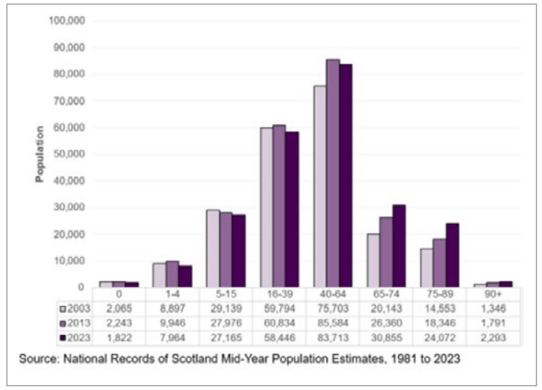
National Context Legislation and Policy	National Strategies and Guidance	Local Strategies and Guidance
Scottish Government National Performance Framework National Health and Wellbeing Outcomes Social Work (Scotland) Act 1968 Community Care and Health (Scotland) Act 2002 Social Care (Self-directed Support) (Scotland) Act 2013 Public Bodies (Joint Working) (Scotland) Act 2014 Community Empowerment (Scotland) Act 2015 Carers (Scotland) Act 2016 Social Security (Scotland) Act 2018 Housing to 2040	Health and Social Care Standards A Fairer Scotland for Older People Digital Health and Social Care SDS Framework and Standards Independent Review of Adult Social Care National Care Service and National Social Care Agency Mental Health Strategy 2017-2027 Keys to Life Strategy 2019-2021 Mental Health Transition and Recovery Plan 2020 Learning / Intellectual Disability and Autism Plan 2021 Coming Home Implementation Plan	Together We Care Joint Strategic Plan Mental Health and Learning Disability Strategy Stronger Together Highland SDS Strategy: Making the Change Together Highland Unpaid Carers Strategy Director of Public Health Report 2022 – Prevention – Moving Upstream

Joint Strategic Needs Assessment

- In June 2025, a Highland Joint Strategic Needs Assessment - Highland Health and Social Care Partnership (JSNA) was published by the Directorate of Public Health and Policy of NHS Highland.
- This JSNA provides an overview of population health and wellbeing needs of the adult population of the Highland council area and looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being, and social care services.
- The key headlines from this published JSNA, relevant to this forward looking commissioning strategy and intentions, are as follows:
  - As of 2024, Highland had a population of **237,920** people. Of these, 15% were children aged 0-15 years, 60% were people aged 16-64 years, and 25% were people aged 65 and over.
  - The population of Highland has continued to age, with increasing numbers of people in older ages, decreasing numbers of working-age individuals, and smaller cohorts of children and young people. There are now **more people aged 65 and over than people under 15**.
  - 2022-based population projections estimate the **population of Highland will increase by 1.8% between 2022 and 2045**. Maintaining or growing population numbers in Highland depends on inward migration, offsetting natural population change, and outward migration.
  - The general demographic picture informing the commissioning of health and care services in Highland is one of **smaller** populations of children and young people, further **reductions** in the working-age population, and a continued **increase** in the proportion of older people, as shown:

Population in Highland by Age Group 2023, 2013, 2043

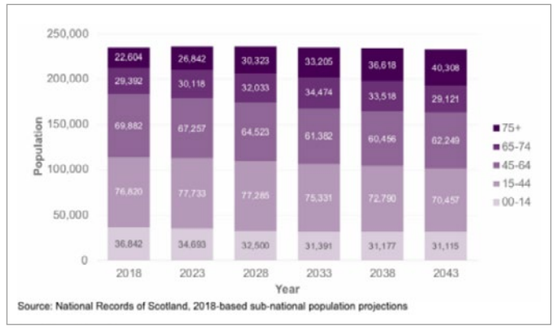
Population in Highland by Age group 2003, 2013 and 2023



	0	1-4	5-15	16-39	40-64	65-74	75-89	90+
2003	2,065	8,897	29,139	59,794	75,703	20,143	14,553	1,346
2013	2,243	9,946	27,976	60,834	85,584	26,360	18,346	1,791
2023	1,822	7,964	27,165	58,446	83,713	30,855	24,072	2,293

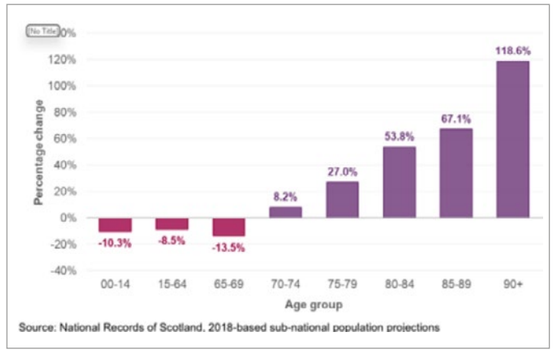
Source: National Records of Scotland Mid-Year Population Estimates, 1981 to 2023

Projected Change in Population 2018 to 2043 by Age Group in Highland



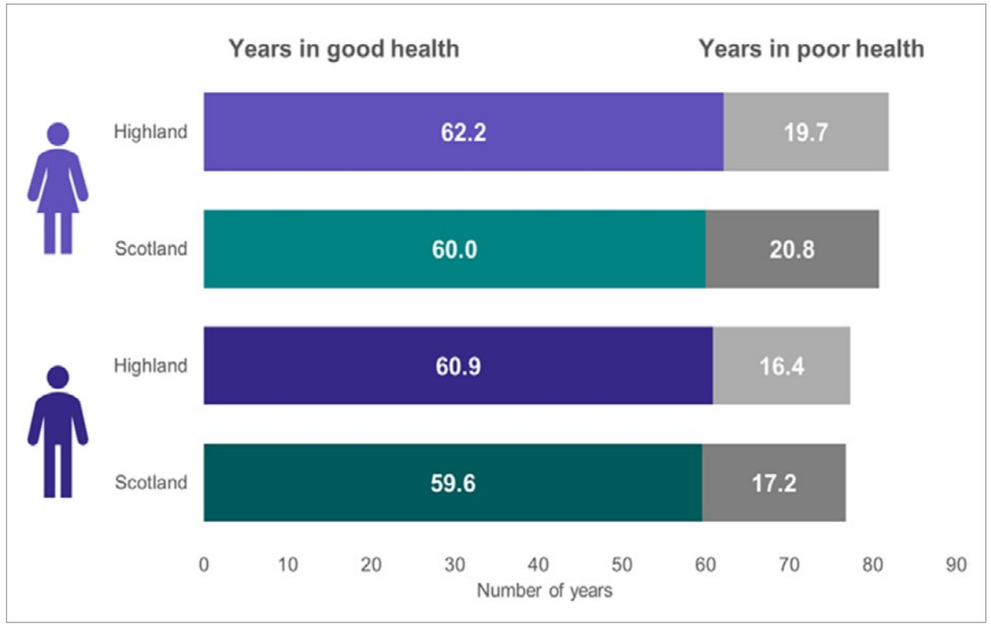
Source: National Records of Scotland, 2018-based sub-national population projections

Projected Percentage Change in Population 2023 to 2043 by Age Group in Highland



Source: National Records of Scotland, 2018-based sub-national population projections

- Highland has a **significant remote and rural geography**. Almost four in ten of the population of Highland live in remote rural areas and almost one in four of the population lives in areas that are classified as very remote rural. **Older age dependency ratios are higher in these areas**.
- **Rural deprivation** is an important concern. In Highland, most income deprived people live in places not identified among the most deprived areas by the Scottish Index of Multiple Deprivation. This distribution is a significant consideration for policy, strategy and the spatial targeting of resources, particularly in rural areas.
- Around **half of the population of Highland** live in the twenty percent most **access deprived areas in Scotland**, with people experiencing longer travel times to local services and poorer digital access.
- **Equality**, or lack of, directly affects people's chances of being and staying in good health. As an Anchor Institution, the role of the Partnership is pivotal to designing and delivering health and care that has the population and local communities as the focus, particularly in the context of the wider determinants of health.
- Life expectancy is a key indicator of a population's health. Recent evidence has highlighted **life expectancy improvements in Highland have stalled** over the last decade.
- The **healthy life expectancy for Highland** shown below, highlights 19.7 years of poor health for women in Highland and 16.4 years for men in Highland:



