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MINUTE of HIGHLAND HEALTH AND SOCIAL CARE COMMITTEE Virtual Meeting Format (Microsoft Teams)	**04 March 2026 13.00 pm**

Present

Cllr. Christopher Birt, Highland Council
Thomas Brown, Lead Doctor (GP)
Louise Bussell, Nurse Director
Claire Copeland, Medical Lead
Cllr. David Fraser, Highland Council
Arlene Johnstone, Chief Officer, Highland Health and Social Care Partnership (HHSCP)
Fiona Malcolm, Highland Council
Joanne McCoy, Non-Executive
Moira Miller, Staff side representative
Gerard O'Brien, Vice Board Chair (Committee Chair)
Kaye Oliver, Staff side representative
Janice Preston, Non-Executive Director
Allyson Turnbull-Jukes, Area Clinical Forum
Elaine Ward, Deputy Director of Finance
Dr Neil Wright, Non-Executive

In Attendance

Natalie Booth, Senior Corporate Administrator
Christopher Arnold, Senior Operations Manager NHS Highland HHSCP
Michelle Kier, Carers Services Development Officer
Michelle Johnstone, Interim Head of Service
Jack Libby, Highland Council
Ian Thomson, Head of Service: Quality Assurance; Adult Social Care
Dominic Watson, Head of Corporate Governance
Ruth MacDonald, Interim Deputy Director, Adult Social Work

Apologies: Phillip MacRae, Fiona Duncan, Jennifer Davies, Paul Chapman, Julie Gilmore, and Helen Eunson.

1.1 Welcome and Apologies for absence

The meeting opened at 13.00 pm, and the Chair welcomed the attendees. The meeting was quorate.

1.2 Declarations of Interest

There were no declarations of interest.

1.3 Minutes of Previous Meetings and Action Plan

The Committee approved the minutes of meeting of 14 January 2026 and noted the action plan and work plan.

It was noted that anticipatory care plans and emergency care records across North Highland would be included in the May 2026 meeting Chief Officer Report. It was also highlighted that upcoming development-session activity would include work on risk-register mitigations and assurance processes, with a planned discussion to determine whether interim feedback could be provided ahead of the next annual cycle.

1.4 Matters Arising

There were no matters arising from last meeting discussed.

2. Finance

2.1 Finance Report – Month 9 2025/2026

The Head of Finance for the HSCP advised that NHS Highland had submitted a financial plan to the Scottish Government for the 2025/2026 in March 2025. The financial plan submitted to Scottish Government (SG) in March 2025 was not accepted and they indicated that a resubmission was necessary. A revised plan was submitted in June 2025 and accepted by SG detailing a net financial deficit of £40.005 million. The Board had continued working with SG to improve the financial position.

At the end of December 2025 (Month 9), an overspend of £45.246 million had been reported, with projections indicating this could increase to £50.043 million by the end of the financial year. A breakeven forecast position could not be achieved in ASC, which showed an overspend of £25.792 million, with this being partly offset by £10 million of additional Scottish Government funding. Within the Highland Health & Social Care Partnership, a year-to-date overspend of £25.675 million had been reported, with forecasts suggesting this could rise to £29.649 million by year-end. This projected overspend included £25.792 million relating to ASC, which the Board had assumed would be brought into financial balance by the end of the financial year.

Further detail was provided in relation to North Highland Communities; Adult Social Care; Mental Health Services; Primary Care; Value & Efficiency; and Supplementary Staffing.

