The Highland Council

Agenda Item	**6**
Report No	**JMC/18/26**

Committee: **Joint Monitoring Committee**

Date: **03 December 2026**

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

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

1 Purpose/Executive Summary

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

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

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

2 Recommendations

2.1 Members are asked to:

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

3 Implications

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

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

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

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

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

4 Impacts

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

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

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

5 Background

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

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

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

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

6.1 Implementation of the Joint Strategic Plan continues through the Partnership's strategic planning, commissioning and transformation activity. The current focus is on refreshing the Plan to ensure that priorities remain aligned with the wider strategic and service context.

6.2 **Review of the Joint Strategic Plan**

Following agreement to undertake an interim refresh of the current Joint Strategic Plan, engagement activity has continued and feedback is now being incorporated into the first draft of the refreshed Plan. The draft will be considered by the Strategic Planning Group in January 2027, ahead of further development and engagement.

7 Performance

7.1 Key performance indicators across Adult Services detailed here continue to reflect a position of sustained demand exceeding available capacity with impact on flow and delay in hospital.

Positive progress is seen in reducing delay associated with care at home provision and the uptake of SDS Options 1 and 2 enabling greater choice in how people access support.

7.2 **Care at Home**

The Partnership's aim remains to reduce unmet assessed critical care needs to zero, but also recognising the pressure on hospital services from delays.

The following graph shows the number of people delayed in hospital and in the community who have been assessed with a care at home need.

Recent initiatives have contributed to a reduction in the number of people delayed in hospital awaiting Care at Home, with a new quarterly low achieved. This has, however, been accompanied by an increase in the number of people waiting for a service within the community.

Balancing pressure and risk across hospital and community settings remains challenging in the context of limited capacity and sustained demand. Medium-term approaches, including Discharge to Assess (D2A) and Community Led Support, are intended to help develop alternative models of support and strengthen community capacity.

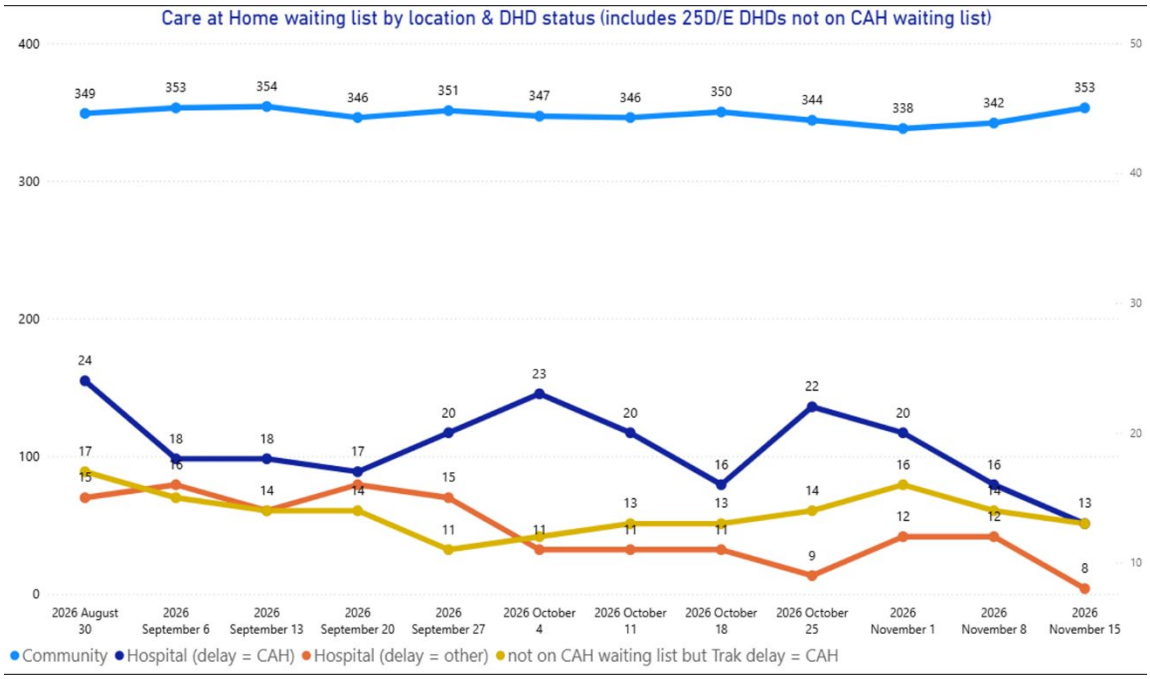


Figure 1: Care at Home Waiting List by location

7.3 **Care Homes**

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

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

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

Demand for placement is the most common reason for being delayed in hospital.