- The general epidemiological picture in Highland is one in which **chronic conditions** related to ageing are prevalent; multimorbidity is common as age increases, and **preventable illnesses** exacerbate health inequalities.
- National evidence suggests a **substantial increase in prevalence of common health conditions** over the next 20 years, due to projected demographic changes. The anticipated rise in a range of diseases including cancer, cardiovascular disease, diabetes and dementia will inevitably place additional pressure on health and care services.
- The harmful use of substances (tobacco, alcohol and drugs), unhealthy diet and physical inactivity are major causes of preventable ill-health and early death. **Reducing these risk factors presents a sizeable opportunity to improve health and wellbeing and reduce health inequalities.**
- The number of people **providing unpaid care increased** over the last decade. In the context of increasing demand and growing levels on unmet need, **more unpaid care is being relied upon** to support people to live at home.
- Current needs and future **requirements for housing** should be aligned to the Partnership's strategic commissioning and planning to support people at all stages of life and **support the shift in the balance of care closer to people's homes.**
- **Care home capacity has reduced** during a period of growth in the older population. **Pressure on the care home market** is recognised to be associated with challenges of rural operation, smaller size of operation, and workforce availability.
- Combined, the data for **delayed discharges**, care at home and care home capacity reflects the challenge of providing services across the Highland geography and high levels of unmet need.
- People at **end of life have relatively high use of health and social care services and demands are forecast to increase**. Experience of end of life care should be good, irrespective of where people live or what they die from.
- The evidence on forecast burden of disease, rising service demand and financial sustainability is clear that **better prevention of poor health and the creation of good health is essential.**
- Improving the health of our population requires a **fundamental shift towards prevention** and mitigating the underlying issues that can impact on health, such as poverty and deprivation.
- To shift the balance of care closer to people's homes, **change is needed** in how we approach the delivery of health and care, **driving investment in prevention and early intervention.**

- From the JSNA, the **key drivers for future planning** of adult social care are therefore noted as follows:
  - There is an **ageing population** with increasingly **large cohorts living into older age**, with an overall static or decreasing total population.
  - Pressure on all care providers resulting from the **challenges of workforce availability** and dependence on international workers.
  - Epidemiological trends forecast an **increase in annual disease burden over the next 20 years.**
  - People at end of life have relatively **high use of health and social care services** and demands are forecast to increase.
  - To shift the balance of care closer to people's homes, **change is needed in how we approach the delivery of health and care**, driving investment in prevention and early intervention.
  - The Partnership, along with its partners and key stakeholders, play a **pivotal role in designing and delivering health and care** that has the population and local communities as the focus.

Housing Need and Demand Assessment

- It is also specifically acknowledged that The Highland Council has initiated a new Housing Need and Demand Assessment (HNDA) to inform the Highland Local Development Plan.
- This plan, which is to conclude in summer 2026, aims to estimate the number of additional housing units needed to meet existing and future housing requirements (social housing) and demand (market housing).
- This plan will be key to supporting the delivery of the ambitions within our commissioning strategy and intentions in terms of helping to support available options to enable people to live independently and also to provide much needed accommodation to support the workforce we need for service delivery.

6 Profile

In order to understand what we need to change, we firstly need describe our current operating landscape.

Activity

- There is an estimated **5,653** people who currently receive **registered adult social care services** in Highland – this is around **2.37% of our total population** of 237,920.
- There are a significant number of people supported by **unpaid carers**, thought to range between 26,000[4] and 79,000[5] and as well as many others who are supported by third sector, community and other arrangements.
- Of those 5,653 people receiving formal adult social care supports:
  - **1,652** people are in a **care home** in Highland
    - 1,450 of these people are in an independent sector care home
    - 202 people of these are in care homes operated by NHS Highland
  - Outwith Highland, 128 people are being cared for and supported in care home placements outside of our area, primarily due to choice to be closer to family or in some cases, due to no alternative provision being available in Highland.
  - **4,001** people receive care or support at home
    - **1,058** of these people receive care at home or home based respite from independent sector providers
    - **619** of these people receive care at home from NHS Highland
    - **1,112** people receive support at home or day care from independent sector providers
    - **875** people receive a direct payment (**SDS Option 1**)
    - **337** people have in place an individual service fund (**SDS Option 2**)
- Overall, we are supporting more people at home compared to March 2023 but there has been a reduction in the number of people receiving care at home. This has been impacted by ongoing sector wide recruitment challenges and provider exits.

[4] Highland Council and Scottish Government Estimate 2024.
[5] Carers UK Ongoing Research – 32% of population

- Option 1s have been increasing (55% increase since March 2023) and we are projecting that we will be supporting more than 900 people through Option 1s by the end of 2026-2027. There has been growth in this area every year since 2023 and we expect and wish for this option to continue to increase. To date, however, Option 1s have been increasing by default due to lack of other available options.
- Option 2s have also been increasing (68% increase since March 2023). We are also looking to support the further increase of this option.
- Our overall current balance of provision is:
  - **57% of older adults** are supported in their **own home** across current service delivery options and **43% reside in a care home**
  - **89% of younger adults** are supported in their **own home** and **11% reside in a care home**

Demand

- Notwithstanding the forecasted pressures within the JSNA, we are already facing sustained pressure from rising demand and increasing numbers of people with complex needs.
- There is more demand than there are services available, across most service areas. This has been an ongoing and increasing trend, which is expected to continue, as described within the JSNA.
- Population projections from National Records Scotland indicate that the population of Highland is expected to increase slightly in the next 5 years, but will become older with an **increase of approximately 2.5%** each year in the over **75 years** age population.
- All services are already operating to a high level of occupancy and capacity and where this is not the case, this is due to challenges in securing staffing.
- Some of these particular pressure areas are noted below:

Hospital Delays

- As at 23 February 2026, there were **198** people **delayed in hospital** awaiting an appropriate placement / care package which was unavailable. Of these,
  - **68** people were delayed awaiting a **care home** placement.
  - **40** people were delayed awaiting a **care at home** placement.
  - **90** people were delayed in hospital for **other reasons** (e.g. due to assessment, complex or guardianship etc reasons).

Younger Adults / Transitions

- Younger adults increasingly need complex, high-cost support in community settings. Demand is shifting from traditional residential care to highly individualised models.
- Investment in prevention and community services is vital, but there is growing pressure for intensive, specialised care and out-of-area placements, especially for younger adults who have higher dependency and cost needs. There is an increasing number of these arrangements.

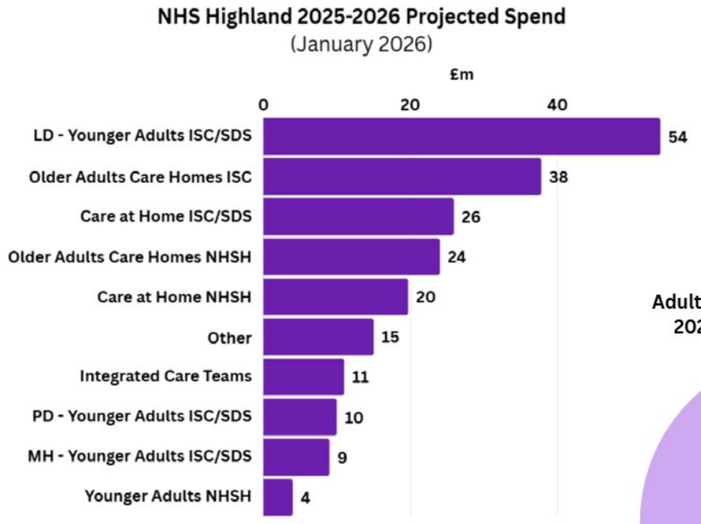
- Presently there are **300** younger adults supported at home across Options 1, 2 and 3, and of this, there are **190** younger adult packages of care which each cost in excess of **£100k** per annum.
- An ongoing area of focus relates to **transitions to adult services** for children with complex needs. This is an area requiring specialist provision and involving high costs. Based on current information, we expect at least 8 individuals to move into adult care over the lifetime of this plan, and a total **increase of 12** over the next **6 year period**, with corresponding service and financial pressures.

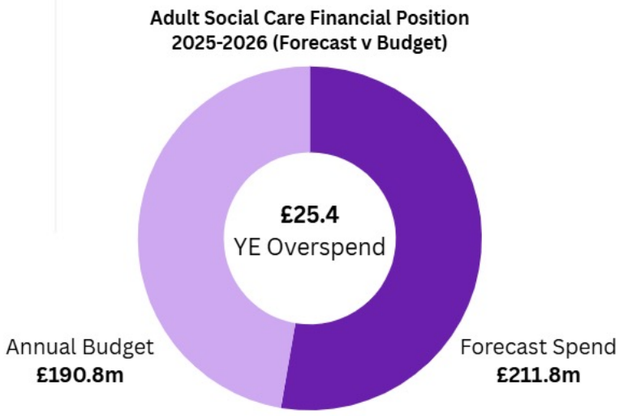
Finance

- The level of funding expended on commissioned and delivered adult social care services is significant at **£190.8m per annum** for 2025-2026.
- However, this is currently insufficient in the current configuration of commissioned and delivered services, due to the current **£25.4m overspend**. There has been recurring overspends over many years.
- This current overspend exists without taking into account the existing level of unmet need or the further expected increase in demand in coming years.
- The Partnership's adult social care projected out-turn for 2025-26 as at the end of January 2026 is expected to be **£211.8m**.
- This expenditure reflects the following composition[6]:
  - In-house spend = **£60.8m**, 28.7% of overall spend
  - Commissioned spend = **£144.3m**, 68.13% of overall spend

[6] Internal costs account for the 3.17% / £6.7m difference.