During discussion, the following points were raised:

- Progress on HSCP Savings Delivery. Members noted that plans against the £7 million savings target totalled just under £6 million, risk-adjusted to just under £5 million, leaving a gap of just over £2 million. Early movement was also being seen across ASC cost-containment work, although delivery remained below target.
- Adult Social Care Savings Gap. It was highlighted that ASC savings plans remained significantly short of the £6 million target, with current delivery around £2.5 million. Workstreams were beginning to show some stabilisation in ASC costs, but further grip and control were required.
- Planning for 2026–27. The committee discussed delays in implementation contributing to the savings gap. Work to bring forward project initiation documents for 2026–27 was underway to ensure earlier programme mobilisation next year.
- Financial Reporting Requirements. Members requested clearer reporting of actual savings achieved to date, including histogram formats and consistent presentation of community out-turns to support understanding of financial variation across districts.
- Supplementary Staffing Pressures. Discussion highlighted the significant impact of supplementary staffing within ASC. A short-life working group was reviewing shift patterns, recruitment, remote and rural challenges and learning from settings with lower agency use.
- Variation Across Districts. It was confirmed that differences in community overspends were primarily driven by ASC demand and the balance between in-house and outsourced provision. A full review of district structures was planned to ensure resources align with population need.
- Safe Staffing and Budget Impact. Questions were raised about whether current budgets fully reflected statutory safe staffing requirements across ASC. Assurance was given that establishments were based on the latest available tools, though vacancies continued to affect service delivery.
- Service Sustainability and External Pressures. Members emphasised concerns about financial pressures moving into the next year, including risks linked to fuel costs, care-at-home capacity and maintaining partnership work with the third sector.

The Committee is **discussed** and **noted** the Highland HSCP financial position at month 9 and associated mitigating actions and accept **limited** assurance.

Performance and Service Delivery

3.1 Integrated Performance and Quality Report

The Senior Operations Manager, HHSCP highlighted ongoing work to update the IPQR, including refining KPIs, introducing local targets where no national target exists, and improving consistency across reporting. The executive summary showed a mix of red, amber and green ratings, reflecting varied performance and differing reporting timeframes. It was noted that further refinement of self-directed support measures was underway, with plans to move to percentage-based indicators. Updates were provided on care homes, care at home and delayed hospital discharges, with continued work to improve flow, reduce delays and support delivery against strategic aims.

During discussion, the following points were raised:

- IPQR Improvements and System Pressure. Members noted ongoing work to refine KPIs and reporting, alongside continued operational pressures linked to high delayed discharge numbers and the early activity of the newly appointed interface manager.
- Impact on Community Hospitals. The committee discussed the significant effect of delays on community hospitals, recognising variation in models, capacity and pathways, and the need for clearer understanding of how blockages limit flow and service delivery.
- Future Strategic Work. It was highlighted that a community hospital strategy was in development, with further work planned to improve pathways, reduce variation and provide the committee with clearer system-wide insight.
- Delayed Discharge Interpretation. Members noted that delays recorded in community hospitals include delays accumulated in acute sites, which can distort the picture for community hospitals but provides a full-system view of patient delay.
- Variation in Care at Home Provision. Discussion highlighted regional differences in external versus in-house care-at-home delivery, with questions raised about provider patterns, demographic demand and whether learning could be taken from variation across areas.
- Local Context and Planning. It was emphasised that community needs, GP practice models and demographic factors differ significantly across Highland, reinforcing that a single model would not suit all areas and that future development sessions should explore this in more depth.
- Need and System Backlog. Members noted that rising numbers of patients added to delayed discharge figures mirrored those discharged, suggesting potential unmet need or a hidden backlog within the system. It was recognised that further analysis would be required to understand whether this represented delayed presentation or underlying demand that had not yet surfaced, with agreement that this should be explored in a future development session.

Following the discussion, the Committee:

- **Considered** the progress made with the development of KPIs across the HSCP to be managed within a performance framework.
- Accepted **limited** assurance and **noted** the continued and sustained stressors facing both NHS and commissioned care services.
- **Considered** further indicators that are required to support the assurance for the Highland Health and Social Care Partnership.

3.2 SDS Assurance Report 25/26

The Head of Service for the Social Work Service, HHSCP outlined progress on self-directed support, noting sustained growth in direct payments and continued work to strengthen the infrastructure that supports individuals and personal assistants. Updates were provided on the streamlining of business processes, resilience measures introduced following recent technical issues with the direct payment card system, and ongoing work to improve access to Option 2. It was highlighted that policy and procedure refresh was being co-produced with people receiving SDS and that Highland continued to contribute nationally to SDS development. Moderate assurance was offered due to ongoing challenges, including reclaims and areas requiring further improvement.