Highland care home providers continue to face significant operational challenges, and collaborative work is ongoing with providers to sustain services.

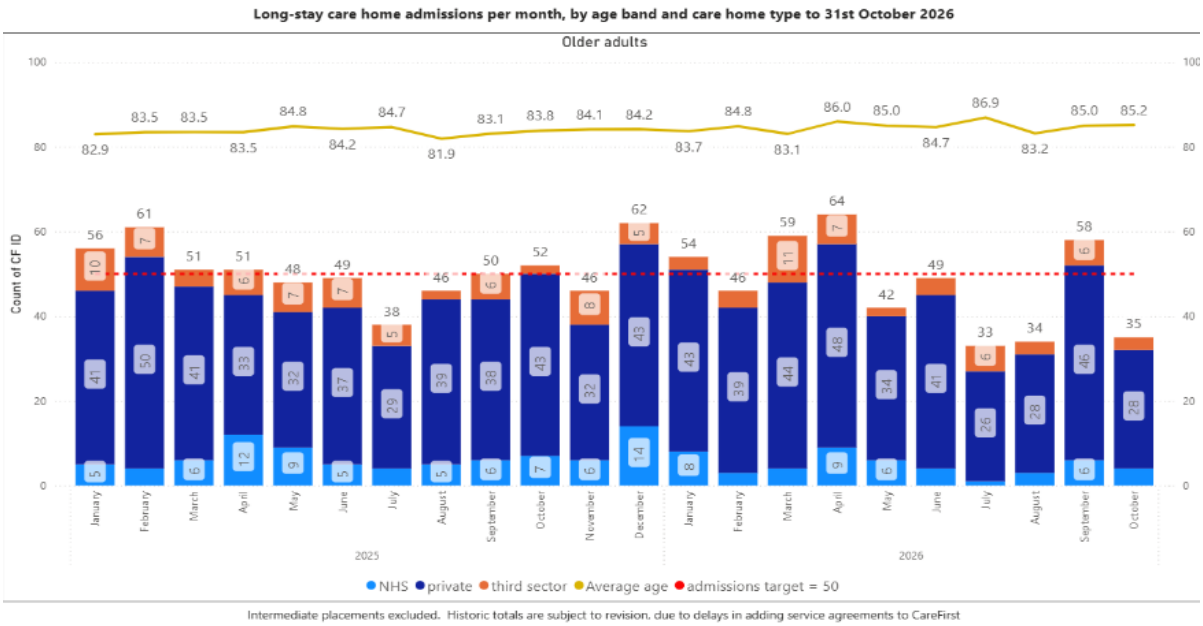


Figure 2: Number of Older Adult Placements per month

7.4 Delayed Hospital Discharges

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

Performance remains off trajectory and 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.

Sustained performance improvement remains dependent on increasing community capacity and strengthening pathways of support across the system. The completion of a focussed plan of action on elements of the Discharge without Delay Programme including embedding Discharge to Assess pathways in districts, establishing Home First principles and discharge pathways across the system has been completed in the immediate period prior to this report.

Testing and further refinement is expected through participation in the West Sub-national System Reset exercise during the first 2 weeks of December.

We are seeing some positive signs with recent work achieving a steady reduction in the Raigmore delays over time as shown by the green line in figure 3. Alongside this we now seeing a turn around to the number of bed days lost to delay from its ongoing rise and peak in September 2026 as shown in figure 4.

Figure 3: Number of patients delayed at Acute Hospitals.