Expenditure is directed into the following activity areas as noted:





- The current projected full year overspend is £25.4m, as at the last reported period.
- In order to meet the increasing future needs, the approach to the type of services commissioned, and the way these are secured and delivered, needs to fundamentally change.
- The opening financial envelope for 2026-2027, before any agreed uplifts, is £190.8m, with the financial gap of £26m carried over from 2025-2026.
- In terms of the financial future for the period of this Commissioning Strategy and Intentions, the Partnership is planning on the basis of continued annual uplifts aligned to previous allocations.
- To deliver within the available financial envelope, significant change and transformation is required in order to achieve a balanced budget.
- We describe in section 7 of this document the changes and transformational actions we need to take.

Workforce

- The adult social care sector in Highland is challenged to recruit and retain a sufficient number of paid carer workforce to meet demand. This is a picture common across the country but is exacerbated in Highland's context.
- Workforce availability is impacted by a combination of factors: geography, demographics, low unemployment, competition from other employment sectors, particularly hospitality and tourism across parts of Highland and other growing sectors (e.g. Greenport).
- Availability is also significantly impacted by pay and conditions, lack of recognition, the value that society places on these roles, ongoing negative media coverage, and access to transport.
- There has been an increasing reliance on overseas recruitment, which is a slow and expensive process, time consuming and requires available accommodation and additional support for international staff to settle, learn cultural differences in delivering care, and integrate into a foreign country. The government policy changes around this area have made this workforce route more challenging and in some cases, this is now not an available avenue.
- There has been recent activity in relation to "displaced workers", these being international workers already in the UK but who are in areas where there is an insufficient volume of work. This is a potential source of workforce to Highland, but can only be successfully accessed where there is availablity of housing.
- This is a challenging context in which to attract and retain a workforce to develop and flourish in this demanding and immensely rewarding role, and highlights both the need to collaborate on strategic solutions and to also ensure genuine alternatives are promoted.

Market

- The Partnership works with a diverse range of providers across the independent, third, voluntary, and community sectors. Throughout this document, where we reference "independent sector", we are referring to this wider collective range of provision (independent, third, voluntary and community sectors), unless otherwise specified.
- The market includes registered services (care home, care at home, support, and day care) and unregistered services (delivering community based preventative and wellbeing supports), in addition to the wider range of flexible options (Options 1 and 2) that we have been promoting over recent years.
- All of these services combined are integral parts of the social care ecosystem.
- The providers of these services vary significantly in scale from large national organisations to small local organisations and social enterprises that play a critical role in preventing or delaying the need for formal care packages and sustaining services in remote communities.
- As part of this mixed economy, NHS Highland is also a provider of registered services, delivering care home, care at home, support, and day care.

- Currently, 14.5% of overall activity is delivered in-house by NHS Highland and 85.5% is externally commissioned and we are looking to further rebalance this, to deliver less in-house provision.
- These in house delivered services are provided across Highland, mainly in areas where independent sector providers find it most challenging to deliver viable and sustainable services. In addressing this, we are looking at realistic alternative options in our most challenging geographies.
- Independent sector commissioned services include mainstream provision as well as more specialist delivery for people with more complex requirements, delivered either in care home facilities or directly within a person's own home environment.
- NHS Highland in house services have a higher unit cost than those secured externally, but those externally commissioned services have also been experiencing financial viability challenges. This has led to a number of service closures and exits, which in the main have required substantial support and input from the Partnership.
- There has been instability across both sectors – care home and care at home closures and exits within the independent sector as well as the closure of some in -house care homes (some permanently closed, some temporarily) also due to acute staffing shortages.
- Across all services, regardless of sector, the challenges presented by an insufficient volume of trained and experienced staff have a destabilising impact on service delivery and sustainability.
- Ultimately, high quality care and support is delivered by trained, experienced, and valued staff; and we need to find new and innovative ways to turn around the reduction in this most valuable of our resources.
- Given the above, the Partnership has supported people to explore what other options exist to find the care and support they need.
- People have successfully been offered budgets to identify support and care themselves (this is often via employing a Personal Assistant where they can be found), and resources are increasingly being used flexibly to create more individualised arrangements with a broader range of services and products which meet their needs.

Summary

- Our challenges are summarised as:





7 Change and Transformation

The extent of challenge we face requires us to make significant changes and bold transformation.

- Our overarching approach is to develop a **Highland Care Model** through fundamental shifts to the way we practice and to the shape of services people can access.
- The aim will be for:
  - our practice to conform to a **Community Led Support ethos** which places good conversations and creative care planning at the heart of our relationships with people who need support; and
  - a profile of services which fully reflects the 4 Self Directed Support (SDS) Options to ensure supported people have **greater choice, flexibility and control** over the care available to them.
- Taken together, this new Highland Care Model will aim to deliver social care that is:
  - Person-centred and rights-based
  - Locality-led and place-based
  - Integrated and multidisciplinary
  - Preventative and proactive with a reablement focus
  - Digitally enabled and data-informed
  - Co-produced with communities
- The intention is to develop **Local Care Models** – which pulls the different parts of the system together behind a common purpose.
- The main aim of creating Local Care Models is to help those people who need support to receive a **constructive, realistic, and co-ordinated response** to meeting their needs.
- It is a way of working that focuses on early **intervention, reablement, maximising access to information, informal support, natural relationships, and community activities**.
- Where formal support is needed, it envisages our community partners working hand-in-hand with professionals from Integrated District Teams to identify which of the four SDS options will offer the most realistic, tangible, and timely help.

We have a clear forward direction of travel, which is illustrated here[7] :



- To support this directional change, we have identified the changes we need to make that will support our priority of keeping people living independently at home for longer. These are focussed around the following areas:

Care pathway redesign

- Care pathways will be modernised to **promote independence and reablement and to reduce reliance on institutional models**.
- We will **prioritise** those who most need our services across all options, with a focus on **critical** needs.
- People will have **access to commissioned regulated care services**, where they are unable to look after themselves or get that **support from their natural supports** in the community. We will ensure that there is a clear understanding and definition of what is expected of people looking after themselves, using their 'natural supports', resources, and the local community resources.

[7] Credit: iHUB / East Ayrshire

Alternative delivery models

- We will encourage and promote a range of **alternative and new delivery options**.
- We will specifically support the development of **Local Care Models**.
- Communities and third sector organisations will be supported to **develop innovative solutions** to support people in their communities, through Option 2 Brokerage and Community Brokerage.
- Our **investment** will be directed towards the most efficient and effective services and we will **disinvest** in traditional and less efficient and effective adult social care services, transitioning to provision being delivered by other options or providers where those options are available.

Service rebalancing

- The delivery landscape will be **restructured to maximise efficiency** and ensure that in-house and independent provision are used to their strengths.
- We will rebalance and **shift towards supporting more people at home** than in residential settings.

Prevention promotion

- We will enable people and communities to take the actions which support their own wellbeing through:
- **Self-care and early intervention** – we will work with communities and organisations to enable the co-creation and development of local options that help people to look after themselves and live in their home for as long as possible.
- **Supporting self-access and management** - we will provide accessible high-quality services that give advice and help people to find local sources of the help that they need. We will make it easy for people to find out what options are available in their locality and how to access them.

Technology transformation

- We will **scale up** use of technology to support **delivery efficiency** and **self care**. Our approach to care will be to **enhance technology**, including digital skills training for workers and better data management.
- Specifically, we will

  - Expand and modernise telecare
  - Adopt a digital first approach to care
  - Reduce reliance on face-to-face care
  - Promote data-driven and proactive care
  - Scale remote monitoring and pathways
  - Enable digital access and virtual services
  - Strengthen infrastructure and national alignment
  - Optimise systems and delivery models

Workforce transformation

- We will adopt a collaborative and strategic approach to **attract, retain, and value the workforce** including investing in domestic talent and creating career progression pathways and professional supports for people in caring roles.
- We recognise and support developing and structuring the care system so that all those willing to care for others are **valued, recognised equally, and supported**.
- We will **support carers' terms and conditions** to meet a consistent minimum standard, which recognises the value of their role supported by following 'Fair Work First' principles.