During discussion, the following points were raised:

- Workforce Availability Risk. Members noted that workforce availability remained a long-standing high risk and sought clearer information on mitigation plans, expected timelines, progress milestones and when these actions were likely to reduce the overall risk level.
- Adult Social Care Financial Risk. Similar requests were made for transparency on Adult Social Care financial containment and transformational plans, with members asking when these actions would realistically influence the financial risk rating.
- CareFirst System Replacement. Concerns were raised about the Highland Council led CareFirst replacement, with members seeking assurance that the new system would interface effectively with NHS systems and support reporting, commissioning and data needs across services.
- Use and Purpose of the Risk Register. The Chief Officer noted that the register aimed to provide assurance on identified risks and mitigations rather than detailed operational updates and advised that broader operational information might be more appropriate for future Chief Officer reports or development sessions.
- Clarity of Mitigations and Tracking Progress. Members reported difficulty linking risks to their associated mitigations and asked for clearer presentation and regular updates to support monitoring of progress and impact.
- System Wide Workforce Impact. It was recognised that workforce shortages underpinned and influenced multiple risks across the HSCP, and members stressed the need for redesign and efficiency rather than assumptions about new staffing availability, given the demographic challenges facing the Highlands.
- Enhanced Service Risks. Concerns were raised regarding risks linked to the diabetes enhanced service, and assurance was provided that the issue was captured on the appropriate risk register and scheduled for discussion at a forthcoming committee.
- Future Development Session. The committee agreed that a development session on the practical use of the risk register, mitigations and assurance processes would be beneficial, and confirmed that no risks required further escalation at this stage.

The Committee **considered** the report and accepted **moderate** assurance.

3.4 Highland Care Model Update

The Committee Chair advised that the Highland Care Model Update would be taken ahead of item 3.3.

The Head of Service: Quality Assurance; Adult Social Care presented an update on the Highland Care Model. He emphasised the committee's shared focus on intentionality and outlined how the transformation programme aims to embed the ethos of self-directed support at local level. He explained that the programme seeks to shift practice toward outcome-focused and relationship-based conversations with professionals working more visibly in communities to understand what people need and shape flexible person-centred responses. Work was underway to broaden the range of support across the four SDS options through stronger personal assistant networks, brokerage and self-employed PA models and through support for community-led and social enterprise solutions where traditional services are limited.

He highlighted the importance of local intelligence, community capacity and grassroots engagement and noted examples where communities were already complementing formal care. A transformational fund would support locally designed initiatives with early work beginning in areas such as Sutherland. The update reinforced that this approach aims to link community assets, SDS options and formal services to build sustainable locally rooted support models with strong national links and growing momentum despite ongoing challenges.

During discussion, the following points were raised:

- Regulation and Role Clarity. Members discussed the challenge of balancing regulated practice with growing community-based support and noted the need for a clearer framework setting out what must be delivered by regulated staff and what could be provided through wider community roles.
- Scope of Social Care. It was highlighted that social care covered a wide range of activity from personal care to broader community support. Members agreed that clearer boundaries were needed to prevent informal helpers from carrying out tasks that required regulation.
- Community-Led Support Framework. Assurance was given that work with the National Development Team for Inclusion would help define responsibilities within community-led models and support more intentional use of SDS options in local pathways.
- Sustainability of Self-Employed PAs. Concerns were raised about the viability of self-employment for personal assistants due to costs, insurance and training. Members noted that although flexibility suited some individuals, the model had to be practical and supported.