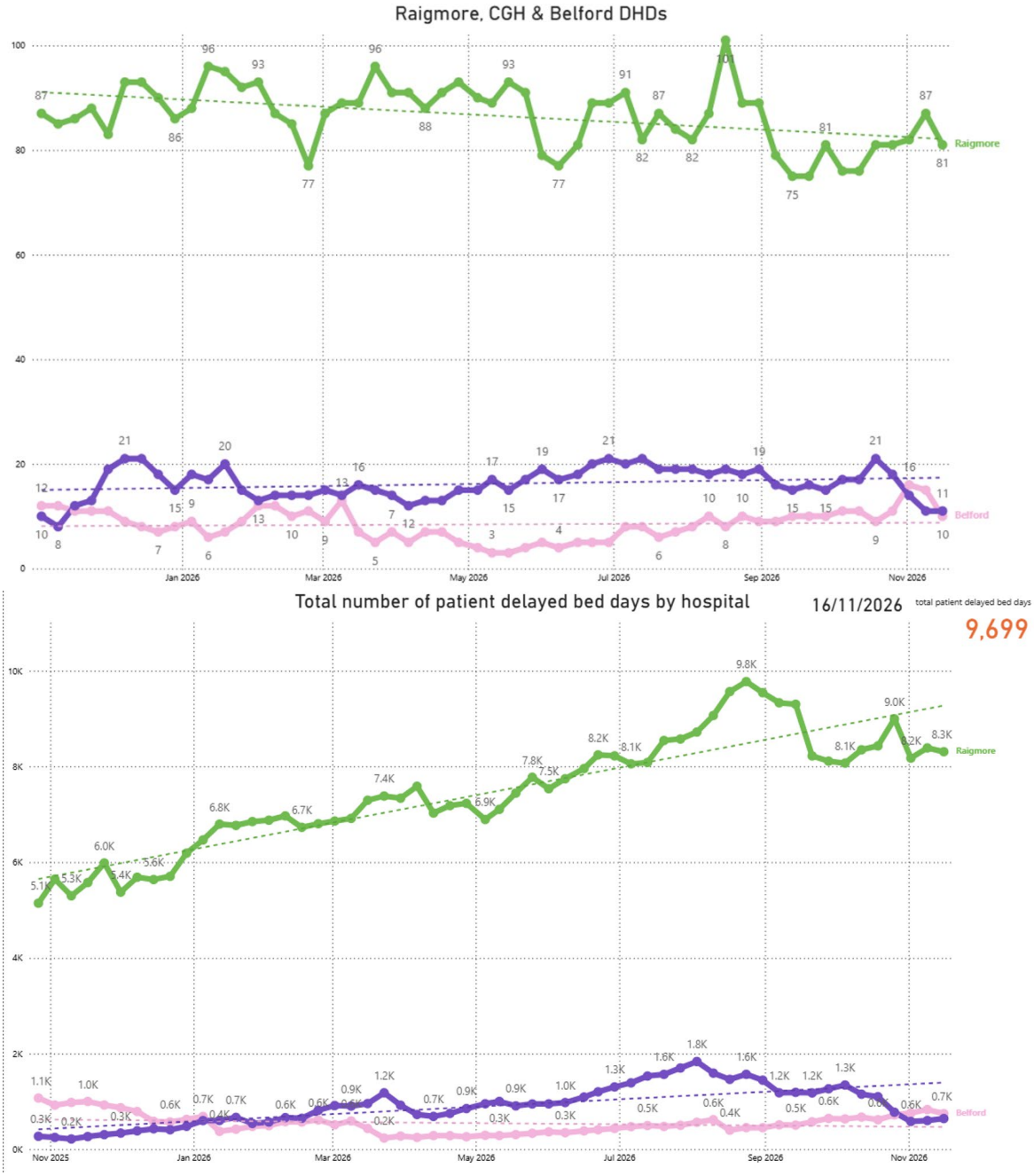


Figure 4 Total number of delayed bed days at acute hospitals

7.5 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.