- As part of our intention of delivering on our ambition and to achieve a balanced budget, we need to rebalance our current spend areas.
- The specific rebalancing intentions we will be progressing are:

Prioritisation

Reduce the number of people with unmet assessed critical care needs

Care Options

Increase the combined number of people actively using Options 1s and 2s
Reduce the number of people actively using current Option 3 services

Care Setting

Increase the number of people supported to live at home
Reduce the number of people supported in residential based settings

Delivery Provider / Sector

Increase the ratio of service activity commissioned from independent providers and alternative community solutions
Reduce the footprint of provision delivered in-house by NHS Highland

8 Commissioning Actions and Intentions

- The Partnership is focussed on meeting individual needs and delivering personalised care.
- Our commissioning approach however is most effectively conducted by distinguishing the service to be delivered.
- Our commissioning intentions for people are therefore centred around services and the range of options and choice that we can facilitate.
- Our identified priority service areas are summarised below:

Care homes

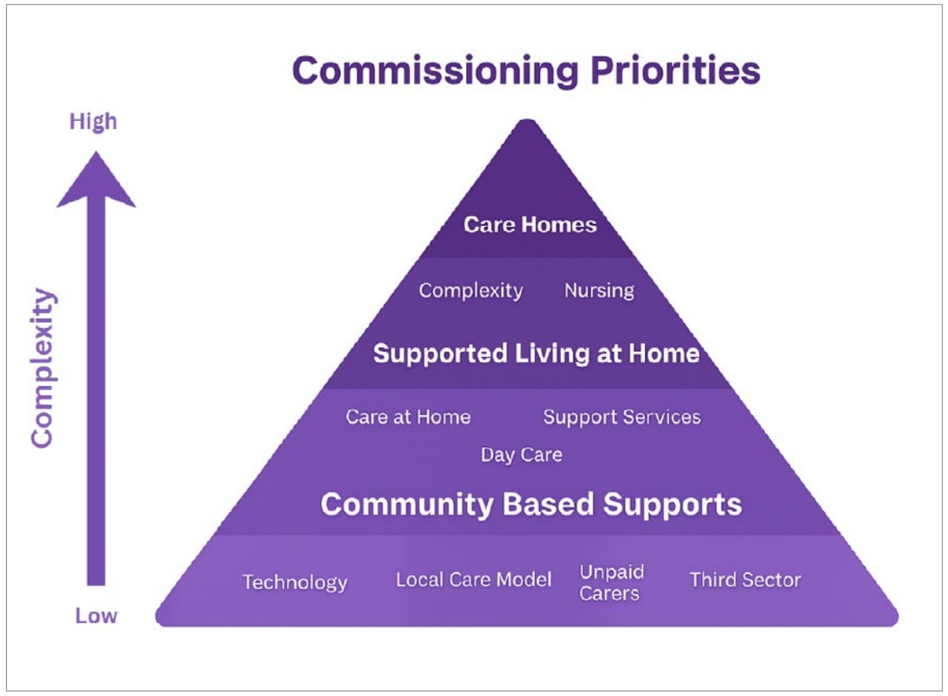
- Complexity
- Nursing

Supported living at home

- Care at home
- Support services
- Day care

Community based supports

- Local care model
- Personal assistants
- Unpaid carers
- Technology
- Third sector / prevention promotion



- To support the change and transformation areas that we have identified for the services we wish to commission, we have developed a **clear and simplified strategic approach** with **clearly defined actions** for each priority service area, covering:
  - Profile / analysis
  - What we have done
  - Strategy and intentions: what we plan to do
  - Investment and shifting of resources.
  - Year 1, 2, 3 priorities and longer term horizon.
- These are provided at **Appendix 1** and a consolidated summary of these actions are at **Appendix 2**.
- The strategic direction and intentions for each of our priority service areas set out a demanding and ambitious programme for the next 3 years.
- Some of the areas we are proposing to embark upon will involve significant organisational change, cultural change, as well as long term procurement projects.
- We recognise and acknowledge the scale and effort that some of these changes will require and we are committed to delivering the level of transformation we know is required.

9 Governance

- This commissioning strategy and intentions document with defined commissioning actions, describes our focus and actions and as referenced above, will be supported by a number of implementation plans which articulate the greater granular detail of our delivery steps.
- It is intended that this strategic document and its supporting plans will be live documents, with governance for delivery via the following routes:

Group	Role
Commissioning Delivery Group	Development and operational progress
Strategic Planning Group	Collaboration and engagement
Joint Officer Group	Oversight
Joint Monitoring Committee	Oversight / Approval
Health and Social Care Committee	Assurance

- It is further intended that this document will serve as a collaborative working document, reviewed on an annual basis and aligned to the periods of the overarching JSP.

10 Conclusion and Next Steps

- This commissioning strategy and intentions document has described what services we need to commission to respond to the current and expected policy, operating and financial context, and has provided a road map for these intentions over the next 3 years.
- The summary **Appendix 2** provides a clear, consolidated, and prioritised overview of these actions across all areas of commissioning activity.
- There are wider actions and environmental conditions which are necessary in order to support the success of this commissioning strategy and intentions and having described the strategic commissioning approach and intent, the following now therefore needs to progress:
  - develop the granular detail required to describe what we need, where, and how much we can afford within the available financial envelope, using our developed Planning Support Tool
  - resource and implement the actions, within a clear governance framework and linked to the Adult Social Care cost containment plan arrangements
  - develop the following enabling plans:

Market facilitation plan
Actions and timescales for how we intend to stimulate a diverse, vibrant and sustainable market, so there are different types of support and provider organisations for supported people to choose from.

Procurement plan
Actions and timescales for how we intend to progress the identified procurement activity and delivery.

Workforce plan
Actions and timescales for how we intend to create and support the future workforce needed to deliver the required services in Highland.



Highland HSCP | **Adult Social Care** Commissioning Strategy and Intentions 2026-2029 Final Draft

APPENDIX

Appendix 1:

Service Area Commissioning Actions

Care Homes – Complexity and Nursing 35
Supported Living at Home - Care at Home 37
Supported Living at Home - Support at Home 39
Community Based Supports - Day Care 41
Community Based Supports - Highland Care Model 43
Community Based Supports - Personal Assistants (PAs) 45
Community Based Supports - Unpaid Carers 47
Community Based Supports - Technology 49
Community Based Supports – Third Sector / Prevention Promotion 50

Appendix 2:

Commissioning Strategy, Intentions and Plan Summary 51

Appendix 3:

Key Terms 53

Appendix 1:
Service Area Commissioning Actions

Care Homes – Complexity and Nursing

Profile / Analysis

Total
- 1894 care home beds (86% independent sector and 14% in-house).
- 62 care homes (16 in house and 46 independent sector).

Older Adults
- £61.5m spend (£23.5m in house and £38m IS).
- 29% of these beds are self funding.

Younger Adults
- Independent sector: £12.8m (gross), 190 beds, 11 providers (plus 9 OOA providers)
- 16 people placed out of area in care homes
- 9 out of area in care home placement >£100k pa each

General
- High in house unit costs. NCHC insufficient for small scale delivery.
- 6 IS care home closures since 2022. 3 NHSH acquisitions since 2020.
- Ongoing significant recruitment issues impacting delivery and viability.
- Various in house care homes temporarily closed due to staffing – pressure ongoing.
- Ongoing high level of DHDs.
- 203 beds lost since 2022. 58 new beds on stream. 26 further new beds anticipated in next 2 years. Current net loss of 119 beds.
- Ageing stock in house and internal.
- High level of small providers with succession planning risk to NHSH.

What We Have Done

- Responded to arising provider viability issues.
- Acquired 3 care homes to avert closure, at significant ongoing cost.
- Raised political profile of need for an alternative funded NCHC in Highland.
- Taken steps to maximise internal occupancy.
- Ongoing supportive provider engagement.
- Progressing dialogue on wider system and interface issues.
- Created Care Home Career and Attraction post hosted by Scottish Care to support sector recruitment. Ongoing Independent Sector Liaison role to support sector relationship and partnership.

What We Plan To Do

Strategy

- Restructure the delivery landscape to maximise efficiency and ensure in-house and independent sector provision are used to their strengths.
- Reprofile in house provision to focus on people with the most complex needs (older adults).
- Independent sector continue to deliver majority of care home provision but within stronger commissioning framework that links fee uplifts to sustainability, quality, and dependency management.
- Quantify locality commissioning volumes of care home provision.
- Reduce reliance on residential care.
- Support seamless transitions from inpatient settings to person centred specialist residential based care for hospital based complex care patients.
- Expand family-based alternatives to residential care for adults with learning disabilities and mental health needs.
- Leverage the Transformation Fund to scale Shared Lives schemes, promoting community inclusion and supporting reducing reliance on residential care

Investment

- Ongoing commissioning from sustainable IS care homes – sustain and maintain.
- Continue to secure complex service from IS provision.
- Reprofile in-house delivery from mainstream to also complex care, as opportunities arise.

Shifting of Resources (Disinvestment)

- Reduce level of overall residential beds (and increase c@h capacity / personal care capacity and personal assistants).
- Disinvest from in-house mainstream provision and consider forward flexible use of buildings.
- Unviable services (in-house and independent sector).

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities

Year 1 (2026-2027)
- Initiate longevity profile assessment of in-house and commissioned facilities.
- Define preferred models, locations and volumes of care home provision.
- Consider complex needs transitional plan (in-house).
- Develop new commissioning framework (sustainability, quality, dependency), including plans for addressing any further closures.
- Third party top up analysis and impact assessment.
- Define locality commissioning volumes in place.

Year 2 (2027-2028)
- Implement new commissioning framework.
- Longevity assessment to inform longer term replacement plan within a long term care home strategy.
- Implement complex needs transitional plan.
- Shift commissioning focus to nursing provision.

Year 3 (2028-2029)
- Prioritise replacement locations and initiate.

Longer Term

- Facilities fit for the future - replacement / commissioning programme over next 5-10 years.
- Sustained provider base - provider succession plan for next 5-10 years.