- Growing Local Care Capacity. Early evidence suggested that self-employed carers experienced positive wellbeing outcomes. Members recognised the potential for local care capacity to grow in remote areas but noted that further clarity and development work were still required.
- Differences in Care Roles and Context. Members observed that private household care differed from delivering support across rural communities and stressed the need to recognise varied working conditions and expectations.
- Range of Care Options and Supply. It was noted that self-employed PAs worked well for some people and could combine SDS-funded and private work. Members emphasised the importance of maintaining a diverse mix of support options rather than relying on one model.
- Intentional Conversations and Local Understanding. The discussion highlighted that clear conversations about what individuals needed were essential, as interpretations of "care at home" differed and flexible local responses were required.
- Sustainability and Use of Transformation Funding. Members asked whether transformation funding would support initiatives to a point where they could operate without recurring cost. It was confirmed that projects had to show long-term value, financial impact or the potential to become self-sustaining.
- Preventative Use of SDS. The committee explored whether SDS could support prevention as well as crisis response. It was noted that while eligibility thresholds applied, Options 1 and 2 could help build community support structures that contributed indirectly to prevention.
- Governance and Accountability. Clarification was sought on oversight of SDS budgets when individuals employed personal assistants. Assurance was if Option 1 and 2 arrangements were set out in legislation and subject to review to ensure needs and outcomes were being met, with further support planned for PA employers and self-employed PAs.

Following discussion, the Committee **noted** the content of the report and agreed to take **moderate** assurance.

The Committee took a break from 14.53 pm until 15.00 pm.

3.3 Carers Strategy Update

The Carers Services Development Officer outlined progress in delivering the Carer Strategy and noted six new services that strengthened support for unpaid carers across Highland. She described growing recognition of carers within NHS Highland and confirmed that carers were now included in updated equality impact assessments. Work continued in hospitals to improve carer identification and involvement in discharge planning. She also highlighted the development of dynamic digital adult carer support plans with Mobilise which would allow carers to complete assessments at any time and early feedback had been positive. Applications to the Carers Wellbeing Fund had decreased, likely due to increased short break funding for carer centres. New community projects such as Care to Connect in Lochaber had been well received, and work was underway to understand carer demographics and support carers linked to unmet-need cases. Priorities for 2026–27 included improving identification in primary and community care, expanding staff training on carer support and increasing access to meaningful breaks.

During discussion, the following points were raised:

- Commitment to Increasing the use of the Engagement Hub. The partnership confirmed its intention to embed the Engagement Hub more fully into everyday practice, ensuring it became a routine and integrated part of engagement activity rather than a standalone process.
- Growth in Engagement and Remaining Limitations. Members recognised progress made through the Hub but noted that overall engagement numbers remained low when compared with the population size, particularly in relation to protected and vulnerable groups.
- Future Representation and Recruitment. Concerns were raised about how representation from vulnerable groups would be secured, with members asking whether future recruitment could be subdivided by topic or need to ensure relevant voices were captured.
- Budget and Resource Constraints. It was highlighted that engagement ambitions were constrained by the limited budget, raising concerns about the Hub's capacity to support meaningful growth and transformation.
- Quality and Nature of Engagement. Members observed that much of the current activity remained consultative rather than collaborative and discussed the need to align future work more clearly with recognised engagement frameworks such as Arnstein's Ladder and the NHS engagement matrix.
- Short-Life Working Group and Wider Collaboration. Assurance was given that a short life working group was being established to strengthen engagement culture, improve structures, and make better use of existing mechanisms such as Community Planning Partnerships and patient experience workstreams.

- Staff Skills, Confidence and Cultural Change. It was noted that staff confidence in undertaking engagement varied, and members recognised the importance of shifting organisational culture so that engagement became embedded, supported and valued across services.
- Reporting Frequency. The committee reflected on the early-stage development, data limitations and resource pressures, and requested a further update later in the year once progress from the short life working group was available.

Following the discussion, the Committee **noted** and took **moderate** assurance on the overview provided in respect of services and support provided to Unpaid Carers in line with the Carers (Scotland) Act 2016 and the Carers Strategy 2025-2028.