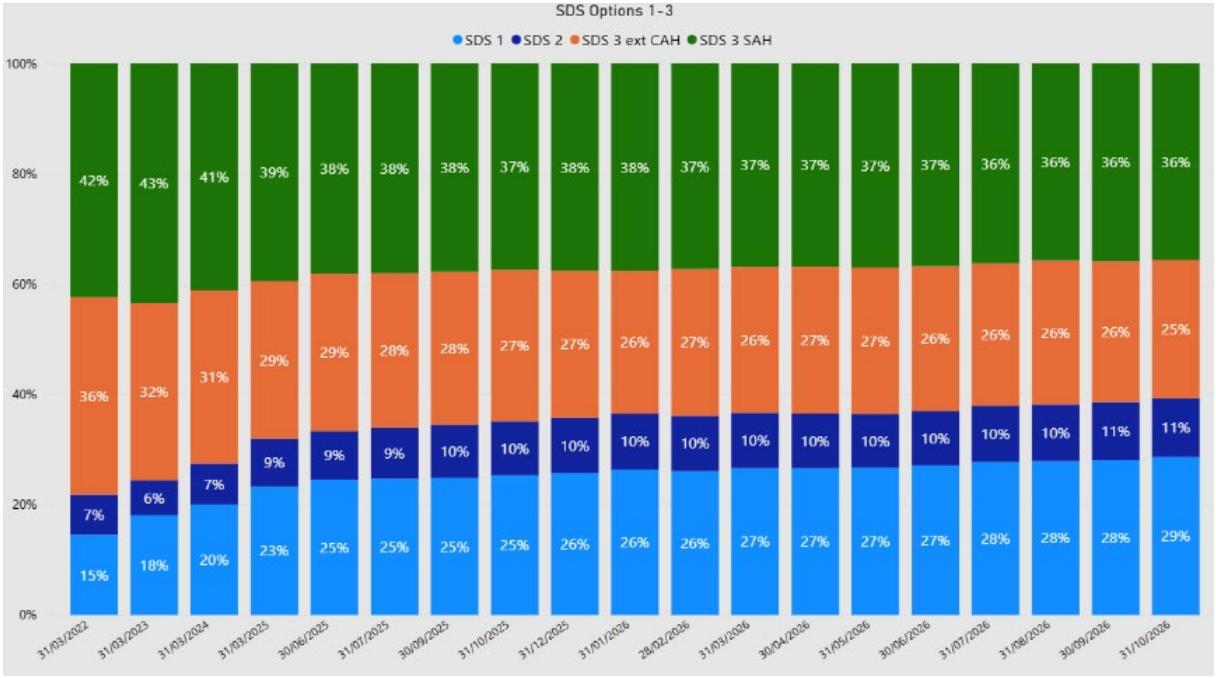
The current aims are to:

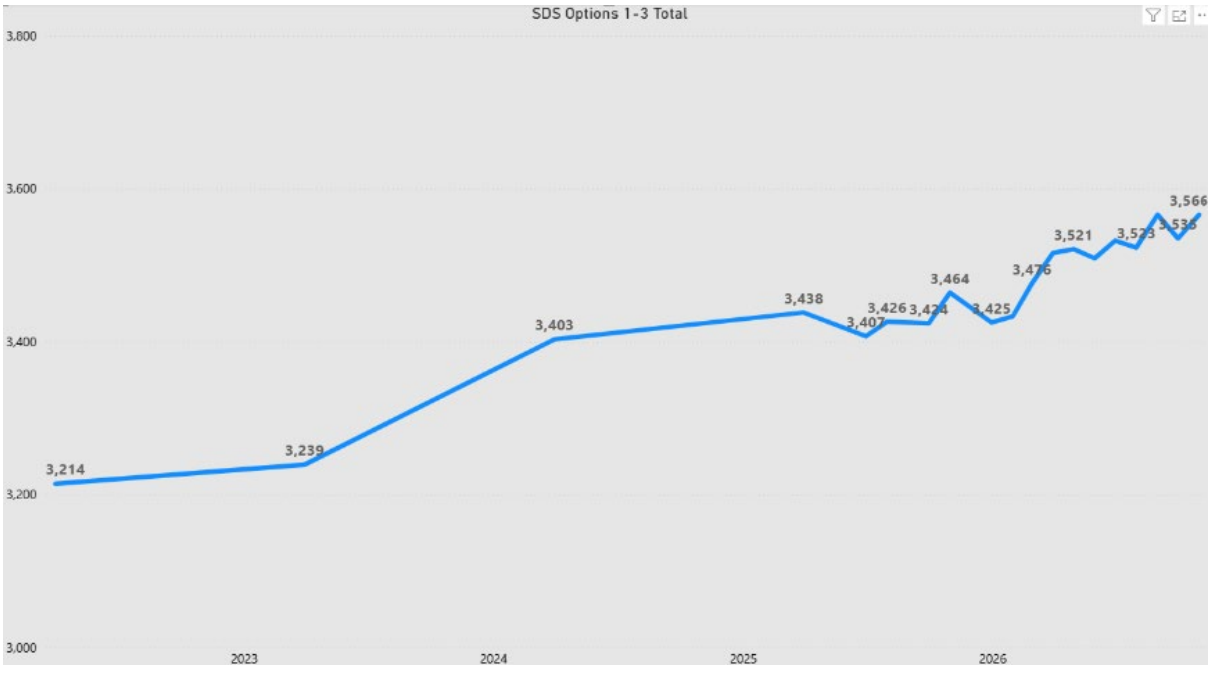
- Increase the proportion of people actively using SDS Option 1 (Direct Payments) to 30%;
- Increase the proportion of people actively using SDS Option 2 (Individual Service Funds) to 11%;
- Reduce the proportion of people supported through SDS Option 3 to 50%; and
- Maintain the overall number of people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