Supported Living at Home - Care at Home

Profile / Analysis

- 9,200 hours pw mainstream c@h (4,000 in-house / 5,200 independent sector).
- £35.4m pa spend (£19.7m in house and £15.7m IS).
- 383 hours pw of reablement / enablement delivered to 57 people.
- Emergency Responder Service in place in the Inverness area
- 16 providers (in-house and 15 independent sector) – total of 24 registered services
- High (double) in-house unit costs (£73 v £30 ph). C@H tariff does not sustain provision or enable growth.
- Highest level of commissioned service tariff in Scotland – but insufficient to ensure stability or growth.
- Ongoing significant recruitment issues impacting delivery and viability.
- Reliance on international workforce and pay parity issues (£12.82 v £12.60)
- Ongoing high level of DHDs
- Loss of 600 IS hours pw since March 2023.
- Commissioning reliance on a range of providers – 4 providers have over 50% of activity. Some very small provision.
- 6 c@h provider exits since 2023. Significant volume to NHSH.
- Ongoing sector fragility at current tariff.
- NHSH currently has a dual role – as a provider and also commissioner of services from the independent sector

What We Have Done

In-House

- Supported exits and picked up exit activity where IS unable to deliver.
- Building and maintaining effective commissioning relationships.
- Ongoing delivery of mainstream, enablement and reablement.
- Overall delivered hours activity levels reasonably flat.
- Work to focus on clarifying c@h pathway.
- Delivery of "last aid care" to care homes and c@h providers.
- Internal provider delivery actions, focussing on:
  - Standardisation improvement, consistency of approach and QA.
  - Localised in-house model established with registered C@H teams
  - Standardised use of CM2000 to support consistency of C@H systems
  - Better visibility regarding travel time, care planning and visit durations etc
  - Increased recruitment visibility and strengthened career pathways.
  - More proactive outreach to potential candidates.
  - Robust induction process for care staff and managers and L&D plan

Commissioner / Independent Sector

- Sector agreed commissioning principles and proposals (January 2024)
- Tariff review (option 3b)
- Internal case made for further tariff increase for sector stabilisation
- Ongoing dialogue regarding interface issues which remain unresolved
- Independent Sector Liaison role to support sector relationship and partnership.
- Some work on clarifying commissioning processes, further progress needed

What We Plan To Do

Strategy

- Restructure and rebalance the delivery landscape to maximise efficiency and ensure that in-house and independent provision are used to their strengths
- Expand independent sector c@h through outcome-based contracts, reflecting lower (than in-house) unit costs and supporting sector sustainability.
- Retain in-house c@h as a strategic rebalancing mechanism, ensuring resilience in fragile rural areas and acting as provider of last resort. Reposition to focus on reablement.
- Clarify commissioner and service provider roles to improve relationships and effectiveness.
- Increase and grow capacity by improving the efficiency of processes and increasing provider autonomy.
- Manage demand by reviewing eligibility thresholds for accessing c@h activity.
- Set locality activity and budget thresholds for c@h activity for commissioned and delivered provision.
- Provide user-friendly, straightforward, equitable access to SDS options 1 and 2 to increase confidence and uptake.
- Work with partners to grow and sustain the available workforce.

Investment

- Early intervention, prevention and reablement.
- Independent sector delivery footprint, tariff levels / unit costs.
- In house delivery in remaining defined, geographic areas.
- Technology to support processes and grow c@h capacity.
- End of life c@h focus and training
- Attract, retain and develop the workforce.
- Relationship management and commissioning process and culture change.

Shifting of Resources (Disinvestment)

- In house delivery to move away from areas where the IS can deliver.

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities

Year 1 (2026-2027)

- Establish the necessary resources to support the required programme of activity.
- Develop plan to reposition in-house provision for reablement focus.
- Identify and confirm geographic delivery focus and develop a transition plan, (including consideration of NHSH staff resource) coproduced with sector.
- Develop an appropriate independent sector rate and outcome based contract - agree and implement.
- Identify and implement improved supporting processes.
- Identify and operate locality activity thresholds.
- Co-produce and implement a plan for growing and sustaining the workforce.
- Identify, scope and pilot supporting digital solutions to improve processes and enable increased service capacity eg (electronic commissioning, Care Technologists, Alexa-style digital technology etc)
- C@h commissioning role delineation and training.
- Develop provider of last resort response.
- Increase availability of end of life training.

Year 2 (2027-2028)

- Progress transition plan for agreed geographic areas; initiate procurement if required.
- Continue to work towards an equal partnership in care provision.
- c@h commissioning arrangements implemented to sustain and maintain.
- Continue to implement workforce actions (recruitment and attraction).
- Progress supporting digital solutions.
- Services operating to thresholds.

Year 3 (2028-2029)

- Continue to support transition plan to embed.
- Implement outcome of procurement if needed.
- Continue to support workforce development.

Longer Term

- Further digital commissioning solutions.
- Market profile and single operator delivery risk / succession planning.
- Continue to proactively develop technological supports to meet demand and optimise the available workforce.

Supported Living at Home - Support at Home

Profile / Analysis

- Independent sector: £33.1m pa: 1,112 people, 25 providers / 54 registered services
- In-house: £5.4m, 6 registered support / day care services
- 190 support at home packages >£100k pa
- Relatively stable IS service delivery
- Significant spend and reliance on providers who deliver MH and LD services and who meet complex needs.
- Increasing demands for services including those with complex support needs
- Ongoing recruitment issues - a number of providers are dependent on overseas recruitment.

What We Have Done

- Implementation of Dynamic Support Register to optimise resource
- Scrutiny of 2:1 support and overnight support
- Moving away from isolated individual packages
- High tariff cases brought back into area
- Steps towards growing existing market, through PCS framework
- Finance authorisation framework (awaiting implementation)
- Explored opportunities for Technology-Enabled Care e.g. Vocala

What We Plan To Do

Strategy

FROM THE FINANCIAL PLAN:

Shared Lives:
Expansion of family-based alternatives to residential care for adults with learning disabilities and mental health needs, supported through the Transformation Fund.
Learning Disabilities:
Services will re-orient towards independence, skills development, and employment, with greater use of Self-Directed Support (SDS) and local micro-enterprises.
Specialist Support:
Use of the Dynamic Support Register and targeted housing solutions to return individuals from high-cost out-of-area placements, reducing spend and improving outcomes.
Housing-with-Support & Reablement:
Transformation Fund investment would support expansion of housing-with-support models and reablement pathways, reducing future reliance on long-term care.

Our commissioning approach will **prioritise independence, inclusion, and sustainability**, ensuring that support at home services are person centred and outcome focussed as well as equitable and financially stable. Our priorities are to:

- Expand capacity to meet current, future and increasingly complex support at home needs.
- Re-orient services towards independence, skills development, and employment through increasing the uptake of Self-Directed Support (SDS) and foster local micro-enterprises to diversify provision and empower choice.
- Embed proactive planning for out of area placements by leveraging the Dynamic Support Register and targeted housing solutions to enable timely access to supported living and community-based support, improving outcomes and ensuring financial sustainability.
- Align with The Highland Council's strategic housing plan to ensure timely development of housing with support models reducing reliance on long-term care.
- Explore appropriate models of blended supported living and community-based support to promote sustainability and resilience.
- Implement a comprehensive governance and financial authorisation framework, establishing a clear framework for 1:1 and 2:1 support and overnight care to ensure consistency and financial efficiency.
- Conduct a comprehensive review of community-based support models and expand access to community-based support to reduce reliance on high-cost care-at-home packages, enhancing social inclusion and outcomes.

Investment

- Independent provider cluster housing models with co-located community-based support services
- Shared care for people in supported living
- Expanded access to community-based support services.

Shifting of Resources (Disinvestment)

- Individual / isolated tenancies with 2:1 / individual overnights
- Out of area placements for people with complex needs.

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities

Year 1 (2026-2027)
- Extend Dynamic Support Register (DSR) to adult mental health and hospital based complex care
- Review of high-cost supported living and community support packages – seek better solutions for complex needs
- Input into THC Strategic Housing Plan and ongoing dialogue for ASC housing units.
- Comprehensive review of community support provision.
- Shared Care procurement and implementation.

Year 2 (2027-2028)
- Begin repatriation planning for returning out of area placements
- Standardise community support provision
- Shared care delivery and review.

Year 3 (2028-2029)
- Implement new commissioning and funding models
- Enable timely transitions from hospital-based complex care and out of area placements into local supported living solutions that deliver person-centred outcomes and financial sustainability.

Longer Term

- To develop and implement integrated models that supported living and community-based support services—creating inclusive, sustainable communities that enhance resilience, improve population health, and deliver cost-effective care across the system.

Community Based Supports - Day Care

Profile / Analysis

Older Adults
- 15 providers (5 in-house and 10 independent sector)
- 289 total capacity of places (134 in-house and 155 independent sector)
- £3.7m pa spend (£1.9m in house and £1.6m IS).
- High in-house unit costs v £8.63 per hour (average) for independent sector.
- Ongoing significant recruitment issues impacting delivery and viability.
- Issues with eligibility criteria and alignment with demand.
- In-house provision:
  - **Occupancy:** Attendance varies between 38% and 89%.
  - **Geography:** 80% delivered in Highland's smaller communities.
  - **Challenges:** Staffing fragility, transport to support utilisation of the service.
- Independent sector provision:
  - Varying size of provider from small local charitable organisation to national charities.
  - Occupancy: attendance varies from 50% to 91% occupancy.
  - Geography: 50% of provision is delivered in Highland's more remote areas - and all by charitable organisations.
  - Challenges: sustainable delivery of services.