3.5 Community Services Report

The Head of Community Services outlined the wide range of services delivered across nine districts and highlighted pressures on social work teams due to rising referrals, high caseloads and workforce gaps. She confirmed that statutory duties continued to be met through strengthened governance, professional supervision and mutual aid, noting increased adults with incapacity and work with partners to promote power of attorney to reduce hospital delays.

She reported progress with the rollout of Morse to community services to improve data collection and reduce duplication, although some delays had occurred due to equipment and training. She also described advancement of the Pan Highland frailty programme, including early identification using the Rockwood Clinical Frailty Scale, district frailty workshops, high completion of frailty training and development of district frailty action plans.

She highlighted ongoing digital enablement work to support sharing of frailty assessments across community, acute and Scottish Ambulance Service settings and confirmed continued collaboration with acute teams on frailty at the front door and the frailty unit. Priorities included strengthening early intervention, improving information sharing and supporting preventative approaches that maintain independence.

During discussion, the following points were raised:

- Focus for Future Deep Dives. Members welcomed the overview of community services and agreed that frailty and digital enablement were priority areas that required more dedicated discussion at a future development session.
- Third-Sector Involvement in Frailty Workshops. Members asked whether partners and community organisations were included in district-level frailty workshops. It was confirmed that partners had participated where possible, though release time for third-sector staff had been challenging.
- Rising Guardianship and Power of Attorney Cases. Concerns were raised about the continued growth in guardianship, powers of attorney and adults with incapacity, with members noting slow national processing times and increasing local demand. Work was underway to strengthen communication on early power of attorney and to engage with the Office of the Public Guardian.
- Assurance on Statutory Responsibilities. Members received assurance that legislation relating to adults with incapacity was applied appropriately and that welfare guardianship cases continued to be supervised by qualified staff despite the scale of demand.
- Impact of Integration Changes. Members sought reassurance that current investment and work within social care would remain relevant after integration changes. Assurance was given that delivery responsibilities for health and social care would remain with the partnership regardless of future governance arrangements.

Following discussion, the Committee **noted** the report and accepted **moderate** assurance.

3.6 Chief Officer's Report

The Chief Officer highlighted Audit Scotland data showing that Highland benchmarks well in adult social care delivery nationally, though delays remain a significant outlier requiring continued focus. She confirmed ongoing negotiations on the vaccination hybrid model, with preparatory governance and workstreams progressing, and outlined the submission of the HMP Highland business case based on the model that best meets operational needs. She also updated members on the strategic commissioning plan, North Coast redesign review, and actions being taken to address operational pressures and improve flow, noting positive progress through strengthened interface working.

During discussion, the following points were raised:

- Appointment of Psychiatrist in Caithness. Members welcomed confirmation that a psychiatrist had been successfully appointed in Caithness for the first time in seven years, with a definite start date expected.
- Hospital at Home and Governance. Clarification was sought on Hospital at Home outcomes and oversight, with assurance that reporting would go through clinical governance, though progress had been slower than hoped and further acceleration work was under way.
- Vaccination Hybrid Model. Members requested an update on wider provider involvement in the vaccination hybrid model. It was confirmed that in-house vaccinators remained active and that future design would balance GP participation with broader place-based delivery, noting ongoing negotiations and interdependent decisions.
- North Coast Redesign Engagement. Assurance was sought regarding community involvement in the refreshed service model. Members were advised that regular engagement meetings continued, the workforce plan was being reviewed, and communities would be fully involved as the new programme board begins its work.

Following discussion, the Committee **noted** the Chief Officers Report and agreed nothing needed escalating the Board.

4. Committee Function and Administration

4.1 Committee Workplan 2026-2027

The Committee **approved** the Workplan for 2026-2027.

4.2 Committee Annual Report 2025-2026

The Committee approved the Annual Report for submission to the Audit Committee.

5. Any Other Competent Business

6. Date of next meeting – Wednesday 6 May 2026 at 1pm

The meeting closed at 16.01 pm.