Performance data continues to demonstrate a positive trajectory against these objectives reflecting continued progress towards more personalised and flexible models of support and greater choice and control for people receiving services.

A key focus in transformation and commissioning plans is on enabling alternative support options and greater choice and control for people over how their support is delivered.

The bottom graph shows a slow increase in the overall number of people receiving support through SDS options 1-3 reflecting the challenge of high demand. A review of allocation processes is planned to support decision making and equity of access to support.





7.6 **Performance Position**

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.

Initiatives such as the new Commissioning Strategy, Community Led Support, Discharge without Delay approach and the System Reset offer opportunities for further medium-term improvement in performance.

7.7 **Adult Social Care Transformation Activity**

Adult Social Care transformation continues to focus on development of the Highland Care Model and the practical changes required to support more sustainable, community-based approaches to care and support. Work during this reporting period has focused on strengthening the transformation programme, progressing key areas of work and increasing engagement with communities, staff and partners.

Recruitment to the Programme Lead post has been completed, with recruitment to other programme posts now under way. Draft project mandates have also been developed to support clearer definition and progression of the programme workstreams.

Work with the National Development Team for Inclusion (NDTi) is now under way with communities and social work teams to explore different ways of working and support development of Community Led Support across Highland. This forms an important part of the developing Highland Care Model, with a focus on strengthening community-based approaches and the relationship between communities and statutory services. Work is also under way to develop proposals for the use of Carers Funding to support further development of community-based support.

The Adult Social Care Commissioning Strategy 2026–2029 has now been completed and provides the strategic framework for future commissioning, market development and service redesign across Highland.
The Highland Adult Social Care Conference, *Developing the Highland Care Model: Conversations about the Future of Adult Social Care in Highland*, takes place on 25 November 2026. The conference will bring together people with lived experience, unpaid carers, staff, providers, communities and partners to inform the next phase of development of the Highland Care Model. This will be followed by a programme of locality-based engagement during 2027, with initial planning for these events now under way.

These developments reflect continued progress in establishing the programme and creating the capacity to take forward the next phase of work. Further development of the programme, alongside the ongoing work with communities, social work teams and partners, will continue to inform the emerging Highland Care Model.

7.8 **Power of Attorney Campaign**

The joint NHS Highland and Highland Council Power of Attorney awareness campaign was delivered throughout June 2026, encouraging people across Highland to understand the importance of putting a Power of Attorney in place before illness, injury or loss of capacity makes this more difficult.

An evaluation of the campaign has now been completed and demonstrates positive reach and engagement. The campaign reached approximately 126,000 people across social media, exceeding the target of 100,000, and generated 488 new followers against a target of 400. The dedicated Power of Attorney webpage attracted approximately 2,100 users and 2,500 page views.

The evaluation also identified useful learning for future joint awareness activity, including the effectiveness of real-life stories and case studies and the value of a coordinated approach across NHS Highland and Highland Council communication channels.

The campaign and evaluation have been considered through the Joint Officer Group, supporting continued joint discussion on Power of Attorney and wider public awareness.

Designation:	Chief Officer, Highland HSCP
Date:	13 November 2026
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Background Papers:	None
Appendices:	None