Younger Adults
- Independent sector: £5.5m

What We Have Done

- Maintained existing provision and commissioned activity.
- Identified the need for consistency of approach within delivered services.
- Acknowledged the need to review this area of activity and develop a consensus forward direction.

What We Plan To Do

Strategy

Older Adults:
- To continue to promote and support day services alongside other prevention focussed services to support people to live independently at home within their community.
- Day services will be increasingly delivered by third sector and independent providers, with in-house resource focused on statutory and complex needs.

Younger Adults:
- Re-orient services towards independence, skills development, and employment through increasing the uptake of Self-Directed Support (SDS) and foster local micro-enterprises to diversify provision and empower choice.
- Conduct a comprehensive review of community-based support models and expand access to community-based support to reduce reliance on high-cost care-at-home packages, enhancing social inclusion and outcomes.

Investment

- Increase in mainstream day care delivered by independent (and third) sector providers.

Shifting of Resources (Disinvestment)

- Delivery of in-house mainstream day care to move to a more complex needs focus.

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities		Longer Term
Year 1 (2026-2027) • Review current provision, future needs and develop a forward direction.	**Year 2 (2027-2028)** • Transition to the identified direction. **Year 3 (2028-2029)** • Reprofiled services in place.	• Longer term approach and actions to be informed by the planned review.

Community Based Supports - Highland Care Model

Profile / Analysis

- Reductions in Option 3 services mean locality need (including eligible need) is no longer able to be met by traditional statutory provision.
- This gap is most acute in remote and rural geographies.
- Increasing demand and complexity are exacerbating the issue.
- Infrastructure is not in place to fully support all SDS Options therefore flexibility, choice and control is more limited.
- Professional practice is characterised as supporting the operation of the traditional Community Care system (purchaser/provider split)
- Local place-based supports and, with that, place-based commissioning is required to develop relevant/ appropriate/sustainable support solutions in localities.
- Preventative supports also need to be fully utilised to help manage demand.
- Support for Community Hubs and Community Organisations is recognised as important in that they offer the potential to:
  - Provide a range of activities to promote well-being and prevent the need for provision of formal SDS budgets;
  - Act as a site of multi-agency help and advice to signpost across whole system of support in line with Community Led Support;
  - Act as a site for integrating community and statutory effort (complementary and collaborative locality care planning)
  - Develop into a range of locally based formal provision (i.e. Hubs+; Social Enterprises; Option 2 Brokerage etc); and
  - Realise the Community Brokerage and Independent Support roles locally
- Development work will be required to ensure statutory partners can adapt successfully to working in different ways.
- Promotion of worker autonomy will be required to move away from traditional patterns of working.

What We Have Done

- Engaged with the community sector across specific geographies to explore their roles in respect of formal SDS and the promotion of wellbeing, notably:
  - Skye and Lochalsh
  - West Lochaber
  - Sutherland (Hubs)
- Supported the development of new approaches and initiatives alongside statutory partners in Strontian/Acharacle.
- Undertaken supported self-evaluation exercise with staff and formal partners to explore the need for system improvements.
- Secured transformational resource aimed at developing a new Highland Care Model, including:
  - Increased levels of Independent Support and Community Brokerage to support locality change efforts;
  - A purchased CLS initiative to support change in identified areas
  - A transformational resource to trial new approaches/ initiatives
  - Financial support to existing Community Hubs to ensure their ability to participate in change.

What We Plan To Do

Strategy

- **Development of community hubs and neighbourhood models** (aligned with NDTi Community Led Support), creating local spaces where health, care, and third-sector organisations collaborate to provide early help and support and reduce demand on statutory services.
- **Local innovation funds, backed by the Transformation Fund**, will support community micro-providers, carers' networks, and third-sector partners to scale community-led support and develop local care models.
- The development of community led local care models and preventative approaches will require:
  - Support for Community Hubs and Community Organisations
  - Appropriate levels of locally available Independent Support and Community Brokerage
  - Developing relationships across the system and collaborative working across the range of Highland geographies
  - Exploring/Trialling new and innovative ways of place-based, community-led working
  - Commissioning local, placed-based initiatives and services
  - Resourcing small scale transformational projects to understand what might work at a local level
  - Providing developmental support to ensure partners can work in new and flexible patterns reflecting the need for co-production across the system of social care and beyond.
  - Resourcing successful initiatives and approaches which can evidence positive impact in terms of increased wellbeing and a reduction in the demand for formal SDS
  - Facilitating supported people to have full choice, flexibility and control to deploy their resources (including but not limited to SDS Budgets) in local care markets (see separate template on Personal Assistants)

Investment

- Learning and development input to help develop new practice approaches across system
- Support for co-working and co-production at a local level, including the space to develop new working relationships.
- Support the infrastructure necessary for the formation of new public-facing networks offering information, advice and assistance
- Support to Community Hubs and Organisations to continue with impactful initiatives and services which:
  - Complement (or provide) care at home / day service capacity
  - Support SDS implementation across localities
  - Promote wellbeing and act preventatively
  - Allow local citizens more routes to self –management and independence
  - Increases social enterprise and community fabric

Shifting of Resources (Disinvestment)

- Traditional Option 3 service provision is shrinking at current rates.
- Rates cannot be increased without further compromising our financial position and/or acting outside agreed arrangements (NCHC etc.)
- In-house provision is delivered at particularly high cost
- Opportunities to rebalance the system of ASC to lower-cost alternatives need to be taken as they arise
- The development of lower-cost alternatives needs to be explored as we co-produce Local Care Models.
- Rebalancing our dependence on Option 3 provision may be realised by:
  - Supporting the creation of more Personal Assistant relationships
  - Brokering more SEPA (Self Employed Personal Assistant) relationships
  - Investing in complementary community effort to reduce overall reliance on Option 3 provision (Hubs+ etc.)
  - Replacing personal care provision with other, ancillary supports to unpaid carers etc
  - Supporting the creation of Social Enterprise in the field of ASC

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities

Year 1 (2026-2027)

- Develop a consolidated approach to developing a Community Led Support ethos to work across the system.
- Define a stepwise, locality-led implementation programme for the development of Highland Care Model
- Clarify the model and (if required) investment available for Option 2 brokerage service.
- Understand the resource available to support the mainstreaming of community-led activities which have evidenced they can:
  - Complement/substitute statutory provision
  - Increase wellbeing in community members

Year 2 (2027-2028)

- Secure greater levels of Option 2 Brokerage.
- Agree on Highland model for Independent Support and Community Brokerage based on experience of CLS initiative.
- Implement Highland Care Models across agreed geographies; including investing in impactful Community initiatives.

Year 3 (2028-2029)

- Procure Independent Support and Community Brokerage.
- Move toward full implementation of Highland Care Model across all geographies.

Longer Term

- Co-produce the establishment of ASC Social Enterprises in defined geographies which meet locality need and Registration and Regulation requirements
- Build on the combined operation of both Community and Option 2 Brokerage to develop a distinct route to commissioning of individualised support arrangements.
- Reduce the levels of centralised bureaucracy by ensuring autonomous social work practitioners can interact flexibly in community settings

Community Based Supports - Personal Assistants (PAs)

Profile / Analysis

- Reductions in Option 3 traditional services, related to:
  - Unit Costs and Rates
  - Staffing and staff dissatisfaction (particularly at C@H model)
- Increased offers of Options 1 and 2
- Good level of Personal Assistant recruitment given lack of investment to date.
- Increasing demand for Personal Assistants ongoing.
- Difficulty of translating individual budgets into Personal Assistants now being widely reported.
- Independent Support capacity fully utilised.
- Potential to recycle lost supply: workers transferring from C@H report significant satisfaction/ benefits of PA role.
- Some SEPAs (Self Employed Personal Assistants) / potential SEPAs report desire to collectivise.
- Many Supported People are not keen to take on PA employer role associated with Option 1.
- Currently significant organisational inflexibility around Option 2.
- Limited organisational support for responding to demand for training/ confidence building etc.

What We Have Done

- Increased rates payable to Option 1 PAEs.
- Sought to raise the profile of PA role:
  - Pop up events in a handful of localities
  - Online sessions
  - Links to Corporate and ASC recruitment efforts.
- Initiation of exploring how to increase Option 2 brokerage.
- Identified increased resource for Independent Support to support a three-year Local Care Model initiative.
- Promoted the role of Independent Support to District Professionals via the Highland SDS Strategy.
- Gathered information in respect of the training accessible to (and accessed by) PAs.
- Undertaking a review of NHSH SDS Policies and Procedures to ensure they are congruent with SDS Framework of Standards.

What We Plan To Do

Strategy

- Promote the PA role across Highland
- Promote the role of Independent Support to District Professional (see also Local Care Model)
- Increase available levels of Independent Support and Community Brokerage to facilitate the development of PA relationships at local level (across Options 1 and 2)
- Commission or develop a model of Option 2 Brokerage to ensure routes for supported people to access SEPAs are maximised at local levels.
- Facilitate a training plan to ensure confidence and competence can be developed across the PA workforce.
- Explore mechanisms to expand markets for the provision of Personal Assistants (websites, events, regular Hub activity).
- Explore local care models and preventative approaches including:
  - Development of community hubs and neighbourhood models;
  - Greater levels of Independent Support and Community Brokerage; and
  - Local innovation funds.
- Ensure SDS budgets can be used flexibly to create supply in personal assistants (including SEPAs)

Investment

- Commission or develop an Option 2 Brokerage Service.
- Invest in higher levels of Independent Support and Community Brokerage.
- Provide PA development and support.
- Support and develop CLS approaches to practice across the system.

Shifting of Resources (Disinvestment)

- Rebalance expenditure from reduced Option 3 market to be realised by:
  - Supporting the creation of more Personal Assistant relationships
  - Brokering more SEPA relationships
  - Investing in complementary community effort to reduce overall reliance on Option 3 provision (Hubs+ etc.)
  - Replacing personal care provision with other, ancillary supports to unpaid carers etc
  - Supporting the creation of Social Enterprise in the field of ASC

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities

Year 1 (2026-2027)

- Clarify the model and investment available for Option 2 brokerage service.
- Link developments into the CLS approach to practice.
- Facilitate new marketplaces.
- Provide dedicated input to recruit, support and develop PAs.
- Delegate greater levels of autonomy to statutory workforce.

Year 2 (2027-2028)

- Procure / support Option 2 Brokerage Service.
- Agree on Highland model for Independent Support and Community Brokerage. based on experience of CLS initiative.

Year 3 (2028-2029)

- Procure Independent Support and Community Brokerage capacity.

Longer Term

- Establish clear developmental/ support routes for Personal Assistants
- Monitor (research) the experience of Personal Assistants

Community Based Supports - Unpaid Carers

Profile / Analysis

- This commissioning activity includes all unpaid adult carers including those who care for children in the Partnership area and includes the following:
  - One singular Carers Centre servicing the whole Partnership area.
    - 4 x under £50k Third Sector Funded projects.
    - 1 x Advocacy Service.
    - 1 x SDS Support Service (1-year funded 2025/26).
    - 1 x Localised Carer Support Service – Lochaber.
    - 1 x Digital Partner.
    - Carers Wellbeing Fund - £600k per annum.

What We Have Done

- One year funding for increased SDS information.
- Tender for under £50k projects for a 3 year period ending 31/03/28.
- Commenced work on service specification for a Carers Centre.
- Developed a contract for both the Carers Centre and Digital Partner

What We Plan To Do

Strategy

- Align with the Scottish Government's Carers Strategy and local priorities.
- Focus on preventative support to reduce crisis interventions.
- Integrate carer support across health and social care pathways.
- Restructure the delivery of Carer Support, ensuring support is meaningful and locally available.
- Restructure of the current delivery model for those carers who are categorised as having a Substantial or Critical need.
- Ensure equitable access across Highland, including rural and remote areas.
- Support the four strategic pillars of the NHS Highland Carers Strategy: Identify, Inform, Involve, Support.

Investment

- Expansion of localised carer support services in under served areas (e.g. Caithness, Sutherland, Skye)
- Investment in community-based respite and wellbeing initiatives aligned with the Carers Wellbeing Fund.
- Increase available replacement care options (eg care home and home-based respite).
- Increased investment in meaningful carer support.

Shifting of Resources (Disinvestment)

- Reduction in investment to centralised support models delivered remotely – moving to a digital option would achieve in the region of £260k pa.
- Review and reallocate funding from underutilised duplicated services: approx. £150k pa in smaller projects that are reaching < 50 unpaid carers pa.
- Reduction or withdrawal from smaller initiatives that have not demonstrated measurable impact in relation to financial input. approx. £150k pa. in smaller projects that are supporting < 50 unpaid carers pa.

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities

Year 1 (2026-2027)

- Commence design of a service specification for a carers centre.
- Continue to co-design with stakeholders to ensure commissioned services are appropriately available in local areas.
- Develop a commissioning framework for Home Based Respite providers.

Year 2 (2027-2028)

- Implement the commissioning framework for Home Based Respite providers and attract provision in rural and remote areas
- Undertake tender process for a carers centre and digital partner.

Year 3 (2028-2029)

- Ascertain impact of smaller initiatives to ascertain continued / future funding
- Assurance of service provision in all areas of Highland, with sustainable access to short break provision.

Longer Term

- Widen the framework to include more respite options.
- Framework design and implementation for Shared Lives as a viable short break option.

Community Based Supports - Technology

Profile / Analysis

- Promotion and provision of technology to support independence at home.

What We Have Done

- Temporary funding secured for tests of change in 3 sites to support the development of a TEC First Framework to optimise utilisation throughout the persons pathway – at first point of contact, while at home and waiting for full assessment, while receiving care and to support discharge
- ASC Transformation Programme is conducting a minimum 6 months proof-of-concept of Vocala Alexa-style technology with up to 50 adults with learning disabilities.
- Further TEC opportunities being explored for support from the Transformation Fund.

What We Plan To Do

Strategy

- **Scale up TEC across Highland**: falls prevention, digital monitoring, medication management, and scheduling — reducing double-up care and improving efficiency.
- **Increase use of TEC**: at all points of the persons care pathway, maintaining independence as close to home as possible and reducing reliance on provided care.
- **Expand and modernise telecare**: increase the range of telecare devices and digital solutions available; identify and introduce new technologies aligned to care needs
- **Digital First approach to care**: (subject to successful proof of concepts) embed digital first assessment in care planning; use TEC as the first step before face-to-face care, enable right-sizing of care packages and reduce over-prescription
- **Reduce reliance on face-to-face care**: (subject to successful proof of concepts) substitute appropriate elements of care with virtual and remote support; promote preventative and responsive digital interventions; increase independence while reducing care hours where safe
- **Data-driven and proactive TEC care**: use TEC for monitoring activities of daily living, supporting early intervention and preventative care; enable data-led decision making and care planning
- **Improve knowledge and uptake of digital care technology solutions**: continue to provide TEC support to Integrated Teams, Care at Home and Commissioned Care at Home Services to increase knowledge and uptake of digital care technology solutions.

Investment

- To be informed by tests of change.

Shifting of Resources (Disinvestment)

- Expected to come from reduced care hours required, care at home budget.
- Shift funding from legacy provision into modern digital solutions

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities

Year 1 (2026-2027)
- Complete tests of change, analyse and plan roll out of successful areas.

Year 2 (2027-2028)
- Continued roll out and embedding of change.

Year 3 (2028-2029)
- Ongoing review of use of TEC and new technologies developing.

Longer Term

Community Based Supports – Third Sector / Prevention Promotion

Profile / Analysis

- NHSH spends £5m pa on 53 third sector services.
- The focus and nature of these services include prevention, health and wellbeing, sensory services, advocacy, befriending, community transport and broader community support activity.
- 17 arrangements through grant funding of £631k from a bidding process and the remainder are under service contracts.
- 8 services are health and wellbeing hubs, in receipt of around £520k pa.
- Many arrangements extended year to year and are overdue a full review.

What We Have Done

- Established a Third Sector Oversight Group to oversee this area of activity.
- Identified required procurements for advocacy and carer services, which will be part of our procurement plan.
- Ongoing process for under £50k and over £50k arrangements.
- Engaged with hub development, alignment and service reshaping.
- Conducted an internal audit report of oversight around third sector activity – resulting in a management action plan to strengthen support around this area.

What We Plan To Do

Strategy

- Extend focus on the availability of prevention, early intervention and community supports to enable people to remain living independently at home for as long as possible.
- Explore place-based commissioning to seek to ensure that we have a balanced system of services and that we invest in the capacity necessary to deliver preventative supports and the 4 SDS Options.

From the Financial Plan:
- Development of community hubs and neighbourhood models (aligned with NDTi Community Led Support), creating local spaces where health, care, and third-sector organisations collaborate to provide early help and support and reduce demand on statutory services.
- Small grant schemes and innovation funds for carers and community groups to deliver localised support, respite, and preventative activities.
- Local innovation funds, backed by the Transformation Fund, will support community micro-providers, carers' networks, and third-sector partners to scale community-led support and develop local care models.

Investment

- Where possible, deploy available budget to mainstream third sector activity within coherent and co-ordinated Local Care Models.
- Invest in capacity which supports the delivery of the 4 SDS Options.
- Support for funding to enable review of all current Third Sector Grant Funding (across NHSH & HC budgets) and recommend future approach to include innovation funding grants.
- Reframing of Local Care Development Model funding to support Community Led Support Approaches and therefore scaling up of implementation of Local Care Models (existing funding agreed).

Shifting of Resources (Disinvestment)

- Use placed based commissioning processes to invest appropriately in the third sector services which support the delivery of impactful preventative services and increase our ability to deliver the 4 SDS Options.

What, Where and How Much

To be developed post strategy.

Year 1, 2, 3 Priorities

Year 1 (2026-2027)
- Sustain and review of third sector funding arrangements and development of a strategy policy on commissioning unregistered services
- Creation of small grant schemes and innovation fund arrangements.
- Support for multi-sustainable third sector and diversification of funding streams.

Year 2 (2027-2028)
- Implement outcome of third sector funding review.
- Review small grant schemes and innovation fund arrangements and adjust.
- Commencement of advocacy tender

Year 3 (2028-2029)
- Ongoing review of use of TEC and new technologies developing.

Longer Term

- Continue support for multi-sustainable third sector and diversification of funding streams.
- Extend conditions to enable providers to leverage in other funding.

Appendix 2:
Commissioning Strategy, Intentions and Plan Summary

Care Homes

	Strategy	Investment	Disinvestment	Priorities (Years 1–3)
Care Homes Complexity, Nursing	- Restructure delivery - Use sectors to their strengths - Focus on complexity - Family based alternatives	- Sustainable IS homes - Reprofile in house for complexity - Shared Lives	- Residential reliance - In-house mainstream beds - Unviable services - Overall bed numbers	- Define preferred models, locations and volumes - Initiate reprovision programme - Develop decommissioning framework - Sustained provider base > succession planning.

Supported Living at Home

	Strategy	Investment	Disinvestment	Priorities (Years 1–3)
Care at Home	- Rebalance delivery to IS - In house reposition to reablement - In house provider of last resort	- IS delivery footprint + tariff levels - In house reablement	- In house to move away from where IS can deliver	- Geographic delivery area plan for in house and IS - Appropriate IS rate and outcome based contract - Initiate procurement if required - Reposition in-house for reablement focus.
Support Services	- Promote independence and inclusion - Expand capacity to meet increasingly complex support at home needs - Reduce high-cost individual packages	- Community-based support - Shared packages - Shared Lives	- Isolated tenancies with 2:1 - Current overnight care models - High cost OOA placements	- Review high-cost packages - Standardise community support - Implement new funding models - Repatriation planning - Shared Care procurement
Day Care	- Re-orient toward independence - Community inclusion focus - Expand access to community based support - Diversify provision + empower choice	- Third-sector day care - Preventative community provision	- In-house mainstream day care - Underutilised services	- Review and agree future direction - Transition to new model - Reprofiled services in place

Community Based Supports

	Strategy	Investment	Disinvestment	Priorities (Years 1–3)
Highland Care Model	- Increase choice for care delivery Embed - Local Care Models and - Community Led Support (CLS) - Reduce Option 3 reliance	- CLS system change - Community hubs - Innovation funds	- Option 3 provision / reliance	- Develop consolidated approach to CLS ethos - Define implementation programme and pilot localities - Expand based on learning > full Highland rollout
Personal Assistants	- Increase choice for care delivery - Expand PA workforce	- Option 2 brokerage - PA development	- Option 3 provision / reliance	- Develop brokerage model and procure - Facilitate new market places. - Expand PA capacity.
Unpaid Carers	- Preventative, localised support, with equitable access, to reduce crisis interventions	- Local services - Respite - Carer wellbeing	- Centralised low-impact provision	- Design carers centre and respite framework - Tender and implement new services - Assure sustainable provision across remote/rural areas.
Technology Enabled Care	- Scale TEC to support independence and efficiency	- Successful tests of change.	- Replacement of traditional care hours.	- Complete pilots - Roll out TEC - Ongoing optimisation.
Third Sector / Prevention Promotion	- Prevention + early intervention - Align funding to outcomes - Support diversification of funding	- Community hubs / neighbourhood models - Innovation funds and small grants	- Rolling unfocused grant funding - Statutory sector reliance	- Review all funding: establish innovation model - Implement funding review - Sustain effective community provision - Funding diversification

Appendix 3:
Key Terms

Annual Financial Statement
The integration authority should draw links between its strategic plan and medium term financial plan, demonstrating how the financial resources available to it will be applied to achieve the outcomes set out in the strategic plan. Further detail on the content of medium term financial plans is available in the finance guidance. The integration authority must publish an annual financial statement upon publication of its first strategic plan and each year after that. The financial statement must set out the total resources that the integration authority intends to allocate under the provisions of the strategic plan.

Complexity
Adults with complex needs are defined as people needing a high level of support with many aspects of their daily life and relying on a range of health and social care services. This may be because of illness, disability, broader life circumstances or a combination of these[8]. The level of complexity does not relate to the care intervention per se but to the extent and range of response needed to support an individual safely and appropriately.

Joint Strategic Needs Assessment (JSNA)
The process of identifying the future health, care and wellbeing needs of the population in a particular area, and planning services to help meet those needs.

Market
The range of current and potential types of support, wider community opportunities and provider organisations, for supported people and commissioners to choose from.

Market Facilitation
The process by which strategic commissioners ensure there is sufficient, appropriate range of provision, available at the right price to meet needs and deliver effective outcomes[9]. Market facilitation is how public authorities stimulate a diverse, vibrant and sustainable market, so there are different types of support and provider organisations for supported people to choose from. Successful market facilitation and shaping relies on collaboration, commissioners need to work with people and providers to understand what's needed, so they can offer the services people need and want, now and in the future[10].

Market Facilitation Plan
A Market Facilitation Plan should be prepared to complement the strategic plan and support its delivery. A Market Facilitation Plan outlines the approach and provides detail on how integration authorities will engage with the existing and prospective market in order to work together with agencies to put the right services and support in place. Based on a shared understanding of need and demand, market facilitation is the process by which all partners ensure there is sufficient, appropriate range of provision to meet needs and deliver effective outcomes[11].

[8] https://www.nice.org.uk/guidance/ng216/documents/final-scope
[9] Public Bodies (Scotland) Act Strategic Commissioning Plans Guidance, Scottish Government, 2015
[10] CCPS Market Facilitation Guide CCPS_Collaborative_Commissioning-Reading_and_Resources.pdf
[11] Health and Social Care Integration: Strategic plans: statutory guidance 2024

Market Shaping
Collaboration with other relevant partners to facilitate the whole market in the area for care, support and related services. This includes services arranged and paid for by the Partnership itself, those services paid by through direct payments, and those services arranged and paid for by individuals from whatever sources (sometimes called 'self-funders'), and services paid for by a combination of these sources. Market shaping activity should stimulate a diverse range of appropriate high quality services (both in terms of the types, volumes and quality of services and the types of provider organisation), and ensure the market as a whole remains vibrant and sustainable.

Option 1 – Direct Payment
The supported person receives a direct payment. NHS Highland will decide how much money they will give to the supported person towards their support. The supported person receives this money and uses it to arrange their own support, which can include employing staff and/or buying goods and services. The supported person has full choice and control and also has the most responsibility for arranging support, which may include employer responsibilities

Option 2 – Individual Service Fund
The supported person decides on the support they want, and support is arranged on their behalf. NHS Highland will decide how much money they will give to the supported person towards their support. The supported person can use the money to choose goods and services, for example from a registered support or other approved provider, and then the support is arranged on their behalf. This can be arranged by NHS Highland or a third party (such as a support provider) managing the money on behalf of the supported person. This way, the supported person has full choice and control over how their support is arranged but does not have to manage the money.

Option 3 – Directly Provided Service
After discussion with the supported person, NHS Highland decides and arranges support. The local authority will decide how much money can be spent. The supported person asks the local authority to choose and arrange the support that it thinks is right for them. With this choice the supported person is not responsible for arranging support, and has less direct choice and control over how support is arranged.

Option 4 – Mix of Option 1, 2 and 3
The supported person uses a mixture of ways to arrange their care and support. Some people will want to have direct control of how some parts of their support is arranged but not other parts. Option 4 lets the supported person pick the parts they want to have direct control over and what parts they want to leave to the local authority.

Procurement
The process of buying goods, works and services from external suppliers. Commissioning provides the context for procurement and contracting to take place.

Procurement Plan
The document setting out how the strategic plan will be delivered, as it relates to procurement, with sufficient detail to direct those responsible for contracting services.

Strategic Commissioning
All the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place as, articulated in a Commissioning Strategy.

Strategic Plan
A document required of the 2014 Act, which sets out arrangements for carrying out integrated functions and outline how these will achieve, or contribute to achieving, the national health and wellbeing outcomes. Through determining needs and developing services to meet these needs, commissioning is a key process in achieving this objective and therefore strategic plans should draw upon output from the commissioning process. The strategic plan is to set out how the Partnership will commission and deliver services for its area over the medium term. Previously referred to as "Strategic Commissioning Plan" in earlier Scottish Government statutory guidance.

Workforce Plan
Workforce planning is a key element in delivering the ambitions set out in strategic plans. Therefore, integration authorities should also consider how workforce planning will enable delivery of its strategic plan. The workforce plan is therefore a document which sets out the actions and timescales required to support the future workforce in order to deliver the required services in Highland, and should also support a workforce strategy.

[12] Learning_Development_Framework.pdf
[13] Health and Social Care Integration: Strategic plans: statutory guidance 2024